How doctors in senior leadership roles establish and maintain a positive patient-centred culture

Research Report for the General Medical Council

Dr Suzanne Shale

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EXECUTIVE SUMMARY

The GMC commissioned this research to understand how doctors in senior leadership roles approach the goal of sustaining and building positive workplace cultures in which patients experience safe, high quality care. Published research evidence, informed commentary and practice wisdom all suggest there is an association between constructive working cultures, and the achievement of measurably better outcomes for patients. Consequently, current frameworks for health care leadership in the UK[1] and elsewhere urge attentiveness to the need to promote patient centred, cohesive, supportive, collaborative and inclusive cultures.

However, there is only a limited evidence base describing the day to day challenges experienced by senior medical leaders in working to achieve positive patient centred cultures. This study therefore sought to capture senior medical leaders' perspectives on the components of positive cultures, and convey to readers their 'lived experience' of attempting to nurture positive cultures in a wide range of health care structures and organisations.

Research themes

This study was framed around four overarching research themes.

- How do senior medical leaders themselves conceptualise a positive culture, and their role in promoting it?
- How do senior medical leaders identify the presence or absence of a positive culture?
- How have senior medical leaders approached the task of building or sustaining a positive culture, and what resources and methods have proved helpful to them?
- How far do senior medical leaders' approaches to thinking about culture, and building supportive cultures, appear to cohere with behaviours being promoted by commentators and system leaders?

While there has been extensive research into health care cultures and leadership, the questions set out above remained unanswered. However, evidence on the association between health care cultures and patient outcomes, findings from research into medical leadership, and studies of high performing health organisations, all provide an important backdrop to this study. That literature is summarised in the full report.

How the research was done

In depth interviews were used to explore the perspectives and experiences of senior medical leaders. Twenty-seven interviews were carried out during 2018 specifically for this project. About one third of participants were women and about one fifth were from BAME groups. The project has also drawn on material from an earlier study of medical directors' perceptions of moral dimensions of leadership completed by the same researcher in 2011. That study consisted of twenty four participants. One fifth were women but none were from BAME groups, reflecting the low proportion of BAME doctors in medical director roles a decade ago.

Senior medical leaders were recruited from a wide range of roles and organisations:

- NHS England mental health trusts, teaching hospitals, district general hospitals.
- NHS England, Health Education England, NHS Improvement
- NHS Scotland

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[1] https://improvement.nhs.uk/resources/developing-people-improving-care/

- Independent hospital groups

The range of participants' roles included:

- Medical Director, Assistant or Associate Medical Director, Divisional leader.
- Consultants with additional significant leadership responsibilities, such as leading and creating specialist care networks.
- GPs who also hold commissioning and educational roles.
- Recent past Presidents of medical Royal Colleges.
- Chief Executive, Non Executive Director (medically qualified).

Key findings

How do senior medical leaders themselves conceptualise a 'positive culture'?

The notion of 'positive culture' in health care settings invokes complex and varied understandings and ideals among senior doctors. Eliciting medical leaders' views on culture demonstrated very clearly that health care is not a single culture. Rather, it is a shifting constellation of intersecting influences and subcultures that challenge, influence, and inform leaders' choices.

Leaders drew on a wide range of reference points to express their conceptions of culture, which were often implicit and embedded within other concepts and ideals. Some conceptions are apparent as 'background conceptions' (ideas which may not always be at the forefront of leaders' day to day thinking but shape their expectations and values); and others as 'role derived conceptions' (which come more to the fore in leaders' day to day thinking because they are elicited by leadership activity).

'Background conceptions' include:

a) Philosophies of care. There are deeply held views on what constitutes good medicine, and therefore what constitutes a good care culture. These perspectives are a cherished element of leaders' professional and personal identities. For example some doctors prize relational care principles highly, prioritising therapeutic relationships with patients and families; others foreground technical clinical excellence and prioritise knowledge, technique and research. Leaders' priorities affect their choices and choices of those around them.

b) Specialty cultures and other specialist knowledges. These cultures inculcate powerful normative expectations. Assessments of culture are coloured by the professional cultures of specialties, for example the extent to which they promote and advance inter-professional working. As medical leaders advance in their specialty or within medical management roles they frequently also acquire additional subject knowledges, such as medical educational knowledge, which in turn elicits attentiveness to aspects of culture such as approaches to training.

c) A sense that generational changes in medical culture, including a more diverse workforce, contributes to shaping new norms. Leaders recognised that different groups have varying needs of work cultures, such as working arrangements that accommodate family obligations, and respect ethnic and cultural differences.

d) Experience in other sectors. Some have experienced approaches to leadership in other sectors, notably the armed services, which prioritise particular aspects of culture such as teamwork.

'Role-derived' conceptions of culture are based in:

e) Specific settings and activities. Different types of care call forth different care cultures and different needs for leadership. For instance, network models of specialist care have to develop working cultures that transcend geographical and organisational boundaries, standardise treatment, and bind together a large and disparate group of clinicians who may rarely meet face to face. A GP partnership faces different challenges, stemming from being a small group of relatively independent decision makers.

f) Specific responsibilities. Leaders responsible for managing performance, revalidation, job planning etc. will be dealing directly with specific aspects of culture. Other special roles, like providing interventions for teams in difficulty, foreground specific types of culture work such as enabling other leaders to manage negative behaviour.

g) Continuing professional development and experience. Medical leaders alter their thinking about culture as they gain leadership experience. They may come to focus more on the need to attend to culture in order to achieve clinical goals.

Senior medical leaders possess rich and diverse views on what medical cultures look like, how medical cultures work in practice, and the structural pressures that may require them to change. Although they may only rarely articulate these views, they contribute to shaping their immediate actions and their plans for the future. Engaging medical leaders in considering their role in building a positive culture invokes complex and diverse ideas in response.

How do senior medical leaders identify the presence or absence of a positive culture?

> *"When you spend some more time, you will know it...It's not just the smiling staff who greet you when you walk in. It takes a bit longer to get to know the team. A dysfunctional team, when they're faced with challenges, it brings out all the issues within the team…A team with a better culture…put aside some of the differences, or they might even use some of the differences in a positive way to focus on what is the task, the patient care...You would still have the conflict, you would still have the problem but the team will trust in each other that actually they are working for a greater cause."*

Leaders have access to a great deal of hard and soft data that can give an indication of the quality of cultures in organisations. There is no shortage of information. Rather, the challenges they face are to make sense out of all of the disparate sources, to manage their own and their colleagues' cognitive and emotional responses to unwelcome information, and to find ways of changing undesirable situations once they have been identified.

Participants referred to a wide range of organisational indicators - such as serious incident rates, staff grievance data, appraisal compliance, staff surveys and safety climate questionnaires – to provide either proxy or direct measures of their organisation's culture and subcultures. They also described using 'soft' signals. These served as rough and ready assessments, an alert to problems, or provided a narrative around quantitative data to aid interpretation.

These soft signals are summarised in the table that appears below (next page). The table is a summary of soft signals that came to the fore in interviews, and should not be viewed as a comprehensive overview of the characteristics of negative and positive cultures. Fuller descriptions are provided in the research report.

Signal type	Positive signs	Negative signs
Appearances	• Environment welcoming, clean & well kempt, tidy • Visible signs (e.g. notice boards) of feedback being acted on and of ongoing improvement activity • Patients engaged, positive, active where possible • Observable staff attitudes, including responsiveness, 'can do' attitude, attention to detail	• Environment unwelcoming, tatty, unkempt, untidy • No visible sign of interest in getting and acting on feedback or of improvement work • Patients not engaged, passive, discouraged • Cynicism, 'don't care' attitude, staff have let things go
Patient experience and needs	• Genuine attentiveness to patient voice and experience as part of clinical excellence • Low level of patient dissatisfaction • Focusing on patient needs helps discourage or resolve professional conflicts	• Lack of interest in patient experience, focus on purely technical clinical outcomes • High level of patient dissatisfaction • Professional conflicts are taking priority and displacing focus on patient needs
Attitude to organisational routines	• Examples include good handovers, willingness to standardise, flexibility • Cooperation	• Lax implementation of protocols such as surgical checklists, resist standardisation, inflexibility • Resistance
Attitudes towards information	• Performance data are welcomed, discussed and viewed as an opportunity for learning	• Performance data are viewed defensively, resisted, dismissed, or selectively analysed
Emotional tone	• Doctors are appropriately managing their own emotions resulting in calm atmosphere and thoughtful decisions • Professionals have sufficient capacity to show compassion towards one another, and take opportunities to interact informally • High morale supports discretionary effort • Appropriate humour supports team functioning	• Doctors' own fear, anxieties or other negative emotions are eliciting these in others and inhibiting team working and decision making • Professionals feel unable to care for each other (possibly owing to stress or burnout) and tend to avoid informal interpersonal contact • Low morale and staff feeling they can't be bothered • Loss of sense of ease & humour in team
Interpersonal interactions	• Supportive approach to trainees and training which results in feelings of security and belonging • Mutually respectful and supportive interprofessional relationships • Willingness to bridge the gap between clinical and managerial language and goals • Civil working relationships even when under pressure, commitment to collective problem solving	• Department not supporting and coaching trainees commensurate with trainee level and experience • Lack of respect for expertise of other health professionals besides doctors • Mutual disdain between doctors and managers and unwillingness to see the others point of view • Uncivil working relationships, belief in blaming and shaming to manage care delivery problems

Participant insights also suggested a typology of notable subcultures with features that many recognised, and that may in their different ways present problems to senior leaders. The five notable subcultures are:

- *Diva subcultures*: these arise when powerful and successful professionals are not called to account for inappropriate behaviour, and colleagues modify their working practices to accommodate them.

- *Factional subcultures*: which arise when disagreement within a team becomes endemic and the group starts to organise itself around continuing conflict.
- *Patronage subcultures*: these emerge when colleagues perceive strong bonds of loyalty, dependence and/or respect towards a benevolent leader possessed of social capital. The clinical group becomes reluctant to question or challenge the patron.
- *Embattled subcultures*: these may arise when resource has long been inadequate and is perennially unequal to demand. The group feels besieged by the unmet need they see in patients, and may exhibit burnout, learned helplessness, and resentment. Clinical decision-making may tend to minimise patient need in preference to recognising that needs cannot be met.
- *Insular subcultures*: groups that have become geographically or psychologically isolated from the cultural mainstream of the larger organisation, with the result that behaviours, professional practice, or standards of care deviate from accepted norms.

In addition, leaders also recognised that their own leadership teams, generally comprising both clinical and managerial staff, possessed their own distinctive subculture. Leadership subcultures could themselves exhibit positive and negative features, and these were often readily apparent to staff in organisations. The way leaders conducted their business signalled to staff what was valued, how to behave, what could be said to authority and what could be expected if staff brought problems to the leadership team.

Senior medical leaders also noted the influence of negative behaviours exhibited by non-executive directors and strategic NHS bodies. Close to one quarter of the sample reported having experienced behaviour directed towards them from these quarters that they perceived as either workplace bullying or grave incivility.

How have senior medical leaders approached the task of building or sustaining a positive culture, and what methods have proved helpful to them?

> *"You just don't know what people will take from the way you behave. I'm really conscious of [role modelling as a leader during] my clinical practice. …It doesn't matter how many times we say to people what we want them to do, it's what people actually observe and experience that counts".*

> *"I instigated a governance programme of reviews for the divisions and I made clear that our governance in this organisation would cover quality and safety first, culture and people, operational delivery and finance…The first divisional reviews people were…terrified. They were still scarred by the nature of the reviews held by the turnaround director. Over time, they have grown pleased and accustomed…to the fact that those review meetings are thorough, I do investigate and follow things through, but they are respectful, even-tempered, collaborative, constructive, open..."*

Organisational culture can be viewed in two broadly differing ways. One is to treat organisational culture as a 'thing', something that exists in organisations as a discrete component of organisational life. On this view culture is a singular characteristic of an organisation that, if it goes awry, should be fixed with some sort of cultural engineering activity. The alternative approach is to view organisational culture as something that organisations 'are', so that culture is synonymous with the notion of organisation itself. Those who view culture as synonymous with organisation argue that, *since organisational leadership is inevitably leadership of cultures*, leaders are doing something to culture in *all* of their core activity and whether they intend to or not. Approaching leadership of organisations in this way, the task is not to think (and lead) *about* culture but to think (and lead) *culturally* (Bate, 2010).

Senior medical leaders described ways of thinking about and acting upon culture that are generally more consistent with the second perspective above, treating leadership of the organisation and leadership of culture as in many respects synonymous. For the most part senior medical leaders do not set out to engineer organisational culture as a discrete activity. Rather, they recognise that their routine and unexceptional leadership activity does (or should) impact on culture.

The leadership activities that participants chose to talk about as particularly pertinent to culture were day-to-day cultural housekeeping, with attentiveness to their own behaviour in routine interactions; change management and quality improvement activity; and dealing with performance and behavioural issues.

'Cultural housekeeping' is the frequent, consistent reinforcement of features of culture that are more or less desirable. Virtually all the participants named the time they invested in building relationships to be one of the most important resources at their disposal. They identified as important their everyday conversations, promoting collaborative problem solving, assigning responsibility for outcomes, providing supportive coaching, and consistently role modelling expectations in both their clinical and their managerial practice.

The chief feature of many participants' accounts of enabling change was how unprepared they had been for this in their early leadership career. Many reflected that they had learned through trial and error that success rested as much on their ability to engage and motivate colleagues as it did on the technical or clinical expertise that they had acquired in their decades of training. They also noted the tendency in health care to invest too little time understanding the problem (particularly from a front line perspective) and to impose quick fixes.

Managing performance, responding to serious incidents, or supporting doctors in difficulty had been a pivotal responsibility for most participants. They viewed this a critical influence on culture for two reasons: first, because it was essential to satisfactorily address performance and safety concerns (including inadvertent error); and second, because it was important to be *seen* to fairly and consistently respond to poor behaviour. Examples were given of the impact on professionals and organisations of handling these matters well, with a strong emphasis on the importance of fair processes and the need to challenge poor behaviour exhibited by high profile doctors.

Leaders also discussed interventions to change the perceived negative culture of a team or subgroup. They recounted dealing with entrenched negative cultures with varying degrees of success. Leaders had generally had recourse to specialist providers, and it was notable that intervening in subgroup cultures was challenging, time-consuming and required continuing attention after the intervention was finished. There is a widespread view that it is extremely difficult to change a 'diva' subculture if the chief actor remains in situ.

How far do senior medical leaders' approaches to thinking about culture, and building supportive cultures, appear to cohere with aspirations being promoted by commentators and system leaders?

> *"In leadership within the NHS it's about truly listening and trying to engage but it's also about not being held to ransom, knowing when to hold your nerve, and where to compromise."*

> *"[A senior colleague] told me to lead with my whole heart, not with my head…What we don't need is people who are trying to be kind of un-emotional people who are just sort of corporate apparatchiks…My job is to create the conditions for other people to give the best care they can. And to do that they have to feel safe, and they have to know that I engage and see them as people."*

One of the aims of the research was to understand the differences and similarities between leaders' accounts of their leadership, and a model of compassionate and inclusive health care leadership being advocated by NHS Improvement and influential commentators such as The Kings Fund (West et al., 2017). The report compares participants' accounts of their activity with ten principles described in the NHS Improvement *Culture and Leadership Programme*. This Programme reflects the leadership model set out in NHS Improvement's *Developing People – Improving Care* which is in turn based on a model of compassionate leadership delineated by Atkins and further developed by West (Atkins and Parker, 2012, West and Chowla, 2017).

Multiple examples from participants show aspects of leadership activity that reflect principles of compassionate and inclusive leadership. The evidence is not that everything leaders currently do is compassionate and inclusive. Rather, for each of the ten principles of behaviour there are illustrative cases of ordinary leadership activity consistent with these aspirations.

In addition, however, it is notable that leaders are seeking to reconcile competing goals, resist perverse incentives, and navigate conflicting values. For nine out of ten of the behavioural principles, a counterpoint is offered. The counterpoints suggest that in some cases the principle requires balancing by other considerations, while in other cases the principle is important but very difficult to realise in the current structures or constraints that some parts of the NHS experience.

Although the participants provided many instances of leadership action consistent with behaviours associated with compassionate and inclusive leadership, they used different terms, concepts and reference points to describe their actions. One reason for this difference is that leaders use concepts they have acquired via the influencing cultures that are described at the beginning of this summary. Another reason is that the leadership activity in which medical leaders are engaged has its own vernacular. For instance, medical leaders will refer to "supporting doctors in difficulty", an activity that in the *Culture and Leadership Programme* would seem to be categorised under the goal "improving the quality of their work". As one participant noted, clinicians and general managers tend to use a *"different lexicon…for talking about the same thing sometimes"* and successful partnership rests on each understanding the other.

Concepts and descriptors in documents such as *Developing People – Improving Care* and the *Culture and Leadership Programme* and their supporting materials[2] tend to reflect the influencing cultures of those contributing to their development just as the concepts and descriptors that senior medical leaders use tend to reflect their influencing cultures. In so far as there are differences in language and perspective between system leaders, regulators, academic researchers and senior medical leaders these may need to be negotiated as part of the collective effort to support doctors and others who lead in healthcare. This study is a contribution to the continuing conversation about medical leadership and health care culture, which has as its goal securing the patient outcomes that all desire.

