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## **The contribution of clinical leadership to service redesign: a naturalistic inquiry**

**John Storey (BA (Hons) MSc (Econ) PhD)  
and Richard Holti (BA MSc, PhD)**

Professor John Storey  
Open University Business School  
The Open University  
Walton Hall  
Milton Keynes  
MK7 6AA  
Tel: 01908 654733  
Email: [J.Storey@open.ac.uk](mailto:J.Storey@open.ac.uk)

### **Abstract**

Numerous policy papers and academic contributions across a range of countries emphasise the importance of clinical leadership in health services. This is seen as especially vital at a time of simultaneous resource constraints and rising demand. Most of the literature in this topic area concerns itself with conceptual clarification of types of leadership and with delineation of requisite competences. But other work on leadership has emphasized the importance of attending to practice in concrete situations in order to identify the dynamics at play and the nature of the challenges. The purpose of this article is to contribute to this latter task by drawing upon a set of data which reveals crucial aspects of the problems facing potential clinical leaders of service redesign. The paper reports on the nature and extent of the challenges as identified by clinicians of different types as well as managers and commissioners.

**KEYWORDS:** Service Redesign; Clinical Leadership; Dementia; Integration; Long Term Conditions;

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## The Idea of Clinical Leadership

The notion that clinicians could be making a far more significant contribution if they would step up to leadership roles has been a theme in many countries [1-6]. This stems from an expectation that if quality, innovation and productivity are to be improved and limited resources used more effectively, then doctors and other clinicians are needed for their special expertise and their peer influence.

The idea that clinical leadership is vital is especially prominent in the political agendas of countries in the UK [7-10]. In these documents, as elsewhere, the value of clinical leadership is strongly urged.

But, while it is evident that the idea of clinical leadership is widely extolled, less clear are the nature and the size of the challenges, and the limits and obstacles to the *realisation* of the idea. From a balanced weighing of both the limits and the possibilities, what are the most promising lines of action for those clinicians and managers who wish to exercise leadership as a means of achieving service improvements?

A recent meta analysis of the *idea* of clinical leadership reached the following observation:

“There is a considerable amount of literature on clinical leadership ...[h]owever, this literature is, on occasion, somewhat limited: there are few definitions of the subject; the approach is centred on recommended leadership behaviours/traits and competencies; there is no account of the situation; and, in most instances, the key issues or realities of leadership – as reported at the coalface – are seldom mentioned.” [11]

This is an observation echoed in other places where focused attention has been paid to the problem of the *practice* of leadership and the need to locate it in concrete contexts [12, 13]. The purpose of this article is to clarify the nature and extent of this challenge. We seek to do this by focusing attention on one service area – Dementia Care – a complex service which is in great need of leadership.

We are less concerned here with micro-leadership of teams or indeed routine leadership within relatively stable organisations by medical directors and others with formal leadership positions. Indeed, we also seek to go beyond the leadership of service changes that might be expected of the new breed of clinical directors within

acute trusts [14]. Rather, we seek to unravel the place of clinicians in more radical, larger-scale changes which cross institutional boundaries and which also challenge traditional and prevailing service boundaries such as ‘primary’, ‘community’, ‘secondary’, ‘mental health’, and ‘health and social care’.

In order to ground the debate in concrete situations we draw upon a study of practices and change processes in two health economies – one in London where large teaching hospitals are especially influential and the other in a large conurbation in the north of England. One of the characteristic features of current practices in the diagnosis and care of dementia is that it is scattered across multiple institutions, agencies and professions. No one can claim to ‘own’ the problem. The task facing any would-be clinical leader or group of leaders is therefore heightened by the need to engage with complex cross-boundary issues – including agencies and bodies external to the health service such as local authorities and independent sector organisations.

Through a detailed study of extant practices, services redesign proposals and patterns of influence, we seek to identify and draw-out the nature and the contours of leadership. We follow the advice of Gronn who argued that ‘leadership would be better served by *understandings more closely connected to the realities of workplace practice*’ [15] (emphasis added).

It is possible to conceive of different degrees or levels of ‘clinical leadership’ – represented as a journey from ‘engagement’ at one end through to transformative leadership at the other. The Medical Leadership Competencies Framework [16] with its levels from junior doctor to senior leader expresses this idea in terms of career stages. This idea of ‘progression’ can also be used as a means to conceptualise the idea into stages towards clinicians becoming the key leaders. For the sake of simplicity, three stages can be considered. We briefly describe all three here, although in this article we are primarily concerned with uncovering the realities of the third and most demanding stage.