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[2] https://improvement.nhs.uk/resources/developing-people-improving-care-short-guides/ - h2-condition-two-compassionate-inclusive-and-effective-leaders-at-all-levels

PART ONE: INTRODUCTION

The GMC commissioned this research to understand how doctors in senior leadership roles approach the goal of sustaining and building positive organisational and team cultures in which patients experience safe, high quality care. Inquiries into serious healthcare failings have repeatedly emphasised the need for leadership to create a positive, open culture. A growing body of research suggests an association between working cultures that are cohesive, supportive, collaborative and inclusive and measurably better outcomes for patients (Braithwaite et al., 2017). And system leaders, coordinated by NHS Improvement, are promoting approaches to health care leadership that aim to build on these insights. The quality of health care cultures makes a difference to the daily life of professionals, and the well being of those for whom they care. This study therefore sought to capture the 'lived experience' of senior medical leaders, exploring their views on what constitutes a positive culture, their experiences of working to sustain and build cultures that support good care, and their understanding of what helps or hinders this work.

The study set out to answer questions grouped into four themes.[3]

The first theme concerns how doctors in senior leadership roles conceptualise a positive culture, and their role in promoting it. Research findings suggest how medical leaders *ought* to think about culture (see for instance the summary published by the Faculty of Medical Leadership and Management) (West et al., 2015a). Aspirations for health care leadership that include promoting a 'compassionate and inclusive' culture have been set out in *Developing People – Improving Care,* a plan for future development adopted by the NHS in England (Anon., 2016b). One aim of this research was therefore to discern how a cohort of senior medical leaders view 'culture' in the context of their leadership responsibilities.

The second theme concerns how doctors in senior leadership roles identify the presence or absence of positive cultures, and their understanding of how these come about. Health care management research identifies that "managing organisational culture in health care involves managing a complex system of interacting and often conflicting subcultures" (West et al., 2014). Subcultures can form around the purpose of supporting excellent care. However, subcultures can emerge that are less positive. This study seeks to describe senior medical leaders perspectives on identifying, judging and negotiating organisational subcultures.

A third theme explores the means by which doctors in senior leadership roles have approached the aim of building or sustaining positive cultures, the methods, processes or structures that they view as supportive, and how far these leaders judge they have succeeded in changing negative cultures for the better. In seeking out leaders' views on 'what works', this theme goes to the heart of the research and its purpose.

The final theme considers the way senior doctors' approaches to leadership cohere with concepts being promoted by system leaders and commentators. Current frameworks for leadership development include *Developing People – Improving Care* (Anon., 2016b);

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[3] A glossary of terms, including 'positive culture' 'compassionate and inclusive leadership', 'outcomes' etc. is provided in Appendix One

equivalent frameworks in health administrations in the three devolved nations;[4] and NHS Improvement's *Culture and Leadership Programme* (Anon., 2016a). These draw on leadership research and commentary, in particular literature advocating for 'compassionate and inclusive' leadership (West and Chowla, 2017).

'Culture', the central concern in this research report, is a slippery concept. By the mid-twentieth century it already had 164 different definitions (Kroeber and Kluckhohn, 1952). Organisational culture is generally taken to mean the values, beliefs and associated behaviours that characterise organisations, often summed up in the phrase 'the way we do things around here' (Shipton et al., 2008). Organisational culture has tended to be viewed in two broadly differing ways. In the 'scientific paradigm' culture is a 'thing', something that organisations 'have' as a discrete component of organisational life. In the 'anthropological paradigm' culture is something that organisations 'are', so the notion of culture is virtually synonymous with the notion of 'organisation' (Bate, 2010). This distinction may appear somewhat theoretical at this point but it is of significance for the third research theme, and will be explored further when reporting those findings in Part Four.

Reviewing the body of research into health care cultures and patient outcomes, Braithwaite chose to define culture as "a composite, complex construct which changes dynamically over time, but there are enduring behavioural and cognitive patterns to its manifestations in situ" (Braithwaite et al., 2017). The value of Braithwaite's definition is that it draws to our attention that cultures *change*, for better and worse; and that whether good or bad, cultures also *endure*.

Research method

The findings reported here are derived from qualitative research. A summary of the research method is provided here, with further details in Appendix One.

Twenty-seven senior medical leaders were interviewed in depth during 2018. These interviews were carried out specifically for the purpose of this study, and questions focused on the four themes summarised above. Additional insights were drawn from an earlier qualitative study by the same researcher, completed in 2011 (Shale, 2012) and comprising twenty four in depth interviews with NHS medical directors. Those interviews sought to understand how medical directors approached the moral challenges inherent in medical leadership, which frequently intersect with varied cultural concerns.

Sampling, recruitment and data analysis

The 2018 sampling and recruitment process aimed to achieve participation from senior medical leaders (defined and tabulated in Appendix One, also referred to as 'senior doctors' within the report) in a wide variety of roles and different types of health care organisation. Individual participants were approached via medical leadership networks, the researcher's professional networks, and introductions by other interviewees. The sampling strategy also sought to recruit clusters of participants from the same organisation, so as to gain some insight into the extent to which perspectives on culture were shared across leadership teams.

The majority of 2018 participants worked in the NHS in England or Scotland and included Medical Directors, Assistant/Associate Medical Directors, or Consultants with additional leadership responsibilities. They had leadership roles in secondary and tertiary care, mental health, community-based services, and in regional structures. Four participants were senior

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[4] https://www.health-ni.gov.uk/sites/default/files/publications/health/hsc-collective-leadership-strategy.pdf, https://www.nes.scot.nhs.uk/media/3399300/scottish_leadership_qualities_framework_-_guidance_notes_july_2014_-_copy.pdf, http://www.wales.nhs.uk/technologymls/english/resources/pdf/Leadership Qual Framework.pdf

General Practitioners with roles in regional leadership, commissioning, or educational leadership. Two were recent past Presidents of medical Royal Colleges, and one was a medically qualified NHS Chief Executive. The sample also included two group Medical Directors leading independent sector providers and a medically qualified medico-legal specialist now a Non-Executive Director in the NHS. Three participants were from Scotland. Nearly one third of participants (eight of twenty seven) were women, and nearly one fifth (five of twenty seven) were from BAME groups.

The 2011 study of medical leadership included twenty-four Medical Directors working in England and Scotland in NHS in acute care hospital trusts, mental health trusts, and primary care trusts (primary care trusts have since been superseded by clinical commissioning groups). All of the interviewees in the 2011 study were of white British origin, while about one fifth were women.

Each of the 2018 cohort of leaders participated in one, ninety minute, semi-structured interview. The majority of interviews were face to face, but where it was more convenient for the participant they were undertaken by telephone. All of the 2011 study interviews were face-to-face, unstructured and varied in duration between one and two hours.

In both the 2018 and 2011 study interviews were recorded and transcribed in full for qualitative analysis. In both studies analysis was carried out by the author, and emergent themes discussed with a research colleague. Further information about the data analysis is included in Appendix One.

Limitations

The design of this study, based in interviews with medical leaders in very varied roles, can aid understanding of how medical leaders approach the question of culture. It relies upon self-reported accounts of leadership action by people who were willing to be interviewed.
As will become apparent, senior medical leadership is a very broad phenomenon. As a result, the deliberately varied sample of participants has made it possible to identify important themes, but many more nuances would emerge in further research. This study suggests some significant factors to take into account in supporting medical leaders, but does not provide a comprehensive account where principles are generalisable to all medical leaders in all roles.

Quotation

Participants consented to anonymised verbatim quotation. Throughout the report, verbatim quotations appear in ***bold italic font***. They indicate a participant's role and the sector in which they worked, unless this would risk breaching their anonymity.

Background literature

Three areas of health care management research supply underlying evidence for this study: findings in respect of the association between leadership, culture and patient outcomes; accounts of the nature and practice of medical leadership; and examination of leadership practices in high performing health organisations. The rest of this introduction provides an overview of the literature and briefly indicates how the study findings relate to them.

What we know about the association between leadership, culture and patient outcomes

A body of evidence from several countries tends to imply an association between positive staff perceptions of their working culture, and better patient outcomes.

A recent systematic review of 62 quantitative and mixed methods studies (Braithwaite et al., 2017) included only those judged reasonably robust using an objective quality classification tool (Hawker et al., 2002). The review examined the relationship between culture (as defined in the studies) and measurable clinical outcomes (including mortality rates, failure to rescue, readmission rates, pressure ulcers, falls, hospital acquired infections and measures of patient wellbeing). A variety of instruments had been used to measure culture in the 62 studies, including workplace culture questionnaires such as the Practice Environment Scale of the Nursing Work Index (PES-NWI); or others such as indices of safety climate.

Just over half of the studies examined nursing perceptions, while most others surveyed mixed staff groups. Only one (see below) focused on physician perceptions of culture and associated outcomes.

Nearly three in four studies reported an association between positive culture (as defined in the study) and favourable patient outcomes. The remaining one quarter showing no association or sometimes contradictory findings. It should also be noted that an earlier review of similar studies had concluded that evidence for an association was weak, with a number of claims based on methodologically poor research (Scott et al., 2003b).

Only one study in Braithwaite's review had explored the relationship between physician perceptions of culture and patient care outcomes. Examining care at breast cancer centres in Germany, researchers found that "in hospitals with higher social capital, where employees trust each other, have common values, and are willing to help each other" patients felt that patient–physician relationships were more supportive (a critical measure of therapeutic quality in cancer care) (Ansmann et al., 2014) (p.358). This study of physician perceptions is suggestive of the potential value of good medical leadership that results in collaborative working which, in turn, translates into measurable quality of care.

However, some of the research illustrates how difficult it may be to change cultures, particularly if the pressures surrounding professionals and their organisations remain the same. One high quality study that sought to gauge the impact of a cultural intervention on patient outcomes was an evaluation of The Health Foundation's Safer Patients Initiative. (Benning et al., 2011a, Benning et al., 2011b) The initiative included action to promote cultural change in intervention sites, and the rigorous evaluation found limited effects. One reason for this is that organisational cultures, including patient safety cultures, do not materialize in a vacuum. They are affected by government policy, regulatory practices, demand, expectations, and so on (Rasmussen, 1997, Cook and Rasmussen, 2005)[5] and take concerted organisational effort to alter. The researchers cautioned against expecting too much from project based interventions that do not meet the requirements - listed in the next paragraph – now recognised as pivotal to sustaining long term change.

The apparent association between positive cultures and patient outcomes, and the limited success of some project based interventions, has posed the question of what medical and nursing leaders should do within their organisations so as to positively influence cultures over the long term (McKee et al., 2010, Dixon-Woods et al., 2014, Braithwaite et al., 2014, Willis et al., 2016). Willis's extensive review of the literature on cultural change in health care identified six core principles:

- align vision and action;
- make incremental changes within a comprehensive transformation strategy;
- foster distributed leadership;

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[5] This is well understood in safety science, following the work of Rasmussen (see bibliography) and others.

- promote staff engagement;
- create collaborative relationships; and
- continuously assess and learn from cultural change.

There is a degree of convergence (notably distributed leadership, staff engagement, collaborative relationships) between those principles and components of compassionate leadership more recently promoted by West and colleagues (West and Chowla, 2017, West et al., 2017) and now incorporated into NHS Improvement's *Culture and Leadership Programme* (Anon., 2016a).

We will see in Part Two how senior medical leaders themselves understand the cultures in which they work and in Part Three how they recognise, in their own terms, positive and negative cultures. We will note in Part Four leaders' own assessment of success or failure in cultivating cultural change and what they think sometimes works. Finally, Part Five illustrates how leaders in this study described actions that appear consistent with principles of compassionate leadership, but that they also identified the presence of conflicting considerations.

What we know about the nature and practice of medical leadership

Studies of hospital leadership have tended to dominate the field of health care leadership research. Researchers have examined the activities of formally appointed medical leaders, in designated roles such as clinical director or medical director (Spehar et al., 2015, Llewellyn, 2001); and also considered the informal medical leadership intrinsic to much doctors' work, where doctors are acting so as to direct, align and secure commitment to group goals (West et al., 2015b, Holmboe et al., 2003, Hopkins et al., 2015).

A recent systematic review synthesized findings from studies of medical leadership in hospitals, selecting from an initial literature search that yielded 6919 items (Berghout et al., 2017). Common findings from the 34 empirical studies that were included after screening included the following.

- There is a constant need to manoeuvre between clinical and organisational objectives to safeguard quality and efficiency of care. For example, clinical goals may be jeopardized in the course of mergers, restructuring, or financial crises. Clinical colleagues look to medical leaders to defend services or find acceptable compromises.
- Medical leadership has a hybrid nature wherein professional role identity is married to a managerial role identity (Montgomery, 2001, McGivern et al., 2015). Medical leaders represent clinical views to management and vice-versa; and many see a significant part of their role to be understanding and reconciling differing perspectives. The hybrid nature of medical leadership is the source of clinicians' frequently stated view that to be respected by other clinicians, medical leaders need clinical credibility; and also the source of wry comment about medical leaders having 'gone over to the dark side'.
- Medical leadership is distinctive owing to the need to reconcile competing logics in hospital systems (e.g. care vs. efficiency, autonomy vs. hierarchy, clinical aims vs. managerial aims). Such tensions are also apparent in studies of the moral dimensions of medical leadership (Shale, 2012, Emanuel, 2000).
- Role ambiguity and lack of clarity about job content is common in medical leadership roles.
- Medical leaders lack time and the support they need to do the job.

Research into quality improvement in the NHS has examined how some medical leaders approach their role. In a major NIHR funded study (Fitzgerald et al., 2006) authors commented on the weakness of medical leadership in several improvement project sites. Clinical leaders had

limited management training and for many doctors leading change meant "just doing it" and expecting colleagues to fall into line. Fitzgerald's study found, as had earlier studies, that collaborative leadership between senior clinical leaders and senior managers was of particular value. Equally valuable was the contribution of senior clinicians working "within the organisation and sometimes across organisational boundaries providing leadership and advice to colleagues, negotiating for resources and constantly pushing the changes forward" (p.175). Similarly, evaluation of the Welsh NHS 1000+ Lives campaign (Herepath et al., 2015) noted that medical leaders "had a valued role to play in reconfiguring other actors' belief systems" (p.163).

> The perspectives of participants interviewed during this study are wholly consistent with this picture of medical leadership. It should be treated as the backdrop to discussion of views about culture that follow. Of particular note is Fitzgerald's finding that doctors have very limited training and support in respect of bringing about desired change. We will see in Part Four how leaders in this study had learned through trial and error how to bring about improvements in care. They frequently found early ambitions thwarted, learning as they went that it was essential to work with the grain of colleagues' purpose, emotions, and motivations.

What we know about leadership practices in high performing health organisations

Studies of high performing health care organisations reveal aspects of organisational culture that leaders should aim to foster, and some make observations about the characteristics of effective leaders (Keroack et al., 2007). A systematic review of 19 qualitative studies (Taylor et al., 2015) identified seven characteristics of excellent health organisations:

- a positive culture (e.g. respect, trust, openness, improvement orientation);
- senior management support;
- effective performance monitoring;
- building and maintaining a proficient workforce;
- developing effective leaders across the organisation;
- embracing expertise-driven practice; and
- interdisciplinary teamwork.

> It will be noticeable throughout this report that individually, many senior medical leaders conceptualise their role in ways that reflect those of leaders in high performing organisations. However, it would appear from the interview data in this study to be uncommon for these principles to be consciously and consistently adopted across entire organisational leadership teams over an extended period of time. As there was limited scope within this research to explore how leadership teams work together, this observation should be treated with caution.

PART TWO: LEADERS' CONCEPTIONS OF CULTURE

> This section considers the first research theme, how senior medical leaders think about and describe a positive culture and their leadership role in relation to it.
>
> The roles held by medically qualified leaders are extraordinarily diverse. Just among those interviewed, the roles included GP leadership in commissioning, primary care reconfiguration and education; leadership of tertiary care provision in research institutions, and leadership in smaller district general hospitals including community services; leadership of independent hospital groups; leadership of mental health trusts providing care in hospitals, community teams, secure units and prisons; and special responsibilities for leading clinical networks, patient safety, medical education, and national improvement projects. All had learned varied

lessons from the different leadership challenges they had encountered across the course of their career.

Exploring leaders' conceptions of culture revealed some important characteristics.

First, there was no strong or widely shared concept of positive care culture that came readily to mind. Leaders' conceptions of culture were largely implicit, embedded within other concepts and ideals, and while they shared some common features were also diverse.

Second, leaders drew on a wide range of different reference points to express their conceptions of culture, as will be seen in the account of 'background conceptions' and 'role derived conceptions' set out below. On the surface of it, frequently mentioned elements of positive culture - such continuous learning – seem obvious. But exactly what learning meant in context, how prominent in leaders' thinking it was, how central it was to their work, and how they supported it, varied considerably.

Third, leaders' reference points for defining culture appear deeply embedded in professional identity and experience, and keenly felt. Leaders' conceptions of culture may be largely implicit, but this should not be taken to mean they are unimportant. Any conversation around culture will, in one way or another, engage these implicit notions and invoke the identities and value commitments that go with them.

'Background' and 'role-derived' conceptions of culture

Leaders' conceptions of culture can be seen to fall into two categories: 'background' conceptions and 'role derived' conceptions. These are introduced here and then explored in further detail.

Taking background conceptions first, these ideas may not always be at the forefront of leaders' day to day thinking but they help shape their expectations and values and their understanding of people and situations.

The background conceptions of culture arise from:

a) Philosophies of care: doctors have deeply held views about what constitutes good medicine, and therefore what constitutes a good care culture.
b) Specialty cultures and specialist knowledges: senior leaders are conscious they have been influenced by the professional cultures of their clinical specialties; some also possess additional subject knowledges (such medical education or clinical human factors) influencing their perception of culture. Diverse knowledge and experience equips medical leaders with distinctive skills and insights and hence distinctive orientations towards leadership and culture.
c) A sense of generational changes in medical culture: senior doctors are responding to generational changes across the profession including a more diverse workforce.
d) Experience in other sectors: some leaders have experienced approaches to leadership and views on culture in other sectors, notably in the armed services.

Turning to role-derived conceptions of culture, leaders' views are also shaped in part by the demands of the different settings in which they work, differing leadership objectives, and differing responsibilities. Role-derived conceptions come more to the fore in leaders' day to day thinking because they are elicited by leadership activity.

The role-derived conceptions of culture are based in:

e) Specific settings and activities: different types of care call forth different care cultures and different needs for leadership. Leading a single clinical service, a clinical network, primary care, community based services, a Scottish Health Board or a national independent sector group affords different perspectives on, and opportunities to shape, cultures.

f) Specific responsibilities: within the diversity of medical leadership roles, some roles - such as continuing professional education or supporting doctors in difficulty – will bring different aspects and understandings of culture to the forefront of daily work.

g) Continuing professional development and experience: medical leaders alter their thinking about culture as they participate in continuing learning about leadership, and as they gain leadership experience. They may move from focusing on tasks and goals to focusing on how to support colleagues and enable people to work together better.

Background conceptions

a) Philosophies of care

Senior medical leaders have thought deeply about the purposes and practice of medicine. This shapes their views on what constitutes good care, and colours their observations of the cultures that emerge around or are needed to support care. To provide a stark example, an advocate of narrative based medicine would judge care episodes and care environments differently than a clinician pursuing a strongly biomedical model of care (Launer, 2017, Greenhalgh and Hurwitz, 1998).

The priorities expressed in different philosophies of care shape decisions and hence care cultures at every level of care systems. One participant compared the two different hospital cultures they had experienced as a leader. A smaller hospital where all complex work was transferred provided good relational care to patients (on relational care, see glossary and (Maben et al., 2010)). It was responsive and collegial but not driven by goals of advancing clinical excellence. By way of contrast, a leading academic tertiary centre was dedicated to advancing scientific and clinical excellence, but the cultivation of expertise and achievement tended to be at the expense of warmth and relational care. In that case, the different philosophies of care that reflected the nature of these organisations' overall goals, were apparent to an outsider joining the system. However, as we will see, most health care organisations consist of multiple subcultures. The philosophies of care associated with different specialties, in particular, reflect specialty goals and shape the culture of specialty groups.

Philosophies of care and value systems associated with medical goals guide the choices that create and sustain care cultures, even if they are not consciously articulated. For instance, choices will be made about the skills and aptitudes of people to be recruited *"we won't appoint you unless we think your beliefs fit" [Divisional Director acute care]*; about the discretionary effort the organisation has chosen to recognise or reward (developing curricula, mentoring colleagues, or analysing research data?) and therefore whom it attracts to work there; about the interpersonal behaviours leaders are inclined to tolerate (does rare and precious technical excellence excuse bullying behaviour?); and so on. Leaders may have their own cultural preferences, but on joining organisations they join systems in which priorities have been embedded over many years.

b) Specialty cultures and specialist knowledges

Senior doctors have learned to lead during years of clinical practice that have taught them how to succeed in their specialty (including General Practice) and about working with colleagues. It is a characteristic of the hybrid nature of medical management that clinical identity is central to the role. Many participants felt strongly that clinical credibility and clinical practice

strengthened their position as medical leaders, and they retained many aspects of their specialist identity with its associated cultural outlook.

A few examples out of many illustrate how clinical experience informs views on leadership and culture. One Medical Director reflected that their particular specialty had been significantly *"under-doctored"* and they had built up their department more or less from nothing. They had *"absolutely relied on the nursing staff as being my eyes and ears and left hands" [MD acute care].* Subsequently, their approach to organisational leadership reflected years of reliance on collaborative and respectful inter-professional working. Differently, a psychiatrist reflected how their clinical practice involved *"wading through a mass of ambiguity and uncertainty so you need to work out what are your solid points, what are your anchors" [MD mental health];* moreover, working in assertive outreach had taught the importance of creating a psychologically safe environment for staff, and supplied years of experience in 'difficult conversations'. The participant saw all of this as valuable preparation for compassionate leadership of colleagues. Another Medical Director was aware of using the consultation model of Ideas, Concerns and Expectations ('ICE') learned years before as a GP, to support colleagues needing to think through organisational problems. Finally, responsibilities as the named doctor for safeguarding had taught another leader valuable *"leadership skills…working with other people type skills…negotiating skills" [Divisional leader acute care].*

Senior doctors typically acquire additional specialist knowledges during their professional careers, and these contain their own propositions regarding management of cultures and behaviours. For instance those leaders who were or had been medical educationalists incorporated sophisticated theoretical and practical knowledge into their approach to learning culture. The literature associated with medical simulation (Rudolph et al., 2006) provided one with a nuanced understanding of colleagues' actions in context, and the ongoing challenge of non-judgmental feedback, and these constantly informed their work supporting teams in difficulty. A few leaders drew on specialist knowledge of improvement science (Marshall et al., 2013). Others had been more influenced by safety science. They were aware of the NHS England Human Factors Concordat[6] and drew on insights from clinical human factors (Flin et al., 2009, Waterson and Catchpole, 2016) to understand culture and systems. References were also made to Hollnagel's concepts of Safety 1 and Safety II (see glossary and (Hollnagel, 2018)) perhaps reflecting that these have been promoted by the Department of Health and Social Care's 'Sign Up To Safety' campaign.

c) A sense of generational changes in medical culture

Some interviewees reflected on broader changes they had observed in medical culture during their career. On the positive side, autocratic and hierarchical doctor behaviours were thought to be less common and therefore perhaps more notable when they did occur. Younger doctors were described as more willing to accept and work with the logics of public sector managerialism. There was perceived to be a cost to this. There was anxiety it reduced engagement and the sense of vocation, and several remarked on the increasing preference for locum working. There was also some concern regarding a perceived reluctance among a younger generation of doctors to take up clinical leadership roles.

Apparent generational changes in medical culture were attributed to a range of factors within medicine, including a shift to more transactional philosophies of care and discontinuity in working relationships due to training rotations and shift patterns.

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[6] https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-hum-fact-concord.pdf

Larger cultural changes surrounding medicine were observed to have led to diversification of the medical workforce including more female entrants, more varied social class, and more diverse ethnicity and cultural identities. These changes are prompting leaders to review how diversity is taken into account, reconsider workforce needs, and structure careers and reward packages in ways that recognise family responsibilities. Some leaders also observed what they identified as broader generational differences (for example, so-called boomers, generation X, or millennials) shaping expectations at work. Whilst concerned that generational differences may occasionally give rise to friction or disenchantment, the expectation was that any generational differences would have to give way to the demands of medicine.

d) Experience in other sectors

Two interviewees had spent some of their career in the armed forces (as had a participant in the 2011 study). Approaches to leadership in the military appeared highly influential. As one reflected, *"I've always been absolutely persuaded of the importance of motivation, teamwork and…culture…Some of that will definitely have come from being part of the military".*

A successful career in a commercial health services environment shaped one participant's assessment of the culture of clinical leadership. They took the view that clinical credibility was over valued at the expense of business acumen: *"to lead in medicine is going to take clinical leadership but it's also going to take business leadership…the people that I think will do really well in terms of leading and making organisations successful…are the ones that can have a foot in each sort of discipline". [Non-Executive Director, NHS]*

Role-derived conceptions

Different challenges and responsibilities bring to the foreground different aspects of culture management. These experiences often change how leaders approach their role.

e) Specific settings and activities.

Participants from primary care pointed out that discussion about care cultures have tended to be hospital-focused and doctor-centred. They expect primary care provision to be transformed in the near future, and positive culture to take on a new form and meaning. One anticipated reduced hierarchy between doctors and primary health professions, with all professionals working flexibly according to competence and not professional title, and high reliance on multi-professional team-wide provision that would not necessarily be led by doctors. A second interviewee described moving away from the GP's role as provider of first recourse, with help-seekers being directed to varied community and professional resources via a central hub. Both argued that the practical actions needed to realise positive cultures in these circumstances would be different from actions needed to build a positive culture in hospital care.

Several participants from secondary care also associated their conceptions of care culture with work on new structures and processes intended to achieve better quality or more efficient care. Redesign can potentially provide a good setting for a positive care culture to emerge, but leaders had discovered that clinical redesign has unintended consequences. The most frequently mentioned examples of these were structures that fragment relationships with colleagues or patients.

Hub and spoke models of specialist care such as vascular or cancer surgery networks require groups of colleagues to co-operate closely in diagnostics, treatment decisions, referrals, shared care and quality management across multiple organisational boundaries. Organisational and team allegiances and loyalties, and personal-professional preferences for carrying out specialist procedures in particular ways, have to be mediated in the process of creating the network. In addition, ways of working have to be developed that rely less on the interpersonal trust and regard that was sufficient in the past.

As one leader pointed out, networks call for the close co-operation of an enlarged group of consultants and juniors working in different locations, and relatively unfamiliar with each other's abilities. For the network to function it is essential that all adopt a similar approach, formally document decisions, comply with accepted protocols and abide by group decisions. The example of on call arrangements was used to illustrate the transition from an informal culture of trust to more formal mechanisms: *"you're talking about moving from perhaps an ad hoc on call service where you were rung up by someone you knew and they said, 'Oh could you give us a hand?'…It was very much consultant to consultant";* now the person at the end of the phone was likely to be a junior doctor working at another trust whom they had never met and whose clinical judgement was an unknown quantity *[Network lead, acute care].*

Networks thus require leaders to engineer in a culture of mutual reliance. As well as protocols, pathways, and governance processes, social relationships have to be built, for instance through shared clinics or joint research. Collaborative decision making is central to networked care and whilst technology can support communication in MDTs, face-to-face interaction appears more conducive to maintaining interpersonal trust: *"although video link is fine and it's better than a phone call, it is better to be there; you get all of the subtle nuances of human interaction and it shows your commitment." [AMD acute care]*

A different example was offered from mental health. The example is not of a hub and spoke model of care but rather an example of modifying structures in an attempt to introduce greater efficiency into care. On the old model, a service user seen in the community and admitted as an inpatient to hospital would continue to be seen by the same psychiatrist who visited the ward and interacted with ward staff. In the new model, care is handed over to the psychiatrist in charge of inpatients. This brings efficiency to inpatient care, but discontinuity into relationships with patients and between community and inpatient colleagues: *"the original model held a continuity of care…that we lost with the functional model" [MD Mental health].* The new model calls for leadership to develop working practices that can mitigate the effects - on both patients and staff - of more fragmented relationships.

Independent sector acute care hospitals present another example of a different setting that has its own cultural quality. This is in part due to a different relationship with patients, who are more clearly customers (although a considerable proportion are receiving NHS funded care, they receive it alongside private patients). It is also in part due to a different relationship between the independent sector provider and the doctors attending the patients who are not, with limited exceptions, their employees. Differences are referred to where relevant in this report.

f) Specific responsibilities.

Perspectives on culture and how to manage it are embedded in different responsibilities.

For example leaders responsible for professional performance are aware that how it is managed has a profound effect on culture. But interviewees' first concern was maintaining safe care, while also being fair to colleagues. As one put it: *"Obviously your first eye is towards patients and keeping patients safe. And then you have to be able to think, "Can I justify…that what we've done is reasonable and proportionate? And, am I being fair to the doctor?" [MD Health Board]*

Similarly, leaders with extensive involvement in education and training emphasised the importance of a culture of learning. As one said, *"in really good environments…people are learning from their trainees, from the nursing staff, from physiotherapy. They invite participation, they invite feedback, they invite challenge" [Past President of Royal College, acute care].* But these leaders promote a learning environment because it will lead to care of the highest quality, and do not ordinarily conceptualise it as 'building a positive culture'.

Other leaders have responsibilities where managing cultures is at the heart of their work. One interviewee was leading elements of a large project to recruit and support overseas doctors to the NHS. The work highlighted that overseas doctors need time and support to acculturate to NHS norms. Identifying and supporting positive GP practice cultures in which to place them was crucial to retaining them as safe and effective practitioners: "*our job is to find a way to make this work, in a way that's safe and fair and supportive and educational*" *[AMD, GP].* Similarly, some medical leaders are directly involved in organisational development, so developing other doctors' capacity to understand their working culture is the core of what they do. This again gives a distinctive outlook on working with culture. As one described their work "*…the listening is the doing, the curiosity is the intervention, the patience to allow resolutions to emerge through dialogue [is key]*" *[Educationalist, GP]*

g) Continuing professional development and experience

Medical leaders develop their thinking about culture as they gain knowledge and experience in their role. Senior doctors draw on academic theories about how organisations work, what culture means, and how leaders impact on culture, in order to make sense of challenges. Such theories circulate through medical leadership communities via development programmes, learning sets, peer advice and self-directed learning.

Two participants made use of ideas associated with adaptive leadership to explain their thinking about culture. This concept, developed by Heifetz and colleagues, may resonate with NHS leaders because at its heart is a critique of "the illusion of the broken system". The authors argue that change initiatives founder on a mistaken belief that an organisation needs to change because it is broken. They suggest that, on the contrary, "any social system [including the NHS] is the way it is because the people in that system (at least those individuals and factions with the most leverage) want it that way" (p.17) (Heifetz et al., 2009). This is a persuasive statement about the interests that sustain certain cultures in the NHS, and the need to understand these as a leader.

Several other leaders referred to ideas drawn from Stacey's theory of organisations. On this account, organisational cultures are patterns of interpersonal interaction arising from "complex responsive processes" (Stacey and Griffin, 2007). Organisations are "widespread patterns of interaction between people" that have recognisable "narrative and propositional themes" reproduced in "myriad local interactions" (p.8) Stacey emphasises first that "there are no forces over and above individuals" so that organisations and their systems are simply the totality of interactions of people in the organisation, often shaped by power relationships. And secondly, there can be no imposed design for an organisation "as a whole", because "designs, programmes, blueprints and plans exist only insofar as people are taking them up in their local interactions"(p.9).

Each of these theories influenced how leaders conceptualised culture in interactions with colleagues, and we return to this in discussion of 'cultural housekeeping' in Part Four.

Listening to several interviewees, it was apparent that as they had acquired experience they had tended to shift from focusing on the goal to focusing on the people whose work would achieve the goal. One leader described learning that for a project to succeed "*what I needed to find was the person who can involve the whole of the team*"; and that while the first priority might sometimes be "*focusing on the task you want to achieve…if you focus on …enabling and building the team, then you are more likely to achieve it and sustain it*" *[MD Mental Health]* Another looked back on their early decision making, and coming to appreciate that collaborative and supportive culture came from taking time to help colleagues to think issues through: "*I caught myself a few times early on, people would come and they would want a decision and if you're really hurried, you just go, 'This is…' and you just do your own thing. Whereas now you have to give yourself that time to say, 'Okay, what do you think? You talk me through what you think'*" *[MD Mental Health]* As well as

learning on the job how to empower staff, the same participant recalled *"I thought being Medical Director was about holding people to account…over time what became apparent to me was it was a bit more about making sure people were being looked after as well"* [MD Mental health].

This trajectory of development from novice clinical leader to expert clinical leader reflects characteristics identified in the general leadership literature (Lord and Hall, 2005) but appears to have been little studied in health care leadership.

Several leaders called attention to the pivotal role of Clinical Directors. They pointed to the paradox that Clinical Directors have perhaps the most difficult of roles in people management terms, and a direct impact on perceived working culture. However, they have the least experience of leadership and little developmental support. This is also true of mid-level clinical managers in other health professions. One leader who facilitates team interventions had observed more problems arising from *"poorly thought out, or well-intended but badly executed changes in practice"* being implemented by middle level clinical managers, than they had observed emanating from commands issued by senior management. *[Consultant & specialist educator, acute care]*

Implications

We have seen in this section that medical leaders draw on perspectives and experiences that provide them with rich, diverse, and nuanced understandings of working cultures, although they may not always recognise the knowledge they have. They draw on a wide range of influences, including core medical values, lived experience as a doctor, different domains of professional activity, sophisticated theories and practical wisdom regarding how people learn and interact, and their own learning about being a leader. Medical leaders' thinking about leadership and culture clearly develops over their medical management career, a period likely to be two decades or more for many. Their approaches to leadership and culture are a response to their environment, the challenges presented to them, and their own experiences of success and failure.

Aspirations to develop leadership and culture can inadvertently characterise the existing state of affairs as lacking. What these findings illustrate is an extensive asset base of cultural wisdom to be respected, acknowledged and cultivated further.

Health care is not a single culture, but a shifting constellation of intersecting influences and subcultures that challenge, influence, and inform leaders choices, in the course of their day-to-day work and over a period of time. The notion of positive culture seems superficially simple, but on examination it invokes complex and varied understandings and ideals. Future discussion of health care workplace cultures will need to recognise and be responsive these diverse conceptions if it is to prove credible, engaging and fruitful.