At the first, embryonic stage, an influential strand of literature sees the core issue as about the nature of the relationship between clinicians and managers [17]. Factors identified as associated with productive relations include alignment of priorities, open communication, collaborative leadership styles and shared decision making [17]. Unproductive relationships occur when doctors feel under threat from managers focused on financial and other issues which seem to disregard or even undermine clinical judgements.

At the second stage, the literatures concerned with dispersed, distributed and shared leadership [15] could be considered as taking the idea forward in so far as there is no necessary presumption that the manager is necessarily the leader, and the clinician merely in a role where he or she has to be, at best, simply ‘engaged’ [18].

The third stage is reached when clinicians are depicted as central to leadership using their skills and authority to *redesign* health service provision and the associated work processes [19]. In the context of the NHS, this means not only confronting ‘the inevitable challenges of managing organizational change but also some specific features of health care organizations that make change particularly problematic’ [19] (p415.) This statement neatly summarises the hypothesised nature of the challenge

though it hints darkly about that challenge rather than spells it out. Working across organisational boundaries has been identified as a key clinical leadership challenge [20]. Integrated care such as the kind promoted by Kaiser Permanente in the USA represents one leading example of cross-boundary thinking and practice [21]. This type of radical thinking expresses some of the principles of fundamental service redesign of the kind envisaged by Porter and Teisberg [22] and Christensen [5].

But if clinical leadership for service redesign is such a good idea, why has so little of it occurred so far? According to research by the management consultants McKinsey, there are three main reasons: ingrained scepticism by clinicians themselves, weak or negative incentives, and little nurturing for leadership [2]. Our concern here is to develop a richer analysis of the dynamics affecting clinicians who choose to respond to the challenges of taking a lead in transforming services. We draw on traditions of organisational research and theorising that put actors such as clinicians in the context of the practices and structures they work within. This means, inter alia, seeking to understand their motivations and orientations [23] as well as the emergent consequences of their interactions within social relations of organising. Hence this takes us beyond a simple description of their rational responses to incentives or of static attitudes such as ‘scepticism’. Within that frame, the research reported here explores the perceptions and interpretations of senior clinicians and managers about the limits and possibilities for clinical leadership.

The next section describes the research design and methods used in the study of health services which is reported in this paper; the following section presents the results and the final section is devoted to discussion and conclusions.

## **Research design, study context and research methods**

The research design was based around naturalistic inquiry [24]. The main approach was not to interrogate clinicians and managers about what they thought clinical leadership was or what it comprised (though we conducted a little of that kind of discussion), rather, we studied real-life concrete attempts at service reform and design and tried to trace what part clinicians had played in those attempts. This also meant tracking passivity, blocking behaviour, marginalisation, rebuffed attempts and positive attempts. It also meant exploring the conditions and other variables which were in evidence when clinical leadership was relatively active and when it was not.

Thus, the study was designed not so much to repeat previous studies of what actors thought clinical leadership should look like or whether they thought it was a good idea in theory, rather, it was designed to trace actual instances and their nature by focusing on naturalistic happenings. A key part of the research design approach was to construct narratives of key events [25] [26, 27] through a series of triangulated interviews with trust managers, clinicians of all kinds, commissioners, network directors, and third sector informants.

Given this approach, the chosen context for our investigation of clinical leadership was purposely a challenging one. We were advised by senior managers and clinicians

that dementia was a suitable subject mainly because dementia services offer huge potential for significant improvements in cost effectiveness and quality if service redesign could be achieved. Current provision is incomplete, fragmented and patchy. Dementia, while not restricted to the elderly, is generally a condition which is more prevalent with age and older people's services have generally been subject to relative neglect. The broad national context is thus one of considerable challenge and a need for reform.

Two different health economies were compared. One of these was in the complex and competitive environment of part of London where multiple teaching hospitals (along with a number of other providers such as mental health) provided overlapping services; the other was in a large city in the North of England with fewer competing providers where partnership working between local authority and the health service was consistently rated as above average and hence where the conditions for cross boundary service redesign could be expected to be more favourable than normal.

Each of the two cases comprised complex service offerings where patients and carers have to navigate their way across institutions comprising multiple commissioners (possibly several primary care trusts, local authorities, and GPs), and multiple providers including acute trusts, mental health trusts with their various units and teams, third sector providers such as the Alzheimer's Society and Age UK, and private sector providers of residential care homes.