PART THREE: IDENTIFYING POSITIVE AND NEGATIVE CULTURES

The second research theme concerns how doctors in senior leadership roles identify the presence or absence of positive culture in their organisation, and their sense of how this comes about. The preceding section explained how medical leaders approached thinking about culture, and this section goes on to discusses how they recognised and characterised different subcultures, including their own leadership subcultures. The leading researchers in the field recently argued that studies of health care organisational culture should explore how subcultures are at different times "driving forces for change, overt defenders of the status quo, or covert countercultures quietly undermining new initiatives." (Mannion and Smith, 2018) Medical

leaders gave fluent accounts of a range of positive, negative and subversive subcultures, as will be seen shortly.

There are four features to note.

First, many participants initially found it difficult to describe features of positive cultures and tended to do so by differentiating them from negative cultures. However, participants with experience leading reviews and inspections, for example through working with CQC, appeared more attuned to positive cultural signs.

Second, although participants referred to organisational indicators such as serious incident rates, staff grievance data, safety climate questionnaires and staff surveys, they dwelt more on the softer signals of culture that are described below. This may be because of the way the question was asked. It may alternatively indicate that when leaders think about cultures they draw extensively on implicit knowledge, using the stories from soft signals to make sense of complex quantitative and informal social data derived from several sources.

Third, it was possible to develop a typology of potentially troubling organisational subcultures from perceptions shared quite widely across the leadership sample.

Finally, many leaders recognised that their own leadership groups constituted a distinct subculture that could have a significant impact on organisational culture. They noticed leadership subcultures affecting how staff related to leaders, what leadership teams will come to hear about organisational difficulties, and how others in the organisation learn to lead.

Quantitative and qualitative indicators

Leadership teams have recourse to a wide variety of performance indicators on which serve as either direct or proxy measures of culture. These are regularly reviewed, and as well as providing an overall picture of organisational performance may give rise to concerns about specific departments.

One participant outlined the indicators listed only under the 'leadership and culture' heading of the performance information their leadership team reviewed at monthly meetings: *"workforce capacity, sickness absence, mandatory training…bank and agency turnover, turnover in staff groups, last year/this year. Absence management, sickness rates, causes for sickness and time off; training and appraisal compliance…Where they are against agency spend, waiting list initiative payments, Outpatients new versus follow-up rates; the same for each of the sub-specialities. Average length of stay for the sub-specialities…"* Some of the other indicators that tended to draw attention to culture included *"complaints, friends and family tests…national audits…mortality reviews, we look at everything"[MD acute care]*

Key indicators of working culture to which other interviewees frequently referred included incident rates, formal patient complaints and staff grievances. For example, one leader had been alerted to a department in difficulty by *"serious incidents, the low morale of the staff…occasional grievances…" [MD mental health]* Further measures of culture that had given leaders pause for thought were a medical engagement survey by CQC and data from the GMC's trainee survey. One participant referred to safety climate questionnaires that had been used by NHS Scotland.[7]

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[7] http://www.scottishpatientsafetyprogramme.scot.nhs.uk/default.aspx?id=1253&n=1&cid=0&rid=0

These quantitative data are augmented with soft signals from the environment and from patient and staff contact: *"you're analysing data and…talking to people…listening to staff; you begin to pick up anxieties and concerns…go back to the data…" [Group MD, independent sector]* Another leader explained how they married soft signals from talking with staff and patients (including criticisms, which rarely end up as formal complaints) with numerical data: *"I think there's the two bits. There's the narrative side, and there's the data side. And it's looking at multitude of things, it's not looking at one particular thing" [Divisional director, acute care]*

Cultural signals

Participants tended to assume the existence of performance indicators as a backdrop and were inclined to be more expansive about the soft signals. These are set out below, starting with a summary table. It should be emphasised that this table by no means represents a comprehensive account of negative and positive cultures, but rather a summary of those soft signals that came most frequently to the fore in interviews.

Signal type	Positive signs	Negative signs
Appearances	• Environment welcoming, clean & well kempt, tidy • Visible signs (e.g. notice boards) of feedback being acted on and of ongoing improvement activity • Patients engaged, positive, active where possible • Observable staff attitudes, including responsiveness, 'can do' attitude, attention to detail	• Environment unwelcoming, tatty, unkempt, untidy • No visible sign of interest in getting and acting on feedback or of improvement work • Patients not engaged, passive, discouraged • Cynicism, 'don't care' attitude, staff have let things go
Patient experience and needs	• Genuine attentiveness to patient voice and experience as part of clinical excellence • Low level of patient dissatisfaction • Focusing on patient needs helps discourage or resolve professional conflicts	• Lack of interest in patient experience, focus on purely technical clinical outcomes • High level of patient dissatisfaction • Professional conflicts are taking priority and displacing focus on patient needs
Attitude to organisational routines	• Examples include good handovers, willingness to standardise, flexibility • Cooperation	• Lax implementation of protocols such as surgical checklists, resist standardisation, inflexibility • Resistance
Attitudes towards information	• Performance data are welcomed, discussed and viewed as an opportunity for learning	• Performance data are viewed defensively, resisted, dismissed, or selectively analysed
Emotional tone	• Doctors are appropriately managing their own emotions resulting in calm atmosphere and thoughtful decisions • Professionals have sufficient capacity to show compassion towards one another, and take opportunities to interact informally • High morale supports discretionary effort • Appropriate humour supports team functioning	• Doctors' own fear, anxieties or other negative emotions are eliciting these in others and inhibiting team working and decision making • Professionals feel unable to care for each other (possibly owing to stress or burnout) and tend to avoid informal interpersonal contact • Low morale and staff feeling they can't be bothered • Loss of sense of ease & humour in team
Interpersonal interactions	• Supportive approach to trainees and training which results in feelings of security and belonging • Mutually respectful and supportive	• Department not supporting and coaching trainees commensurate with trainee level and experience • Lack of respect for expertise of other

	interprofessional relationships	health professionals besides doctors
	• Willingness to bridge the gap between clinical and managerial language and goals	• Mutual disdain between doctors and managers and unwillingness to see the others point of view
	• Civil working relationships even when under pressure, commitment to collective problem solving	• Uncivil working relationships, belief in blaming and shaming to manage care delivery problems

Appearances

Many interviewees noted that staff interactions and attitudes gave an immediate sense of the prevailing culture, as did the appearance of sites and wards. An interviewee with extensive experience with CQC brought the two together: *"What does the place look like from the outside? How easy it is to get in, and what's the first greeting you get…Visual cues, particularly notice boards…a quality improvement/patient engagement wall which is populated with stuff...What are the patients doing? Are they active, or are they just sitting there…if you walk onto a ward and it's busy, that's a good sign."[MD mental health].*

Group leaders in the independent sector gave a similar précis of what to look for on site visits, with the addition of customer focus: *"Attitudinal things: absence of cynicism; authenticity; attention to detail…visible indications that we've paid attention to what our customers have said, patients have said." [Group MD, independent sector]* As the care culture in this sector accords high priority to quality of facilities, interviewees were especially alert to physical appearance. One compared two buildings within their group: the first *"looked cluttered, didn't look terribly clean, carpets were stained. The next…was absolutely spotless...an indication about the motivation of the staff to do well for the patients." [Group MD, independent sector]*

But one NHS leader with long experience of inspections cautioned against fixating on the easily measurable to gauge culture: "*you get caught on the things that are very absolute and practical: ligature points in old Victorian buildings…has everybody signed their thing…fridge temperatures…we lost track…Were we looking for the fundamentals?"* The fundamentals of good care may manifest in less visible signs, such as time spent on relational care, or the 'emotional holding' (described below) that leads to calm and supportive therapeutic environments.

Patient experience

An unambiguous focus on patient experience (not just measurable care outcomes) was frequently noted as the mark of a positive culture. One Medical Director had made patient experience the driving force in their organisation's improvement journey, telling staff: *"I want to turn up the sound of the patient voice in the organisation…a patient perspective that is front and central to you. So, you can't ignore it. And you've got to attend to that, as well as do all the technical medical stuff". [National leader, former MD acute care]*

In another organisation it was the Chief Executive who consistently reinforced an expectation that clinical leaders would attend to patient experience: *"there was no criticism, there was no 'do your job'. It was just 'I've listened [to a patient issue], now what are we going to do about it?'"* *[Divisional Director, acute care].*

Formal patient complaints are generally included as performance indicators. In the case of one insular culture (see the discussion of notable subcultures below) *"it was actually the patient complaints which really exemplified what had been going wrong" [MD mental health].* But the qualities of the response complainants receive, and informal patient complaints, are an additional cultural signal. Another leader noted their concern at how, in a previous NHS post *"there had been a number of serious complaints which had indicated poor levels of care on the wards, but also indicated an inability to resolve and manage complaints effectively" [Group MD, independent sector]*

By the same token, losing patient focus signalled cultural trouble. With extensive experience of working with clinical teams in difficulty, one leader emphasised the importance of coaching consultants to redirect their attention to the primacy of patients' needs. The suggestion would be *"it's about looking after the patient, not about your feelings as such…You should be doing this for the patient's care. And then you should be looking after the team around you, and their wellbeing, as well as your own". [Consultant & specialist educator acute care]*

Attitudes towards organisational routines

Medical leaders prized willing cooperation with organisational routines as a sign that patient interests were taking precedence. Attitudes towards protocols and processes were frequently cited as a measure of cultural quality: *"whether it's hand washing or the surgical checklist, or starting on time, or writing the notes, or [not] being rude to staff. [Group MD, independent sector]*

Similar telling signs of cultural quality included effective or chaotic handovers; flexibility or intransigence around standardisation (e.g. demanding different sutures, prostheses, or medication regimens from the rest of the team); compromise or obstinacy over rotas and job planning; and co-operative or dismissive attitudes towards appraisals.

Team and individual attitudes towards unwelcome information

Professionals' attitudes towards negative data of one kind or another indicate both positive and negative aspects of culture.

Leaders recognise that there is a debate to be had about data quality and interpretation, and want to be able to treat it as the starting point for learning and improvement. As one commented *"doctors fight all the time about data, we're complaining all the time that we don't have enough data; once we get data and show it to doctors, all they do is argue about why it's wrong…For me, data's the start of the conversation" [Divisional Director, acute care]*

Groups seeking to use data as a stimulus for improvement were met with approval. For example, 'quality clusters' introduced to support general practice development in Scotland require system data to underpin their work. System leaders: *"have been quite careful about data provision and data analysis - it's important for the clusters to be able to get the data they need to assess problems and to assess progress and look at outcomes" [AMD Health Board]*

On the negative side, three types of response from clinical teams troubled leaders: questioning or dismissing negative data, normalising it and explaining it away. On the first of these, there are always reasonable questions to ask about whether data are accurate or what story they are telling. But a concerning response to negative-seeming data is to dismiss it out of hand on grounds 'it isn't 100% correct': *"there was a big issue before and people said, "Well, that data's all wrong, we just don't accept it. We're not going to change anything, because we don't agree with that," [Divisional leader, acute care]* That leader had subsequently engaged their clinician colleagues in helping to develop data sets that most would agree were accurate and useful.

A second response is to normalise poor outcomes, on grounds that 'this is health care, stuff happens'. Normalising poor practice, and not seeking data that challenge it, may be a particular pitfall for individuals or groups working independently, in relatively isolated situations, or in small specialties: *"if you're just in your practice, whether that's big or small, how do you know that what you're doing is good if you can't benchmark it to anything else?" [AMD, GP]*

A third negative response is to explain data away on the grounds they 'don't account for us and our unique challenges'. For example, groups have been noted to argue away the results of the GMC's trainee survey by suggesting their trainees are uniquely difficult or overly sensitive, or to challenge outcome data on grounds that their patient population is uniquely frail or complex. This can be symptomatic of an insular subculture (discussed below): groups argue *"It isn't the*

same - we cannot use the same IT systems / we cannot use the same [whatever] / patients complain about us because / this is different because…" [Non Executive Director]

Participants recognised there was commonly a degree of defensiveness in group responses to unexpected negative data, and expected middle and senior level medical leaders to challenge this. One Medical Director recalled that a department's trainee survey included findings critical of the consultants who *"didn't believe it and were challenging back".* It was noted with approval that the divisional lead was the one to insist *"you've got to realise this is how [trainees] feel. It's irrelevant whether it's absolutely true or not. This is how you are making them feel." [MD acute care]* One independent sector Medical Director judged the quality and influence of individual hospital Medical Advisory Committees (MACs) in part by their attitude to data: *"When there's a piece of data that says we're not performing very well, do they say, 'It's just one, oh, that's healthcare'; or do they say, 'What's the organisation doing about it? How are we going to know that we've improved?'" [Group MD, independent sector].*

Attitudes towards unwelcome findings are also a feature of leadership cultures, discussed below.

Emotional tone

Interviewees drew a direct connection between the expression of emotions at work and the quality of care patients were likely to experience. For those leaders who identified emotions as part of the cultural landscape to which they paid attention, it appeared obvious that the way group members feel will shape at least some of what they do, particularly in interaction with patients and colleagues.

It is a mainstay of literature on emotions at work that organisations "require the display of positive (cheerful, friendly) emotions" (Fisher and Ashkanasy, 2000) and interviewees frequently mentioned a positive emotional atmosphere as a sign of a positive culture. Conversely, negative emotional dynamics in a group, such as low morale, were associated with the emergence of a negative culture of care.

As one interviewee recalled, *"all of the healthy team cultures that I can think, there's a reasonable level of at least being able to joke, find humour in things, use it appropriately as a defence…" [MD, mental health]* Another supplied the contrary example of emotional tone, low morale, and spoke of how it dampened the discretionary effort on which good care rests (Williams et al., 2001). This leader had experienced it personally during a particularly turbulent period in a trust: *"people were not pulling together, people were fed up, people were disillusioned…I didn't feel I could make a difference…Me working harder, and doing all these extra hours, and sorting people out, actually wasn't enough anymore…I was going, "No, I can't be bothered." [MD acute care]*

Another type of emotion management is the way professionals informally care for each other in the day to day hurly burly of clinical work, or when things go wrong. A GP leader described the importance of informal support mechanisms (particularly for doctors in difficulty and in training practices) such as routinely meeting for coffee at the end of morning surgeries: *"the fact that they recognise the importance of coming together allows people then to say 'I had a really difficult morning' or 'I'm stuck with this". [AMD, GP]*

Rather differently, two interviewees from mental health referred to the phenomenon of emotional holding in psychiatric care, and how this subtle and under examined behaviour could impact on outcomes. For these leaders, emotional holding was a characteristic of good teams, benefitting both patients and professionals. (Emotional holding broadly entails balancing a group's desire to feel safe with recognising and managing painful emotions. (Finlay, 2015)) One leader suggested emotional holding was an under-acknowledged aspect of supportive consultant leadership, recalling changes to one high risk ward after a colleague departed: *"suddenly that calm…the [team's] ability to stop and hold things had clearly just gone…we had [more]*

incidents, the first two deaths…on the ward for a considerable period of time…it was a palpable change in the feel". (MD, mental health)

Leaders also drew attention to negative cultures of so called learned helplessness, discussed in Part Four in the context of change management.

Interpersonal interactions

The observable quality of interpersonal interactions constituted a large group of positive and negative features of culture. We start first with those that are largely positive.

Attitudes to trainees and training were frequently mentioned as features of group culture, both in terms of how well trainees were supported and in terms of how interactions with trainees might indicate quality of patient care. In noticeably happy departments, notwithstanding demanding circumstances trainees *"get some feeling of belonging and of coaching"* that supports their wellbeing; *"…you can have the same zoo and the same difficulties, but the difference is the feeling of belonging" [Past President of Royal College, acute care]* An educationalist noted how interactions between consultants and medical trainees could be indicative of interactions with patients: *"if you've got good interactional skills with one lot of people - with colleagues or with trainees - you've usually got it with patients as well. There's just sort of a consciousness that every utterance matters" [Educationalist and GP].*

Inter-professional working relationships were viewed as a particularly telling measure of culture. Positive cultures were believed to rest on inclusive, mutually respectful and supportive relationships between doctors, nurses and other health professionals: *"If you actually care about each other the service sort of takes care of itself…[In our clinical service] we appointed people who had a good sensible broader view of what nursing was about…they were nice people and cared about standards" [MD acute care].*

Several leaders also viewed working relationships between doctors and managers as a good cultural indicator. One noted that in a collaborative care culture general managers and clinical staff have overcome the *"different lexicon that they use for talking about the same thing sometimes…successful clinical and general managers are able to bridge that divide and interpret things so it makes sense to the people on that other side" [AMD Health Board].*

Some level of disagreement, dispute and conflict are constant companions in any human endeavour. One leader pointed out that teams responded differently to pressure, and how they would do so is not apparent on brief acquaintance: *"You will know it from the way people are…responding to challenges…It's not just the smiling staff who greet you when you walk in" [MD, mental health].* Resources from the Medical Mediation Foundation and Evelina Project[8] had helped another leader to notice how there could be an association between team conflicts and subsequent conflict with patients.

Turning to overtly negative behaviours, interviewees shared accounts of bullying and incivility, undermining, unproductive conflict, factionalism and in fighting. Negative behaviours frequently come together into recognisable types of subculture, and these are described next.

Notable clinical subcultures

A typology of cultures that may present problems became apparent in participants' reflections. Clearly each of these subcultures has a different cause. However, there is a degree of consensus that they emerge over a period of time during which clinical managers and leaders have not

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[8] https://www.medicalmediation.org.uk/evelina-resolution-project/

engaged consistently with groups to maintain constructive oversight, promote high standards of behaviour, or monitor performance. In the case of embattled cultures, they have also not ensured adequate resources are available.

"Diva" subcultures

In "diva" subcultures (the term was coined by one participant and widely recognised by others) powerful and successful professionals are not called to account for inappropriate behaviour. Left unchecked, divas come to be viewed as untouchable, and colleagues accommodate and work around them to reduce their detrimental impact. Diva behaviour includes bullying, faction-fighting, ill-tempered outbursts, disrespecting managers and professional colleagues, exploiting juniors, ignoring protocols, and other misdemeanours. In some cases divas seem impervious to criticism or direction; in others *"it's because no one's ever, ever said no to them; because they've always been top of the pile…" (Past President of Royal College, acute care]* Their profile makes it difficult for those who work with them to raise issues or concerns about them or about patient care, and their behaviour has deleterious effects across the wider organisation: *"the higher their profile, the more important is their role-modelling. And if they're untouchable, then others in the organisation say -* **that** *is the role model…" [CEO acute care]*

Divas generally enjoy high status within their specialty, have followers and supporters who benefit from their success, and have allowances made by their employer in exchange for clinical prowess. An interviewee noted, *"it takes leaders with courage, not just leaders with aptitude" [Non Executive Director]* to challenge them. Having learned the lessons of high profile cases, one leader viewed diva behaviour as a red flag signal: *"there's a big character, etc., they sail close to the wind…those are my alarm bells. [Group MD independent sector]* One leader recalled addressing the behaviour of such a colleague in a previous role. The diva was *"internationally respected…but just completely disruptive…"* When it was insisted that the person step down from a leadership role *"they left, in high dudgeon. I don't think X ever quite believed…we would let X go because X genuinely was an international superstar".*

Factional subcultures

Disagreement is an inescapable aspect of group life. Good teams do not suppress disagreements, but deal with them effectively. Factional subcultures arise when disagreement becomes endemic, and the group starts to organise itself around continuing conflict. Those in dispute look for support and loyalty from colleagues, staff may seek to avoid working with or communicating with those apparently on the other side, and in serious cases patient care may be compromised.

One participant set out very clearly how factional cultures arise: usually *"strong personalities with entrenched positions who don't like to listen to other people. But they've got themselves entrenched and…they dig themselves deeper in. They often feel that the other team is getting at them, which they may well be, sniping away, so you get these little battles. You get somebody with a strong personality and a fixed set of views on something who becomes evermore fixed and fixated." [AMD, acute care]*

If - as is not uncommon - the dispute is about different approaches to treatment, there is a danger that decisions about patient care will be coloured by factionalism instead of being made purely in patients' best interests. What is then needed is to *"get people on the opposite side to recognise that often there's two ways of dealing with this problem and neither of them may be completely right…you can often work out patients who would be best served by one or the other." [AMD, acute care]*

As well as disagreement over approaches to treatment, examples were given of factionalism arising out of interpersonal conflict, intimate and family relationships, and arguments about private practice.

Patronage subcultures

These arise around influential leaders possessed of social capital in the form of specialist knowledge, professional connections, high status, respect, and access to resources. An interviewee noted *"…senior members of the profession wield a huge amount of influence with their colleagues; particularly where they've got college roles or senior academic positions…people are dependent on them for a lot of development roles"*. Patronage cultures are distinct from 'diva' cultures because the currency of power is judicious benefaction of social advantage, not jealous protection of one's own position.

Patronage cultures are frequently centres of excellence, led by influential role models who do enormous social good. Their downside is that professionals' sense of obligation to a patron, being dependent on their goodwill, or fearing the consequences of questioning a respected figure, makes patrons difficult to challenge. Patronage can serve as a bulwark against change, mute concerns about a department, or buttress alliances that may not always work to the overall good of an organisation.

Embattled subcultures

Where resource has long been inadequate, and is perennially unequal to demand, practitioners eventually become overwhelmed. The service feels besieged by all of the unmet need they see in patients. Professionals may exhibit behaviours associated with chronic stress, including short temper and anxiety, or symptoms associated with burnout (Schaufeli et al., 2009).

One leader vividly described the sense of being embattled, and its effects, in a mental health crisis service: *"It's an unconscious defence mechanism. Because if you know you don't have the resources to give something, it's easier to not <u>see</u> the need than…have to <u>refuse</u> the need…When [staff] get overwhelmed, they start to go, "Well, [that patient's] not really ill; they're [personality disordered]…Everything's out there, it's all of them, we must protect our boundaries…" [MD Mental health]*

As groups become overwhelmed a first sign may be loss of discretionary effort, which feeds a downward spiral: *"when people feel that the problem is so big that no matter what they do they can't do anything…they stop working that extra bit which is what keeps the NHS going".* [MD acute care]

Some depicted overwhelmed teams as liable to learned helplessness where they abdicate responsibility for problem solving, reject all help, solutions, support or examples of what works, because experience has taught them that changing their circumstances is impossible: *"this real feeling of learned helplessness, sitting back and saying 'Well, here's the problem - what are the trust going to do?'...Doctors tell me they have no power anymore, and everybody else tells me they can't do anything because only the doctors have got the power…" [MD mental health]* Another described it as *"front line staff feeling quite helpless…they talk about the negative things, and they focus on what's not possible…no matter whatever I do, it's not going to change…" [MD mental health]*

Participants from primary care noted the current difficulties confronting general practice and recognised some practices as embattled: *"a lot of practices are really struggling with the volume and complexity of workload; there are recruitment problems, skill-mix problems, premises, IT. General practice is really struggling at the moment".*

Insular subcultures

Leaders perceived some units had become isolated from the cultural mainstream of a larger organisation or community of practice, with the result that professional practice or standards of care deviated from expected norms.

Some isolation is geographical, and teams have lacked oversight: such as *"a team going absolutely rotten out in the sticks…delivering community care" [MD Mental health]*.

Some isolation is psychological, a general defensiveness underpinning justifications for poor performance. We noted an example earlier of groups responding to data by claiming it does not apply to them because they are somehow unique. Even geographically co-located services such as forensic psychiatry can become psychologically isolated behind high security boundaries, with staff losing a vision of care and focusing on containment and incarceration.

Another example was of a previously thriving service that had been downgraded to become *'an isolated ward…in a building which is 20 years past its sale date" [MD mental health]* resulting in loss of morale and a sense of helplessness.

Insularity may also become apparent in general practice, for structural reasons stemming from the model of the GP as independent contractor. The prevalent model (until the recent development of larger corporate GP practices) has been that every GP partnership is a separate small organisation. These GP practices do not receive regular, direct management oversight from outside the practice, in the way that an equivalent size department in a hospital trust would do.

The quality of leadership cultures

Interviewees commented with candour and insight about the leadership subcultures of which they were a part. Whatever staff might be told in policies, value statements and official internal communications it was the way leaders conducted business that signalled to staff what was valued, how to behave, what could be said to authority and what would be done about problems. The perceptible subculture of those at the top has notable impact on the wider organisational culture.

Management team behaviours

Management team subcultures are created by both clinical and non-clinical leaders, and it was observed that they can at times exert a negative effect by modelling uncivil behaviours.

One leader had had experience of working with senior teams in other provider organisations, investigating performance and care quality issues. They recalled an example of poor behaviour at the top which clearly licensed poor behaviour in others lower down the hierarchy: *"that showed me…that the culture in that [NHS] directorate was a direct result of the culture at the top of the [NHS] organisation…a culture in which Clinical Directors felt the way they got results was by shouting" (Group MD, independent sector]*

Similarly, on joining their organisation, one leader had observed *"site management meetings…were awful. They had role-modelled this behaviour, this shouty behaviour…there'd be pressure in the system, people would be under a lot of stress, not enough beds, too many patients, matrons would be hauled in to explain what they were doing and asked to find three beds and sent off again in tears to go and do it, really quite awful, awful meetings…What we needed to try and get to very early on was get past this fear, aggression, macho behaviour…"* After a period demonstrating and role modelling a more collaborative and respectful approach, there were noticeable changes: *"meetings were being held in a well-managed way, with an agenda in which everyone knew their part…We still had not enough beds and too many patients. But people were coming with the information they needed ready, giving it in, there'd be an issue on the table about so what do we now do? A set of actions [would be agreed] and people would go".*

In Part Five of this report, items (ix) and (x) also illustrate the impact of unhelpful managerial behaviours.

Leader attitudes towards unwelcome information

Leaders recognised that leadership teams sometimes defended themselves from unwelcome information in the same way that they observed clinical groups doing. The consequences of leaders denying bad news have been widely remarked ever since the Bristol Royal Infirmary Inquiry, and have been reprised in several inquiries since. Senior leaders were conscious of having to guard against three problematic responses: discounting bad news, dismissing it, and being immobilised in the face of difficulty.

Discounting may occur when senior doctors become inured to harm and death, and over time recalibrate what they view as normal or acceptable. Interviewees explained discounting not as an excuse, but to warn against it*: "there's a degree of desensitisation that wouldn't occur if somebody was doing my role and hadn't been experienced in healthcare. So they will be questioning every patient's death…[But] the clinician might say 'It's a recognised complication, the patient was elderly, multiple co-morbidity, these things happen'" (Group MD, independent sector)* The participant went on to observe that having realised they had themselves *"moved away quite considerably from where normal is"* they started to rethink their organisation's assurance systems so as to counteract the normalisation effect.

Leaders may deal with unwelcome information by disbelieving or otherwise dismissing it. One interviewee reflected on how an insular, bullying subculture had emerged in a team in a previous organisation, and that in hindsight: *"the warning signs were there, the smoke signals, but even with that, people still didn't want to believe that it could have been possibly true" [MD mental health].*

Dismissing bad news sends a powerful message through organisations to conceal it. Staff learning not to report bad news was sometimes ascribed to oppressive leadership styles, but was as often ascribed to false positivity. One described the corrosive effects of a previous trust leadership: *"as long as everything looked green on a scorecard, don't tell us there are problems…There'd been a lot of years of learning of 'just don't raise a problem'…[Some years on] we haven't really managed to unpick all of that…" [MD mental health]* Another recounted joining a trust where statistics but not the damning comments from their NHS staff survey were reported to the Board, which had the effect of sanitising the findings: *"there was a degree of protection…One person says 'well, maybe we haven't got many people doing the survey; it's only disgruntled people'. They sort of push that away" [MD mental health]*

Leaders also recognised that unwelcome news may be met by inaction simply because people or problems seem too challenging to confront. It has been noted there may be considerable reluctance to take on powerfully disruptive individuals in an organisation. One medical director reflected that their predecessor put them *"in the too difficult box"*; and their own resolve had sometimes been bolstered through working with a chief executive determined to instil medical discipline. Other interviewees observed that interpersonal friendship or bonds of collegiality could also inhibit leaders from taking action, particularly where the issue was one of questionable behaviour towards colleagues rather than patients.

Negative behaviours from the top

Close to a quarter of the sample (seven out of twenty seven medical leaders) reported having experienced negative behaviours directed towards themselves or senior colleagues either from the very top of their own organisation, from NHS Improvement, or from NHS England. At worst these behaviours correspond with descriptors of workplace bullying (Einarsen et al., 2009) and at lower levels with workplace incivility (Estes and Wang, 2008).

Within organisations, senior leaders reported what they experienced as humiliating 'assurance' behaviour and senior management meetings that were toxic: *"I didn't realise I was being bullied at the time; I thought it was me. I thought they were humiliating me in front of my peers, by pointing out*

that I've not been able to produce the results that they wanted…" This Medical Director described the experience as akin to being *"psychologically flogged…it was quite brutal stuff"*; only later did they understand their treatment amounted to *"institutional bullying"* [MD mental health]

In relation to NHS bodies beyond their employing organisation, one experienced and respected leader described *"most awful behaviours from NHS Improvement…unreasonable targets being set, castigated for not achieving those unreasonable targets in a ridiculous timeframe…open threats in meetings very early on about not being good enough…my job being insecure, and me being threatened with the sack…"* A decision was made to formally complain. One reason for doing so was because leading cultural change in the trust meant the interviewee was asking their own staff to come forward to identify poor behaviour: *"that's a brave thing for people to do…If I'm asking my teams to do this, and I don't do it on my own [and my colleagues'] behalf then I'm not living through what I'm wanting others to do."*

Implications

There are many formal performance indicators that may signal a positive or negative subculture, but medical leaders also rely on a wide range of soft signals. Some mentioned, such as those itemised above under Appearances, will be familiar to many leaders; and using them has been promoted as an improvement tool (see NHS England's 2017 "Fifteen Steps Challenge"[9]). Others, such as the notion of emotional holding are recognisable in specialist communities (in this case psychiatry) but may be unfamiliar to others. Leaders do not lack data they can use about the quality of cultures. The challenge for leaders is to make sense out of all of the disparate sources, manage their own and their colleagues' cognitive and emotional responses to unwelcome information, and find ways of changing undesirable situations once they have been identified.

Medical leaders were astute to a range of subcultures, including the subculture of leadership teams. They also recognised that by the time clinical subcultures came to their attention they had often been in the making for some while. We see in the next part that established negative cultures take considerable time and effort to change.

PART FOUR: BUILDING POSITIVE CARE CULTURES

This section considers the third research theme, the means by which senior leaders approached the task of building or sustaining a positive culture.

For the purposes of this section it is helpful to be aware of different perspectives in the literature about what organisational culture means, and how organisational culture can be influenced. Views on organisational culture tend to lean either towards a 'scientific paradigm' in which culture is viewed as a 'thing' that organisations have, and can be changed without fundamentally altering other organisational variables; or towards an 'anthropological paradigm' in which the notion of culture is synonymous with the notion of organisation itself and cannot therefore be a single variable. (Bate, 2010).

Those who view culture as a 'thing' that organisations 'have' will interpret leadership of cultural change as meaning that leaders should develop discrete 'culture management' strategies, and that they should design a strategy to cultivate a particular type of culture. Those who view culture as synonymous with organisation will interpret leadership of cultural change as meaning that, *since leadership is unavoidably also leadership of culture*, leaders will be impacting on cultures in *all* of their core activity. From this perspective "anyone engaged in

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[9] https://www.england.nhs.uk/wp-content/uploads/2017/11/15-steps-inpatient.pdf

active change in organisations is involved, therefore, in cultural change" (Anderson-Wallace and Blantern, 2005).

It will become apparent in this part of the report that the way senior medical leaders 'think culture' and 'do culture' is more consistent with the 'anthropological' paradigm. From their perspective, medical leaders are 'doing culture' through the leadership activity that is pertinent to their role. For the most part they do not set out to do culture management as a discrete task, but rather they have found that some element of culture management is necessarily embedded in their leadership activity.

However, there are special cases where leaders do deliberately set out to change undesirable aspects of behaviour in an organisation or subgroup. These challenging and time-consuming interventions meet with varying degrees of success.

Cultural housekeeping

Cultural housekeeping is the day to day, consistent reinforcement of features of culture that are more or less desirable. For most participants, how leaders engaged with those they encountered in the course of their day-to-day work was one of the most immediate ways in which cultures and subcultures were influenced.

It was noted in Part Two that leaders draw on formal leadership concepts and theories to inform how they work, and that principles associated with complex responsive processes (Stacey and Griffin, 2007) and with adaptive leadership (Heifetz et al., 2009) were both found useful.

A few leaders referenced Stacey's perspective of complex responsive processes, which proposes that organisations are not static systems but "ongoing, iterated processes of cooperative and competitive relating between people" (Stacey and Griffin, 2007) (p.1) Adopting this perspective, one leader had come to understand that "*every conversation makes a change",* but noted conversations did not always go as hoped: *"I can have fantastic conversations with people. And then, I can have not such fantastic conversations with people - and what people remember is that!" [Divisional Director acute care]*

Differently, another interviewee emphasised how Heifetz's adaptive leadership model prompted them to consider *"how you support a team to find an answer to a problem for which there's not a straightforward off the shelf answer…and create the environment, the holding environment, to allow that team to do that work." [MD Health Board]* An important element of day-to-day culture work is hence promoting collaborative problem solving, assigning responsibility for outcomes, and providing supportive coaching. Encouraging a collective solution to problem solving had come to others through experience, and then perhaps been conceptualised in terms consistent with adaptive leadership *"It's something I guess that I had probably been doing unconsciously…not, "I'm going to find a solution for you," [but] "What are we going to do about it? What are you going to do about it? How can I help you do it?" [AMD Health Board)*

Conversations prompted by negative assessments of colleagues' work were recognised to be difficult for clinical leaders, and that it was important to find the right approach: *"We just don't like doing it. It's embarrassing, or it's potentially challenging. So you have to find a different way to explore it - with intent, with curiosity". [Consultant & specialist educator acute care*]

Role modelling

Role modelling was cited frequently as a way of exerting influence. One Medical Director recalled hearing it said *"you never know where your shadow falls"*: *"that's really true; you just don't know what people will take from the way you behave. I'm really conscious of [role modelling as a leader during] my clinical practice. …It doesn't matter how many times we say to people what we want them to do, it's what people actually observe and experience that counts". [MD Health Board]*

A younger participant still relatively new to a formal leadership role acknowledged coming late to the realisation that "*as a doctor you're in a leadership role from day one…It's a mindset and it's about role modelling*" [AMD, GP]

Changing the work, changing the culture

To achieve continuous improvement in the quality of care, leaders are necessarily working with or against the grain of existing organisational practices and cultures.