This set of contextual considerations contributes to a massively challenging environment within which to attempt to 'take a lead'. In the two cases which follow, we describe and examine the ways in which managers and clinicians perceived and interpreted the nature and the scale of the challenges. We also report on the practical dynamics involved in specific attempts to negotiate cross-boundary service redesign.

The research methods comprised semi-structured interviews with a total of 39 informants - 22 clinicians and managers in the northern case and 17 in the London case. Each of the interviews lasted just over one hour and each interview was digitally recorded and transcribed. The occupational breakdown of the interviewees is shown in Table 1.

{Table 1 about here}

This research design allowed a comparison of multiple perspectives. A semi-structured interview schedule was used and so each interview was asked broadly the same set of questions although these were adapted to take account of, and indeed advantage of, the diverse roles. In addition to the interviews, relevant documentation including policy documents and reports were analysed.

Interview transcripts were analysed using NVivo software. Two rounds of coding were undertaken: the first was descriptive and the second was explanatory. The first round built a set of first level codes that were derived from the key phenomena under investigation. This led to an initial case analysis which was summarised and fed-back

in workshops to the informants. The results of this phase were used to inform the second phase which focused on explanatory variables. Again at the end of this phase presentations were made to workshops which included the persons interviewed, in order to test out an emerging analysis of the challenges facing clinical leadership.

Research ethics approval was sought and granted by the National Research Ethics Service and by each of the provider and commissioning trusts locally that were involved in the research. The fieldwork took place over a twelve month period from January to December 2011.

## **Findings**

The Northern case is presented first and then the London case. The notations in squared brackets – for example [6:22] - refer to transcript number and page number respectively and they were used by the research team to keep track of verbatim quotes.

### ***Case A: Northern City***

Interviewees described a complex array of service offerings for people with dementia. The normal pattern is for General Practitioners (GPs) to refer people they suspect of having some form of dementia to a memory assessment service, run by the mental health trust. For those patients with treatable Alzheimer's disease this memory assessment service makes the diagnosis, prescribes medication and retains them for periodic review. It refers back to GPs those patients with non-treatable vascular dementia. The Community Mental Health Teams (CMHTs) attend to patients with more severe needs who present periodically with crisis situations. Services for mild to moderate sufferers living at home are offered by community health and by the local authority social care teams. There are also services provided by the Third Sector. There is also an "In-reach team" provided by the Mental Health Trust. Additionally, there are NHS inpatient psychiatric wards for people whose behaviours have become too challenging for other settings. And finally, the local acute hospital has a Psychiatric Liaison Service.

This complex picture involves cross-cutting and overlapping provision by multiple institutions and agencies and by a range of professionals including psychiatrists, psychologists, GPs, general and psychiatric nurses, occupational therapists, geriatricians and neurologists. One consequence of complexity was that a significant proportion of the clinicians and managers interviewed reported that they themselves had a very limited understanding of the various parts of the system, how they worked together or even how they were supposed to work together. For example, one GP observed: 'My personal view is that there is a lot of confusion about who is in charge of what. And the referral pathways have become confused and muddled' [60: 2]. Consultants too felt marginalised and they complained of being ignored and even actively prevented from 'interfering' outside their allocated job remits.

Thus, themes which emerged from these interviews were problems of awareness and understanding about how the wider set of services operated and who did what; and problems of disengagement and marginalisation – even the most senior clinicians perceived that their input was not wanted outside certain given boundaries.

Any service changes that did occur were seen as designed by managers (of both commissioning bodies and provider trusts) mainly in response to national level targets and directives and/or prompted by cost-cutting opportunities within trusts. The commitment of senior management to the needs of old age services and dementia in particular was widely questioned by clinicians, given that until recently these have not been national priorities. Clinicians in the mental health trust argued that the executives on the board of the trust had both a poor understanding of dementia services and that they tended to give these services a low priority [56: 2]. One said: ‘We are powerless. Change takes place without the approval of clinicians [55: 13]. These kinds of perceptions raise issues about governance. The trust board of the mental health trust was seen as the primary agent which authorised or discouraged proposals for change. There was a network group but this was perceived to lack decision making power and was used mainly as a forum for the exchange of information by a number of stakeholders.

A governing body (the Older Person’s Mental Health Partnership Board) which one might have thought had some potential for enabling concerted effort and which might have harnessed clinical leadership, appeared not to rise to this challenge.