Echoing the health care leadership research referenced in Part One, many leaders recognised they knew little about enabling change when they started medical management roles. They had learned, frequently through trial and error, that successful change rested as much on their ability to engage with colleagues as on their expert knowledge. As one noted *"I've become much more aware of all the things I don't know, [especially] the huge importance of getting people on side before you try and make any change"* [GP leader, new models of care].

Diagnosis

Leaders acknowledged that it was a cultural tendency in health care – driven by operational pressure - to adopt superficially alluring quick fixes. *"Often we're in such a rush to come up with the solution that we don't understand the problem well enough…It takes a while to understand the problem. Then it takes a while to design a good solution…test it, pilot it somewhere…figure out how you're going to get buy-in…"* [Group MD, independent sector Careful diagnosis of care problems, and thoughtful consultation with those in sharp end roles, were regarded by many as preconditions for successful change.

Professional groups frequently possess a shared understanding of problems and a view on likely solutions, which may be accurate or erroneous. But this is one reason off the peg solutions frequently fail to achieve the improvements seen elsewhere. (Dixon-Woods et al., 2013) For one hospital, expert analysis of their emergency department patient flow done by an Academic Health Science Network was of far greater value than ready made solutions because it offered a sound diagnosis devoid of simplistic advice: analysis revealed *"what the problems were historically over the past three years. They didn't try and impose their ideas on us, they simply said, here's where we think the changes have happened…What they didn't do was bring a set of preconceived solutions"*. [CEO acute care]

A participant working in acute care gave an account of how one NHS trust's mortality review process provides a diagnostic foundation for change. Death certificates are issued following a structured discussion (sometimes within an hour or so of the patient's death) between the senior medical leader leading the review and, usually, a junior doctor representing the care team involved. This enables the trust to diagnose the system, rapidly identifying where problems may be occurring in care delivery and why. Potentially vulnerable patient groups are identified *"if you were independent before, if you had a survivable diagnosis, why didn't you leave hospital alive?"* and then the review discussion builds understanding of how patients' care is being managed: *"What were the events that occurred when they were in? [And] key decision points, what was it that changed the trajectory of care? Why did they go from active management to palliation?"* When systemic problems have been spotted and their features properly understood, a patient safety team works to support organisation-wide learning and change.

The call to action

Several leaders spoke of motivating change through a determined focus on patient experience and perspectives. One had experienced implacable resistance to service development until a distressing letter from a patient's mother altered colleagues' views: *"I learnt the importance*

of…patients' experience again. Patients' stories are what can change people's attitudes." [National leader and former MD acute care]

Interviewees also recognised staff sometimes resist imposed changes in NHS services precisely because they do not see these serving clients, and cannot be fooled into thinking otherwise: *"sometimes we can manage the win-win, and it's a better way to do it anyway. But most of the time [change is] driven by money, and staff know that" [MD mental health].*

Attending to concerns about change

Leaders spoke of the need to be attentive to colleagues' concerns, the sense of loss they experience when cherished services will not be supported, and their capacity for change in already demanding situations.

The inescapable work of change, whether on small or large, local or national projects, is listening to views and acknowledging that anxieties are real: *"…days, weeks, talking to the staff, listening, acknowledging all of their concerns…There's no point trying to tell people that their concerns are unfounded; it's about acknowledging their concerns…And saying, "Well, how do we work through this?" [Divisional Director acute care].*

Whilst there was empathy for colleagues' concerns derived from a commitment to service there were also critical comments about private practice fuelling opposition to change. One participant noted *"there are people who are earning three times their NHS salary from doing private work…that inevitably is going to make them conflicted" [Past President Royal College acute care]* Another commented that where private practice was driving resistance to service development then *"negotiated change"* was never going to work and *"sometimes push comes to shove, 'That's what's going to happen. End of story.'" [Network lead, acute care]*

As noted earlier, practitioners can sometimes come to feel helpless and unable to initiate change even if they would welcome it. A participant leading a national project was all too aware that many GPs felt overwhelmed by current demands on general practice, in itself the driver for introducing new models of care. On the one hand *"because they were* **so** *pushed and they are* **so** *fed up"* GPs are ready for action; on the other *"one of my fundamental things when I go into a practice is 'how am I not going to get them to have to do more work? How do I get them to be leaner when they're already probably falling over?'" [GP leader, new models of care]*

A culture of high standards

Leaders are conscious that good performance management, and work with doctors in difficulty, has both direct and indirect effects on culture. The direct effect is to maintain high standards by upholding individual accountability, and promoting individual learning. The indirect effect is to communicate to everyone the standards that leaders require, and signal how people can expect to be treated when competence or behaviour falls below these standards.

Putting individual performance in context

Scholarship, policy initiatives and campaigns such as the Department of Health and Social Care's 'Sign up to Safety' initiative have contributed to increased understanding of the structural, cultural and individual factors shaping professional actions.

Many acute care leaders referred to the association between group cultures and safe outcomes. Around a quarter of the sample explicitly referred to clinical human factors helping them to understand cultural factors affecting care delivery. For example one leader had noted the correlation between surgical 'never events' and operating theatre cultures: *"it was clear that there were common factors across all the hospitals that had had never events. [They] related to the relationship between the doctors in the operating theatres and the rest of the staff, and the human factors involved". [Group MD, independent sector]*

In interviews with primary care leaders, concepts derived from patient safety discourse were less prominent. However there was an understanding – partly from involvement in education and partly from managing performance issues – that practice cultures had a significant impact on GPs performance. Working with doctors in difficulty, the starting point for one would be *"how they've got to where they are now…the context in which they're working, and the team within which they're working…how they deliver care and the aspects of the culture that they work within and the environment that they work within".* This interviewee argued that insight was not an *individual* attribute but an attribute *"shaped by our environment…You don't know what you don't know unless you have those conversations with people, and have that reflective mirror put in front of you"* [AMD GP].

Managing individual behaviour, competence, ill health and harmful errors.

Participants spoke more about the cultural impact of managing inappropriate behaviour, competence issues and ill health than responding to serious error. Behavioural issues that had come to attention included bullying, verbal aggression, throwing equipment, ill temper, refusal to comply with bare below the elbow requirements, intoxication and substance misuse, and disrespectful behaviour towards colleagues. Misconduct in the form of sexual harassment, inappropriate relationships with patients, and dishonesty also received mention. Competence issues, reports of which were sometimes provoked by underlying conflict between doctors, included concerns about clinical judgement and decision making, choice of procedure, outdated approaches, unorthodox technique, inadequate technical skills, failure to follow NICE guidelines or local protocols, and inadequate record keeping. Some participants spoke about supportively managing doctors who suffered ill health, for instance depression or a major illness. Only one major error was discussed.

How does each of these play into culture?

First, for many, *addressing* causes for concern was a pivotal responsibility and the most direct way in which they impacted on culture day to day. As one medical director pointed out, *"it's just part of the job…30%-40% of being Medical Director is HR…if you're not prepared to do it, you shouldn't be Medical Director". [MD acute care]* There was little disagreement about the need to address poor clinical performance. But there were contrasting views about how far poor behaviour should be tolerated, and when strong disciplinary action or dismissal for persistent poor behaviour was warranted. Some argued poor behaviour is itself a safety issue: *"The direct connection [between standards of behaviour and quality of care] is safety, and I make this point over and over again…In all sorts of little ways - just being respectful - is better for patients". [CEO acute care]* Several took the view that organisations were too ready to tolerate disruptive behaviour from otherwise 'good' clinicians: *"we spend a lot of time trying to deal with people and keep people to the detriment of the whole hospital" [Past President Royal College, acute care],* but also recognised that disciplinary proceedings and dismissals were almost equally difficult and disruptive at least in the short term. Another leader pointed to how workforce shortages created pressure to retain staff who were regarded as clinically sound even if their behaviour required modification: *"the reality is that we've got a 25% vacancy rate, relying on agency fill…If I've got a highly trained UK consultant here, you'd really have to go some for me to want to move them on" [MD Mental health].*

Managing negative behaviours is potentially easier in the independent sector because it is simpler to revoke a consultant's practising privileges than to terminate a contract of employment. However, taking this step generally falls to an individual hospital director (generally a non-clinical manager) for whom there is a disincentive in the form of lost revenue from badly behaved high earners. This had been a matter of concern for one of the participants on joining the independent sector, so *"we revised the Practising Privileges Policy…I provided a handbook for hospital directors on how to manage practising privileges [and] a parallel handbook for the Chairmen of MACs about how to work with hospital directors to help them do the performance management…" [Group MD, independent sector]*

As well as actually addressing concerns it is important to *be seen* to tackle persistent poor behaviour. Several interviewees observed that when high profile miscreants were challenged, calling them to account communicated a clear message that poor behaviour would not be tolerated: ***"the biggest signal that went around the organisation was I suspended two people…I have to be careful of witch hunts; we cannot do that…But I also know that we [cannot] allow ourselves to condone behaviours by allowing them to continue"***.

Additionally, it was widely viewed as essential to a healthy culture to be perceived as fair and reasonable in managing performance and behaviour. Leaders were strongly committed to implementing due process both for moral-cultural reasons, and in order to avoid future problems such as legal challenges. This is one leader's summary of good outcomes from recent cases: ***"we did the right thing by the individual, and the patient group, and their colleagues. There were concerns, we listened to them and we investigated. [We] took some steps to mitigate risk, and then to reintroduce a person in a managed way." [MD Health Board]***

Building a culture of trust and fairness also means differentiating deliberate behaviours from inadvertent errors. Notably, only four participants (none whom worked in NHS acute care) explicitly referred to 'just culture'. Several did however refer to a blame culture surrounding error, a culture that included a tendency among clinicians to self-blame. One leader reflected on how (in a previous role as an NHS leader) their firm disciplinary approach to poor behaviour, which was accompanied by a compassionate approach to a catastrophic error, had a noticeable impact on the consultant body***: "they were contrasting what had happened to the doctor who refused to cooperate, and what had happened to [another] consultant who…continued to have the confidence of the organisation because [his] was a simple error...Those things…help to change a cultural environment" (Group MD, independent sector).***

Finally, several leaders argued that compassion and kindness had to accompany fairness in dealing with untoward outcomes. One spoke of coaching their trust's clinical directors to recognise that when they are investigating complaints or clinical incidents ***"you do have to be human; doctors are not automated machines…that's not being soft, that's just being considerate" [MD mental health].***

Cultural interventions

Some negative subcultures had changed following fairly intensive interventions. However, diva subcultures were perceived to be remarkably resistant.

Influencing negative subcultures

Among the participants who reported attempts to tackle negative subcultures, commissioning in-house specialists or external consultancies to work with groups in difficulty had achieved some degree of success (see below). They described organisational development processes akin to those used in mediation, including one-to-one interviews to capture individual perspectives, facilitated group meetings where perspectives are shared in a safe space, collaborative problem solving and sometimes behavioural contracts developed with or by the group.

Participants reported how negative behaviours arising out of interpersonal conflict and petty actions (including competition for private practice) could engulf an entire service. But one factional subculture "***in uproar"*** had been turned around by a programme of the sort outlined above, together with management support: "***We created an additional post to strengthen management, [and] laid down some very clear ground rules and expectations";*** a year later an external accreditation team ***"remarked on the very strong sense of fairness, of teamwork and a good cultural dynamic".***

One embattled subculture, where learned helplessness threatened to undermine roll out of improved facilities and expanded services, required a more intensive intervention. An external provider ran a programme for consultants including individual coaching, MBTI (Myers-Briggs Type Indicator) analysis, workshops, and action learning sets. The programme ran for well over a year: *"it took a long time, and it still goes backwards and forwards at points"*. However, it has had significant impact on consultant attitudes: *"if there are problems, there are problems - and we can grip them…"* In this example, the success may be partly attributable to structural factors, such as high demand and inadequate facilities, also being resolved.

Other services in difficulty had been helped to redirect themselves following a commissioned Royal College review. Reviews appear to support development of individual and group insight in part due to the authority of senior peer review by neutral observers: *"that external view is really helpful for people to hear messages that they don't like to hear" [MD Health Board]*. Additionally, standards produced by the Colleges enable both the reviewers and the clinical leaders to state authoritatively what colleagues *"should now be…doing to firm up standards and operate to a certain level". [Network lead, acute care]*

There was widespread pessimism that diva subcultures could be changed if the diva remained. Generally, where leaders reported resolution, it was because a diva had left voluntarily, retired, or had been removed.

Several leaders noted how difficult it was to dismiss an NHS consultant for diva type behaviours where clinical outcomes appeared satisfactory but continuing conflict with colleagues potentially put patients at risk. Medical directors interviewed in the 2011 study viewed cases of this sort as the most difficult to equitably resolve. Concerned for future patients, they nevertheless felt inhibited from taking steps to remove the person from the situation without better evidence that care was potentially unsafe. A typical case would be that of a high-flyer clashing with other consultants who view themselves as the reigning departmental rulers. Where governance processes are underdeveloped, allegations about unusual practice and poor outcomes can be neither proven nor disproven. Organisational development interventions including individual meetings and mediation may be tried, and new governance processes can be put in place. Often, however, such situations are only finally resolved if the diva departs. As one leader reflected, *"when you've got cultural problems and interpersonal problems that go as deep as that it's hard to get through them and usually someone leaves or retires. I think we tried to do the right things there; it was solved despite us rather than because of us...Or maybe it was we were starting to make things difficult for X to misbehave…"*

There was one rare report of a positive outcome from persisting with and retaining a diva-like individual whose colleagues had submitted to years of intimidating behaviour. He was spoken to several times: *"this was not acceptable. Gave X an informal warning and advice that this would be taken to disciplinary process if it continued; but pointed out to X the importance of X's role as a role-model and leader"*. Some time later staff reported that *"they no longer had to tiptoe around him; they still recognised that he was an assertive character, but in a confident way. They were no longer frightened of X"*.

Culture building resources

One of the research aims was to identify the resources and tools (such as policies, structures, decision support tools or interventions) that senior medical leaders used when working to build a positive culture. It was noted however at the outset to this part of the report that working on culture is rarely a discrete task, but rather embedded in day-to-day leadership activity. Moreover tools are only of value when deployed effectively in an appropriate context. Context, not seeming usefulness to others, should guide decisions on what tools to use and when. For this reason, the specific items listed below should be treated with caution. They will be useful, and work effectively, in some situations, and for certain purposes.

The importance of relationships

Notwithstanding the warning above, there was one culture building resource named by virtually all of the interviewees: the time they invested in building relationships with the people they lead. This cannot be overemphasised. One explained that in mentoring other potential leaders their first advice is *"why the time invested in getting to know people is so valuable" [Non Executive Director].* Another spoke of building more than purely transactional relationships: *"I just talk to people…talking about stuff which is completely unrelated to work. So, I'm more curious about the person, their football team, where they live, where they're from and what they like to eat and drink." [MD mental health]* Other leaders had a more austere style, but placed a high value on creating, and role modelling, cordial relationships with staff of all grades and professions.

Many interviewees emphasised the importance of inclusive listening, ensuring that voices are heard: as one summed it up *"if you're going to truly advance collaboration, how can you do it with at least listening to the contribution of everybody involved?" [Educationalist & GP]*

One reason for the emphasis on relationship building is the view that *"all doctor-managers manage by consent. You have to have the confidence of the people you manage, to continue. If you lost that then you just cannot do the job". [AMD Health Board]* Excessive collegiality of course has well-recognized downsides including, as many participants in the 2011 study acknowledged, reluctance to jeopardize relationships in the course of management action.

For those who do find themselves in situations where patients' interests have to be put before those of colleagues, this is *"a worry for medical leaders who see themselves as doing it on a temporary basis. So many clinical directors are clinical directors for 2, 3, 4, 5 years, but they always know they're going to go back to being one of the troops. And I do think some of them fear what happens when they are one of the troops again…"* Several leaders cited this anxiety as a disincentive to others to take on a clinical director role.

The rest of this section summarises the resources that leaders identified as useful in certain contexts. Their perceived utility was a matter of judgment, not formal evaluation.

Governance

- Mortality and Morbidity meetings (M&M). It was recognised that M&M meetings are potentially valuable but frequently need improving. One leader was undertaking a review of all M&Ms within their organisation and had identified over fifty, all with varying approaches and degrees of effectiveness. *"Sometimes people aren't very good at articulating what is the purpose of an M&M. They are a crucible for learning…not a way of scoring points against colleagues, or of justifying what you did to other people."* It was noted that the Royal College of Surgeons has produced useful guidance on M&Ms.[10]
- Multi disciplinary team meetings (MDTs). While good MDTs are supportive for both staff and patients, several interviewees had experience of MDTs going badly wrong and requiring senior support to reset them. However, it was suggested that doctors have *"adapted to more MDT. The days when an individual consultant was responsible for every aspect of the care and had the whole thing on his own plate have gone" [AMD acute care].* It was commented that poor ICT frequently undermined communication in MDTs that have to function across geographically dispersed clinical networks.
- Responsible Officer regulations. These were cited as an important lever to make inquiries into professional performance across organisational boundaries, particularly between the independent sector and NHS.

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[10] https://www.rcseng.ac.uk/-/.../morbidity-and-mortality--a-guide-to-good-practice.pdf

- Mortality review. An example of how mortality review supported learning and improvement was discussed earlier (p.36).

Organisational practices

- Education and training practices. Several leaders cited the quality of all components of the training environment within NHS hospitals as critically important to overall culture. Good educational practices supported trainees effectively, and junior doctors were eager to apply for posts in places where they had enjoyed training.
- Peer review and support. Several people described how peer review groups sustained professionals within communities of practice. One had introduced them to an expanding community based paediatric service, to ensure that practice was aligned, guidelines were implemented, and people had an opportunity to share experience and difficult cases. Another described how qualified GPs had carried on their training group *"through the years, so although they're working in different practices, they have a forum to calibrate" [AMD, GP].* Appraiser and Medical Director networks were also considered valuable, both for sharing practice and providing social support.
- Job planning. It was commented that job planning *"is seen unfortunately as a slightly negative tool" [AMD acute care];* but argued to be of real value in understanding activity patterns, allocating work fairly, and supporting general management activity. Others noted how inadequate job planning could lead to diverse problems; especially conflict within teams and with general managers.
- Appraisal. It was argued that there was unhelpful variation among appraisers as to the purpose of appraisal: *"some appraisers feel very much like their role is an advocate in support of the GP…and there'll be others that see appraisal as quality improvement…" [AMD, GP];* another regretted that appraisal had become *"a tick box exercise for revalidation" [Divisional Director acute care].* But done well it was viewed as supportive of personal development as well as contributing to good care.
- Consultant monthly away day. A regular monthly away day for consultants, which started with a meeting with the CEO and Medical Director in which there was genuine openness and debate, was viewed as a very valuable forum in one trust where it had been introduced.

Authoritative professional guidance

- GMC Good Medical Practice (GMP) A number of leaders referred to the value of GMP, often using it as the starting point in discussion with doctors around performance and team working issues. They noted that doctors were less familiar with it than they should be: *"When was the last time you read this?" is a common phrase I use, and mostly the answer is, "I don't know. Never." [AMD Health Board]*
- Royal College Invited Review Mechanism (IRM). It was noted in the section *Influencing negative subcultures* that College IRMs could be influential through providing an external, authoritative assessment of individual or team functioning.
- Royal College developed Standards and Guidance. It was noted in the section *Influencing negative subcultures* that College guidance could be useful as a way of authoritatively determining expectations of a service.

Support for professional well-being

For the most part the leaders interviewed in this study did not view themselves as having direct responsibility for ensuring that doctors' well being was supported. Many viewed this as falling into the domain of occupational health. Where a leader's portfolio included a reporting line from occupational health, that had drawn consideration of staff well being into their role.

- Schwartz rounds A handful of participants' organisations had adopted Schwartz rounds, a structured forum for staff to reflect on the emotional effects of caring for patients[11]. Originating in US health care they have recently been evaluated positively in the UK context (Maben et al., 2018). One noted *"Schwartz Rounds were really effective in allowing people a psychologically safe space to express their anxieties, their worries, their feelings about episodes or about issues" [National leader & former MD acute care].* Others were exploring introducing them.
- Specialist health services. The Practitioner Health Programme and GP Health Service[12] received mention and one leader noted *"all the performance cases are stressful, so in early contact, we will make sure the doctor has been signposted for support" [AMD GP]* Another valued resource was the Psychiatrists' Support Service provided by the Royal College of Psychiatrists.

Hopeful initiatives

- Disclosure coaching. Disclosure coaching is designed to support a culture of openness following adverse events by helping professionals disclose them empathetically and honestly to patients and/or their supporters. A trained colleague coaches their peer through the disclosure process, but does not do it for them. Disclosure coaching gives patients a better experience and supports professionals through what may be a distressful event (Plews-Ogan et al., 2016, White et al., 2017, White and Gallagher, 2013) One scheme in which "*doctors, nurses, other clinicians and managers trained as coaches"* was described by a participant. The scheme aimed to ensure that those who were responsible for ensuring the statutory duty of candour was implemented *"had the opportunity to speak to somebody and say, "I'm struggling a bit here, what can I do, how do I need to be approaching this?"* The scheme had not yet been evaluated.
- Team STEPPS. Two interviewees referred to the value of Team STEPPS, a human factors informed programme developed in the US (King et al., 2008) to support optimal team working. One noted that in the UK an NHS trust had introduced a rebadged version modified for local use.
- Medical Mediation Foundation / Evelina Project. Noted above under *Interpersonal interactions*.
- NHSI *Culture and Leadership Programme*. Noted above under *Influencing organisational cultures*.

Personal development

Two approaches to personal development are included here because both were described as life changing.

- Compassion training. Courses in living and working with compassion first developed by Gilbert are now provided by The Compassionate Mind Foundation.[13] One leader explained, *"the approach to shame just completely changed my life; I've not really suffered from any level of stress or anxiety since…It changed my medical practice…and then I thought, "This can apply to management and organisational culture" [MD mental health].* Compassionate mind training emphasises that compassion is not simply kindness, but also requires courage, honesty, and competence (Gilbert, 2010).

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[11] https://www.pointofcarefoundation.org.uk/our-work/schwartz-rounds/

[12] http://php.nhs.uk
http://gphealth.nhs.uk
[13] https://compassionatemind.co.uk

- Appropriate leadership development Whilst there were mixed experiences of leadership development, those who participated in a well-designed programme at the right time of their career found them invaluable. More than one had experienced The Health Foundation's Generation Q programme. One concluded, ***"I now feel as though I can fulfil my own potential, because I'm very aware of who I am and where I fit in within the structures…It changed my life"***

Implications

It was noted in the introduction to this section that organisational culture tends to be viewed in two differing ways. According to the scientific paradigm culture is a 'thing', a discrete component of organisations; whereas according to the anthropological paradigm it is simply synonymous with the notion of organisation (Bate, 2010). Thus anyone engaged in change in organisations is involved in cultural change (Anderson-Wallace and Blantern, 2005). The findings reported here indicate that the way in which senior medical leaders 'think culture' and 'do culture' is consistent with the anthropological paradigm, the idea that culture and organisation are synonymous.

Reflecting on their leadership experience, many interviewees explained how their activities impacted on culture, but they rarely set out solely to manage culture as a single variable. What senior leaders believed they were doing to influence cultures was embedded in day-to-day leadership activity, and in many instances, culture (and culture change) appeared to be an outcome of other goals. A few leaders, whose organisations had been through a period of great difficulty, were conscious of needing to change cultural expectations and indeed scholars have observed that organisational crises frequently prompt 'culture work' (Schein, 2010). But this was done within their broader organisational leadership role and as part of attending to other urgent problems. Those leaders who had intervened in negative departmental subcultures did view this as a special cultural project. But it constituted a very small part of their overall activity, and as we have seen, specific interventions were generally outsourced to specialists.

The scientific paradigm of culture as a 'thing' gives rise to projects that aim to change the culture of the organisation. Such strategies seek to adopt interventions, methods and tools for change. Bate cautions that strategies based on the scientific paradigm should be avoided as they are trying to develop something that does not exist: they are "mythical strategies for mythical entities" (p.14) (Bate, 2010).

The anthropological paradigm, on the other hand, gives rise to strategies of cultural change based on the notion of 'thinking culturally'. For leaders, to think culturally is to be aware of how all leadership activity bears on culture, whether leaders intend it to or not. We have seen throughout this report that leaders 'think culturally' when they are invited to reflect on their work and organisational culture. It may not always, however, be the guiding principle of their approach to leadership. Promoting the importance of 'thinking culturally' about leadership and change is of value, and is quite different from promoting generic strategies for cultural improvement.

Finally, leaders in both the 2018 and 2011 studies noted that soft signals are valuable, but the stories they tell may be unclear. We noted earlier, and again in this section, how soft signals can raise important questions about performance; but how in the absence of harder evidence, soft signals can pose a dilemma for leaders concerned both about clinical outcomes and fairness in their treatment of fellow professionals. These findings appear to intersect with those in the GMC Research Report '*Understanding employer's referrals of doctors to the General Medical*

Council'[14]. There may be value in dialogue with leaders - particularly relatively novice clinical leaders - about how soft signals are construed and acted upon.

PART FIVE: COMPARING LEADERSHIP BEHAVIOURS WITH SYSTEM ASPIRATIONS

This section addresses the fourth research theme, comparing how medical leaders described their work with leadership models promoted by NHS system leaders.

In 2016 NHS Improvement adopted *Developing People – Improving Care* (Anon., 2016b). Endorsed by bodies including Health Education England and the NHS Leadership Academy this national framework "emphasises compassionate and inclusive leadership…paying close attention to all the people you lead, understanding in detail the situations they face, responding empathetically and taking thoughtful and appropriate action to help"(p.7). Although the source is not cited, this formulation appears based on a model proposed by Atkins (Atkins and Parker, 2012), and other scholarship on compassionate leadership summarised by West and Chowla (West and Chowla, 2017). National endorsement of principles of compassionate leadership would seem to partially supersede the NHS Leadership Academy's own nine dimension model (Storey and Holti, 2013).

Northern Ireland, Scotland and Wales all have their own leadership frameworks.[15] Northern Ireland's 2017 *Collective Leadership Strategy* incorporates the same four dimensions of compassionate leadership as *Developing People*.

The definition of compassionate and inclusive leadership supplied in *Developing People – Improving Care* is augmented by NHS Improvement's *Culture & Leadership Programme* (Anon., 2016a) which sets out ten sets of desirable leadership behaviours akin to those in West and Chowla. These ten behaviours are therefore used here for comparison.

Interview extracts illustrate how medical leaders spoke to an aspect of the desired behaviour, and tend to show that they use a different lexicon to describe their actions from that used in leadership frameworks. Moreover, leaders must frequently reconcile competing goals, resist perverse incentives, and navigate conflicting values. Counterpoint quotations illustrate these tensions.

i) Ensuring direction and alignment

Focusing activity in the face of multiple priorities is a core leadership role. This extract is part of a story about a new leadership team starting their work in a trust rated Inadequate by CQC. They faced a plethora of priorities including A&E performance, poor conduct, and extremely low staff engagement scores. Addressing the A&E challenge and resetting behavioural expectations helped to shift the organisational climate.

> *It was very difficult to prioritise…There was joint work…to get the consultants to accept that the 4-hour target is a hospital target rather than an A&E target…People had retracted into their own little bubbles and were*

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[14] https://www.gmc-uk.org/-/media/documents/GMC_Employer_referrals_report_FINAL_01.03.17.pdf_69525003.pdf

[15] https://www.health-ni.gov.uk/sites/default/files/publications/health/hsc-collective-leadership-strategy.pdf
https://www.nes.scot.nhs.uk/media/3399300/scottish_leadership_qualities_framework_-_guidance_notes_july_2014_-_copy.pdf
http://www.wales.nhs.uk/technologymls/english/resources/pdf/Leadership Qual Framework.pdf

looking after the patient in front of them, but were not bothered about looking at the wider issues...There was a lot of work dealing with…people who had been behaving badly…One or two people got suspended, one or two people got sacked…As finally the A&E target started to improve, I think people started to feel a bit better about the hospital as a whole…People think, "Well actually maybe this new approach can work, and we can pull ourselves up." [MD acute care]

Counterpoint

Medical leaders do not work in a vacuum, but have to manage external demands. One leader reflected that for clinical staff, a positive culture was one where people understood the purpose of care was to relieve suffering; but system leaders had been conveying a different message.

There's something about clarity of purpose and meaning. That's something that overall, trusts (mine included) and the NHS has really lost in the last couple of years with austerity. So much of the messaging has been about…your purpose is to be efficient. Well, our <u>purpose</u> isn't to be efficient…It's taken an awful lot of the soul out of what people are doing and delivering, and you can really see it and feel it. [MD mental health]

ii) Developing positivity, pride and identity

Organisations going through periods of crisis have a particular need for confident and hopeful leadership. One leader described the message he wanted to convey at his first meeting with the consultant body upon joining a trust that had been in difficulty for some time.

I made several things very clear…That I was not going to tolerate bullying, aggression or inappropriate behaviour. That we could and should be an organisation that we would all be proud to work in, but they were critical to that. That I saw the medical body as essential to leadership and success in the organisation, and that I was looking to them to achieve those things. [CEO acute care]

Counterpoint

Leaders were conscious of the dangers in maintaining false pride and positivity. One described how NHS internal market pressures created a perverse incentive to discount negative information about services.

You're bidding for work. You don't want to be going to your commissioners and saying 'We're losing control of certain things', because then they lose confidence in you…There are some perverse incentives there. That might have been the case down in [previous trust]…where we were anxious about there being problems, for the simple reason that how many of the commissioners would take their services elsewhere if they felt we couldn't do our job?

iii) Ensuring effective performance

This leadership task is often portrayed through examples of single hospital services. However, network models of care require performance to be orchestrated across several locations in complex multi-organisational structures. This account of setting up a specialist surgical network hints at the co-ordination challenges.

I led that process which involved a lot of interaction with teams in Site 1, Site 2, Site 3, and Site 4…setting up clinics in both Site 1 and 4, serving [a large geographical area]. Lots of interacting with other teams and

> *managing difficult change…helping them to understand the benefits of change, and making it something that still worked for them…[We created] combined team clinics. We set up sub-regional MDTs…which served to maintain people's interest so they didn't feel like all the [specialty] work had just been taken away from them. We managed the specialist expertise in those areas and tried to foster it, rather than undermine it. [AMD acute care]*

Counterpoint

The small scale and independence of General Practice presents a different set of difficulties to organisations tasked with ensuring effective performance. This leader reflected on the deleterious impact on patients and staff of dysfunctional behaviour in GP partnerships, and how anxiety about raising concerns inhibits the scope for an external body to intervene.

> *We're probably not as aware as we should be of [dysfunctional GP partnerships] because the partnerships are separate organisations. Until things get really bad it might not be apparent to anyone from outside that partnership…[In the system we have] the first step is for people to raise concerns about something…[We] need to be able to gather specific information about specific incidents…and [we] need to be able to go to the GP and say, 'This is what I've been made aware of; and this is where it came from.' And [practice staff] are often quite worried about that. [AMD Health Board]*

iv) Ensuring the necessary resources are available and used well.

Even in challenged health economies well-run services can thrive. In the next example, securing resources was achieved as part of a larger project of service improvement.

> *We've recruited three doctors…They've all left [neighbouring county] to come here because they feel it's positive and dynamic… and they're saying, "Well, how come you're getting investment in your service and no one else is?"…There has been some investment, but it's [more] changing how we've done things [such as introducing] peer review…people say it feels like a really supportive culture. [The Specialty Lead] also had a public health background and she helped devise the business case…I think clear leadership and her vision in terms of populations…was hugely helpful. [Divisional Lead acute care]*

Counterpoint

The CLP suggests good leaders 'win' the necessary resources for their own service. But competition for resources potentially undermines co-operation.

> *There was **lots** of talk about all the benefits, from a clinical point of view, of integration of care…The structure that got in the way was budget setting!...Three separate directorates that had their own separate budgets, to which they were each held accountable. Of course directorate A isn't going to give directorate B time - because it would have to pay for that…[MD mental health]*

v) Enabling learning and innovation

The need for leaders to create psychological safety to support learning from error is widely recognised. However, as the example below illustrates doing so is equally important to quality improvement. This extract is from an account of a successful project to reduce out of county mental health placements.

> *We used a quality improvement model, looking at the drivers of the problems…[Front line people] may not realise it, but if you work with them, they will give you the right intelligence into why the drivers are working in the way they're working now…We had a no blame approach…So then people were more open…They just didn't realise the way they did things contributed significantly to the problem...What we did was to bring it out…with no blame, because people then found solutions to it. [MD mental health]*

Counterpoint

Uncomfortable work climates can inhibit learning. But one leader voiced a problem that was also implied by others: cordial relationships between leaders can also inhibit openness.

> *The [candid conversations] I find most difficult are peer to peer... when I'm struggling with something with one of the other execs…We all like each other, so we all avoid saying difficult things to each other. [MD mental health]*

vi) Helping people to grow and lead

Several leaders recalled that experience had taught them not to supply solutions to problems, but to coach colleagues to find answers for themselves. Many spoke with passion about supporting others to develop.

> *In the same way that people encouraged me into things that they thought I should do and I've in general enjoyed doing, I want to see people developing, moving on, gaining experience. [AMD Health Board]*

Counterpoint

We have noted that Clinical Directors are a critical link in the leadership chain, but are often expected to 'sink or swim'. Several leaders had sought more developmental support for Clinical Directors, but with limited resources trusts had been reluctant to invest.

> *[Ideally they would] get some training and development before they even take up posts…Once you appoint a CD…what they need is an individual plan that supports them, at least in the first twelve months. And that doesn't happen…It's very difficult, when we have vacancies, to get people to even consider thinking about it. [AMD mental health]*

vii) Modelling support and compassion

Participants detailed multiple examples of supporting colleagues and patients with compassion. Sometimes, notably after a catastrophic event, they are supporting both parties simultaneously. Here we learn how a leader's compassionate response to a serious incident supported both the surgeon and the patient's family. It also altered the course of the leader's relationship with the consultant body, which had been difficult from the outset.

> *A consultant had made a catastrophic error in the operating theatre…He phoned me up at about two o'clock in the morning in tears and we had a long conversation. Then I came in the next morning and said, 'Have you spoken to your patient's wife?' … and he said, 'No, no, I thought you could do that.' I said, 'No, I'm not going to do that but I'll help you, we'll do it together…' We had a long conversation with the poor man's wife…When those things happen it spreads, and [colleagues] talk. And the nature of*

> *what they say [about you] changes. [Group MD, independent sector, formerly NHS]*

Counterpoint

As one leader observed, leading change requires understanding towards people who are anxious or fearful, and also steady resolve. True compassion calls for courage as well as empathy (Gilbert, 2010).

> *In leadership within the NHS it's about truly listening and trying to engage but it's also about not being held to ransom, knowing when to hold your nerve, and where to compromise. [Divisional Director acute care]*

viii) Valuing diversity and fairness

We have seen how leaders view fairness as central to their role in managing professional performance. To respect equality and diversity calls for additional consideration. This leader, involved in a project to recruit overseas GPs, argued it was both clinically and morally important to acknowledge the doctors' circumstances, anticipate their needs and provide appropriate support.

> *If I take myself out of my current context and put me in another one where I don't know the system, and the language is not my first language, and they practise quite differently, I suddenly become more at risk. That doesn't mean that I haven't been any good, it just means in that context I'm more at risk…We need to ensure that, as part of the training, we look at the culture and values and how we work with patients here, which is quite different to other countries…Within England there are huge cultural differences…We need to understand how we teach, support, expose people to those sorts of micro cultures. [AMD GP]*

ix) Building effective teams

Rich and diverse conceptions of team building were described. Leaders spoke of the importance of modelling teamwork and respectful working relationships across professions and hierarchies. Setting clear goals, empowering staff to take responsibility, coaching team leaders to alter unhelpful behaviours, and ensuring teams had reliable data to measure performance were all mentioned. Some leaders described setting out to create a supportive 'family' atmosphere in units they led.

Leaders with an understanding of clinical human factors are able to draw on sophisticated conceptions of team interaction within organisational systems. The following story is of working with a surgical team in difficulty. It started with a facilitated multi-professional away day providing a 'mirror' in which the group could see its own behaviours.

> *The key bit was getting senior clinicians to take a leading role; commit to it, show by their behaviours, by their actions, that they were keen to change some of the conditions under which the team was working. [They decided] we can do a 'huddle' here, or we can do a 'stop moment', or we can brief a bit better. They adopted some of the tools very quickly, because we linked it into a governance framework for them. We knew that they were a very proud service who wanted to be respected. [For more intractable problems, we said] 'We'll work with you to find different solutions for that, but you'll*

already have your ideas. So we'll use your solutions. We'll facilitate it happening.' [Consultant & specialist educator acute care]

Counterpoint.

Effective teams that share clarity of purpose and close bonds are powerful social groups, whose leaders may challenge 'outsiders' who threaten their interests. A Medical Director recalled defending their own cherished department in earlier days.

> *They had a turnaround guy in…He took away all of our admin – or tried to. And I had a big row…'You touch my staff and I'll make sure it gets into the papers that you are ruining the service.' I was really quite angry and aggressive about it. I defended the department absolutely like a lion, and actually we got off relatively unscathed. We lost some staff, but not very many. However, just transiently it got so bad, that I didn't feel I could make a difference anymore. [MD acute care)*

x) Building partnerships between teams, departments, and organisations

This leader intentionally modelled behaviours that enabled his co-leaders to thrive, pull together, and reset behaviours across the organisation.

> *I instigated a governance programme of reviews for the divisions and I made clear that our governance in this organisation would cover quality and safety first, culture and people, operational delivery and finance…The first divisional reviews people were…terrified. They were still scarred by the nature of the reviews held by the turnaround director. Over time, they have grown pleased and accustomed…to the fact that those review meetings are thorough, I do investigate and follow things through, but they are respectful, even-tempered, collaborative, constructive, open...[CEO acute care)*

Counterpoint

West and Chowla's original formulation of this tenth leadership behaviour (West and Chowla, 2017) characterised it as 'building relationships across boundaries'. A leader involved in difficult national commissioning decisions reflected that there remain significant boundaries to be overcome between system leaders, patient activists, and a wider public.

> *How do we empower the public? One of the things we do very badly as the NHS is, we don't tell our stories very well. We don't give them the true story…We don't treat the public as adults, as part of the conversation. It's not how do we bring small groups of activists in. But how do we have proper discussions, and policy discussions, about how hard things are? [Divisional Director acute care]*

Implications

This section has shown aspects of current leadership activity reflecting behaviours associated with compassionate and inclusive leadership set out in the *Culture and Leadership Programme*. The evidence is not that everything leaders currently do is compassionate and inclusive, but that some of the activities they described are consistent with these aspirations.

Although the participants provided many instances of leadership action consistent with behaviours associated with compassionate and inclusive leadership, they used different terms, concepts and reference points to describe their actions. One reason for this difference is that leaders use concepts they have acquired via the influencing cultures that are described at the

beginning of this report. Another reason is that the leadership activity in which medical leaders are engaged has its own vernacular. For instance, medical leaders will refer to "supporting doctors in difficulty", an activity which in *Developing People – Improving Care* would seem to be categorised under the goal "improving the quality of their work". As one participant noted, clinicians and general managers tend to use a ***"different lexicon…for talking about the same thing sometimes"*** and successful partnership rests on each understanding the other.

Concepts and descriptors in documents such as *Developing People – Improving Care* and the *Culture and Leadership Programme* and their supporting materials[16] tend to reflect the influencing cultures of those contributing to their development just as the concepts and descriptors that senior medical leaders use tend to reflect their influencing cultures. There are differences in language and perspective between system leaders, regulators, academic researchers and senior medical leaders. These may need to be negotiated as part of the collective effort to support doctors and others who lead in healthcare.

CONCLUDING COMMENTS

Key implications have been discussed at the end of each section of this report. However, three important conclusions are summarised here.

First, health care organisations are not single cultures but a richly diverse set of intersecting influences and subcultures that challenge, influence, and inform leaders' perspectives and actions. Moreover, while the generalities of a positive culture - cohesive, supportive, collaborative, and inclusive – may be easily stated, the expression of these qualities differs across care settings (e.g. in patient care, care networks, primary care, community care) and leadership tasks. At the same time, it is clear that medical leaders are astute to a range of recognisably positive and negative organisational subcultures, including the subcultures of leadership teams.

In some cases professional conceptions associated with culture have been informed by propositional knowledge (for example, knowledge acquired during specialty training or in medical education). These knowledges are both subtle and sophisticated. However, much cultural knowledge is tacit and not easily reduced to formal or explicit concepts or propositions. This is to be expected, because much of what we learn about culture is learned through the experience of being in it. But the specialisation, diversity, and geographic mobility of the global medical workforce means that professionals bring differing conceptions of positive care culture to their work.

It has been noted that emerging network models of secondary care, and the generally small scale and independence of General Practice partnerships, each in their own way present complex organisational cultural challenges. Studies of leadership within single institutions have tended to dominate research in the area of leadership and culture. However, as care structures, pathways, integrated provision and other responses to patient needs change, this is inevitably creating new cultural demands and new subculture dynamics.

This first set of findings implies that the best leaders will likely be those who are aware of how their own cultural experiences have shaped their thinking, be aware in their leadership of the need to 'think culturally', be able to articulate expectations around culture and behaviour as part

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[16] https://improvement.nhs.uk/resources/developing-people-improving-care-short-guides/ - h2-condition-two-compassionate-inclusive-and-effective-leaders-at-all-levels

of their leadership role, and be astute to changing cultural dynamics in changing patterns of care provision. These are qualities that support for medical leadership should seek to cultivate.

Second, it is apparent from the reflections of senior medical leaders that in some respects the most demanding but unsupported period of the medical leadership journey is in the first step beyond consultant (or equivalent) leadership, often as a clinical director. Many participants acknowledged that performance in these roles can be central to the experience of colleagues, but that they are undertaken by those who are still novice leaders and receiving limited developmental support.

The nature of the trajectory from novice to expert medical leader is one which appears to be critical to health care organisations, but it seems to have been little explored in the literature. The evidence from this study suggests that as medical leaders mature they make an important shift of emphasis from a focus on achieving tasks, to a focus on enabling people. Given the different effects that both novice and expert medical leaders can have on colleagues, services and patients, an important question is whether and how this process of maturation may be supported and accelerated.

Third, senior medical leaders are undoubtedly doing 'culture work'. But they tend to treat 'doing culture' as an intrinsic component of 'doing leadership'. Again, those whose professional roles include a focus on enhancing team cultures (for example, through leading educational interventions) or those leaders attending to organisations in crisis, may concentrate more overtly on culture change strategies. But leadership is inescapably about leadership of culture, whether or not leaders are focusing on elements of cultural change, and whether or not the culture they see is the culture they wanted to create.

Additionally, we have observed that senior medical leaders are enacting elements of 'compassionate and inclusive leadership'. However, they do not conceptualise their activity as such, even when what they are doing seems to match the descriptions. And some of what they do, for good reason, suggests there may be pressures at the heart of medical leadership that are not easily resolved by precepts associated with compassion and inclusion.

This third set of findings calls attention to conceptual and lexical gaps that exist between different communities of practice in health care. People talking about 'culture' are frequently ascribing different understandings to it; and there are differing perspectives on how leaders impact on culture or should set about changing it. Initiatives that will involve a range of stakeholders - NHS bodies, regulators, academics, medical educators, improvement scientists, senior medical professionals - may find it difficult to make progress unless there is continuing awareness of the need to navigate a path through these different understandings. This study is a contribution to the continuing conversation about medical leadership and health care culture, which has as its goal securing the patient outcomes that all desire.

APPENDIX ONE – GLOSSARY AND RESEARCH METHOD

'Compassionate and inclusive leadership'	The policy aim for NHS leadership. It is defined in *Developing People – Improving Care* as 'paying close attention to all the people you lead, understanding in detail the situations they face, responding empathetically and taking thoughtful and appropriate action to help. It means progressing equality, valuing diversity and challenging existing power imbalances.'
Formal medical leadership	Generally defined as senior doctors who have assumed management responsibilities, who may or may not retain a role in clinical work (Llewellyn, 2001, Spehar et al., 2015);
Informal medical leadership	Demonstrating leadership action within clinical work, e.g. 'champions' 'change agents' 'visionaries' (Holmboe et al., 2003, Hopkins et al., 2015); activity that produces direction, alignment with collective goals, and commitment to the collective. (West et al., 2015a)
Senior medical leader	See table below. Participants were formal medical leaders who held leadership roles over and above Consultant or GP partner level. Some were also designated leaders (e.g. College President) not medical managers.
Hybrid roles	Professionals engaged in managing professional work, professional colleagues, and other staff. Hybrid roles are shaped and constrained by both professional and managerial logics, and are found globally across healthcare systems. (McGivern et al., 2015)
Leadership	Leadership is a highly contested concept (Bass and Stogdill, 1990) Defined in terms of structures, leadership consists in a leader or leaders, followers, and a common goal they want to achieve. (Bennis, 2007) Defined in terms of function, the leadership task is to ensure direction, alignment and commitment within teams and organisations (Drath et al., 2008).
Leader attribution error	Mistakenly viewing leaders as the main influence on what transpires in social systems. (Hackman and Wageman, 2007) Leaders actions may take place in a context in which they cannot make a constructive difference.
Organisational culture	Values, behaviours, goals, attitudes, practices and beliefs shared across a whole organisation (Scott et al., 2003a); a composite complex construct which changes dynamically over time, with enduring behavioural and cognitive patterns. (Braithwaite et al., 2017)
Workplace culture	A specific subculture involving an identifiable sub-grouping, e.g. a unit, ward or department or a professional group. (Braithwaite et al., 2016)
Positive culture	'A cohesive, supportive, collaborative, inclusive culture' (Braithwaite et al., 2017) In many studies this has been measured using validated instruments such as the Practice Environment Scale of the Nursing Work Index (PES-NWI).
Patient outcomes	The consequences of patient care, which may be either positive (e.g. satisfaction, reduced length of stay) or negative (e.g. disability, hospital acquired infection, avoidable death). (MacDavitt et al., 2007)
'Safety 1' & 'Safety 2'	Safety 1 is the view is that "erratic people degrade an otherwise safe system…work on safety means protecting the system from unreliable people". Safety 2 is the view that "people create safety at all levels of the socio-technical system by learning and adapting to information…Progress comes from helping people to create safety". (Hollnagel, 2018)
Relational care	A distinction is drawn in the nursing literature between 'transactional' models of care (in which the individual is cared 'for') and 'relational' models (where the individual is cared 'about'). It has been observed that modern industrialised care systems tend towards the transactional.

Further information on research method

Recruitment

All participants were recruited according to the protocol that was granted ethical approval by the Health Research Authority. While some individuals were approached directly, in the case of organisations, approaches to potential participants were made following an introduction by the most senior medical leader.

The following tables indicate the range of organisations in which participants worked, and their roles. Many participants have dual roles: for instance GPs with a leadership role in commissioning or education who continue to work in general practice, and Royal College Presidents who continue to work in their specialty.

Organisations

NHS England secondary / tertiary care provider (inc. community services)	11
NHS England mental health care provider	6
NHS Scotland Health Board	3
NHS England / Health Education England / NHS Improvement (inc. GPs)	5
UK independent sector provider	2
Total	27

Roles

Medical Director / Chief Executive	10
Assistant / Associate Medical Director	8
Consultant with additional leadership role	2
GP with leadership, commissioning, education role	4
Recent past President of Royal College	2
Non Executive Director	1
Total	27

Analysis

Analysis started with close attention to the data to identify emerging concepts (Glaser, 1992). As the data accumulated, these concepts were first developed into overarching themes and then organised into a schematic framework (Gale et al., 2013) for further comparison.

Analysis and interpretation of the 2018 data was informed by material from the 2011 study. The 2011 study identified distinctive patterns of moral thought and action apparent in medical management, and these are briefly summarised in Appendix Two. The 2011 study also illustrated how cultures are shaped by the choices leaders make when confronted with conflicting goals and values. These findings sensitised the researcher to particular descriptions of value, culture and subculture in the 2018 interviews and made it possible to discern similar and contrasting themes in the 2018 data.

Limitations

Further to the limitations identified in the main body of this report, an observational study would be likely to have generated different findings, as might a study of those unwilling to reflect on their thoughts about culture and leadership.

Some interviewees were invited to participate as members of a leadership team in a given organisation, with the intention of understanding something of how leadership groups

understood and worked with culture. However, it proved difficult to recruit whole teams, and limited data on collective leadership emerged from these interviews.

Qualitative researchers refer to 'saturation' to decide when to stop collecting data. Saturation is the point at which no meaningful differences can be discerned in new data. The number of interviews required to reach saturation depends in part on what is being investigated. It was noted in the main body of the report that medical leadership is a very wide phenomenon, and a deliberately wide sample was selected so as to achieve maximum variation. As a consequence, the number of interviews carried out enabled the researcher to identify significant themes but further participants would have been required to achieve saturation at a more granular level.

Ethical approval

Ethical approval for the 2018 study was given by the Health Research Authority, IRAS Project ID 244034. The earlier study was approved by an NHS Research Ethics Committee, Reference 06/Q1606/105.

APPENDIX TWO - VALUE SETS IN MEDICAL LEADERSHIP

As noted in the introduction, the current study was informed by earlier research (Shale, 2012) that investigated the moral dimensions of medical leadership. This appendix provides a very brief summary of five sets of values apparent in and underpinning medical leadership activities.

Fiduciary	Fiduciary values reflect that doctors' first priority is to attend to patients' needs. These values are evident in an unwavering focus on patient well being, and can give rise to courageous action on patients' behalf. Claims of commitment to patients may also be used to justify uncivil or bullying behaviour towards colleagues or so-called 'shroud waving'. Good clinical leaders constantly reinforce fiduciary values, maintaining focus on patient care particularly when groups are facing disruption, change, conflict or other difficulties.
Bureaucratic	Bureaucratic values come to the fore when those in public institutions commit to serving the public fairly. Public organisations that embrace the virtues of bureaucracy, such as fairness and transparency, serve the public better than organisations that tolerate conflicts of interest, nepotism, or corruption. Good clinical leaders are (possibly rather well-disguised) virtuous bureaucrats.
Collegial	Collegial values are in evidence when teams work well together to meet patients' needs through co-operation, collaboration and 'discretionary effort' (going the extra mile). At their best, collegial values cement the team bonds that make patient care better or even possible. The downside is that they can lead to loyalty to colleagues, or other collegial concerns, being prioritised over patient interests (e.g. tolerating poor practice or favouring certain departments). Good clinical leaders exhibit a balanced approach to collegiality, recognising its importance while not being unduly swayed by it in their decision-making.
Inquisitorial	Inquisitorial values are those exercised when allegations of poor performance, misconduct, or harmful treatment arise. Responding to such issues calls for leaders to demonstrate candour, objectivity, neutrality and openness to 'hearing the other side'. Good clinical leaders are able to exercise inquisitorial values effectively, particularly in the face of collegial pressures to minimise misconduct or otherwise protect colleagues.
Restorative	Restorative values help to restore relationships after something has gone wrong, and are particularly important when patients or colleagues have come to harm. They reflect the importance of acknowledging harm, taking responsibility, and respecting the point of view of an injured person. Good clinical leaders model a restorative approach, and elicit it in others.

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