Clinicians at all levels reported that the series of reorganisations which had occurred merely amounted to ‘a moving around of the furniture’ rather than a fundamental attempt to tackle core issues. Overall, the clinicians we interviewed from across the primary, acute, and mental health services perceived an inchoate, complex system created over time by a series of piecemeal organisational changes. No part of the service ‘owned’ dementia; and few, if any, of the parts viewed dementia as their main priority.

However, despite this extremely challenging state of affairs, some notable examples of the exercise of clinical leadership were uncovered. These were all the more remarkable because of the nature of the difficulties. One form of clinical leadership was clinician involvement in forums responsible for shaping how the service is resourced and delivered. Clinicians reported how they were involved in some of the discussions with service managers about developments in their particular part of the services on offer. The establishment of the memory service and the development of the case for initial funding were led by a clinician. But there was much less evidence of clinician involvement in shaping the system of care outside of their particular service or clinical microsystem.

A number of clinicians were able to explain how they had gone about achieving a measure of informal integration across service boundaries. This occurred without being involved in any formal cross-boundary working group. For example, the head of the psychiatric liaison service provided by the mental health trust at the acute medical hospital welcomed the appointment of the lead dementia nurse within the hospital as offering a clearer route to influence the acute trust senior management. Similarly, although the lead geriatrician at the acute trust had experienced a past lack



of support from the PCT for his input into community rehabilitation services, he saw the recent integration of community nursing services into the acute trust as a way to rebuild this clinical collaboration. These examples illustrate how the practical exercise of clinical leadership involves taking advantage of developments as they arise.

In summary, the Northern Case revealed a very challenging context for the exercise of leadership. There was complexity, fragmentation, and even alleged active discouragement of clinical leadership and even discouragement of engagement in matters beyond their 'normal' duties. In such a context, it required considerable energy, skill and commitment to seek to exert the much-lauded clinical leadership of service redesign. Hence, not surprisingly, the instances found were relatively modest.

### ***Case B: London Dementia Care Reform***

This case illustrates how a measure of cross boundary service redesign was achieved through the establishment of what was described as an 'integrated memory service'. Three London Boroughs and PCTs were involved along with two large hospital trusts, a mental health trust, GP services, voluntary sector agencies and local authority social services.

Memory services for diagnosing different forms of dementia had previously been available across a number of different locations and were inconsistent in their approach. Geriatricians in acute hospital trusts offered outpatient memory clinics where patients would also be assessed for a range of physical problems. Alternatively, patients might find themselves referred by their GPs for assessment by psychologists or nurses working within psychiatrist-led old age community mental health teams run by the mental health trust. In this health economy, even more than was the case above, GPs were unclear as to where to refer patients for diagnosis and treatment and so there was a degree of happenchance about where a patient might end up and indeed in the kind of diagnosis and treatment they might then receive in consequence. Once dementia was diagnosed, patients would be referred on to a network of supporting services in essence similar in its complex and uncoordinated nature to that found in the Northern case. However, many of these services, particularly those offered by social services were less well funded and developed in this London case.

Over a number of years, while many geriatricians and psychiatrists worked apart from each other in institutional silos, a few had established informal contacts with one another. These latter expressed their mutual dissatisfaction with the uncoordinated nature of their services in separate clinics [12: 14]. They were also aware that the capacity of their separate services was inadequate to accommodate the number of people likely to need a dementia assessment. However, initial attempts by managers and clinicians in the mental health trust to establish a new specialised memory service in one borough foundered due to lack of funding from the PCT. Then, in 2009, the commissioners across a number of PCTs responded to the National Dementia Strategy (as reinforced and reinterpreted by a London Dementia Strategy with additional funding) by taking steps to launch a new and expanded memory service to serve two boroughs. This provided GPs with a single point of referral and a consistent approach to diagnosis.

Under the direction of a senior psychiatric consultant leading the service, most of the assessments were to be administered by specialised nurses. This largely followed the pattern already established within most parts of the mental health trust, but contrasted with more consultant-led memory services also in existence across the range of teaching hospitals involved. This model of working was attractive to commissioners keen to rationalise the use of expensive senior doctors in expanding memory services. Once commissioners began to take up their own leading role, several of these senior clinicians became decidedly uncomfortable about the initiative as they were fearful about the consequences for the future of their own existing clinics.

After the phase of initial campaigning led by a handful of senior clinicians, the project was driven by the commissioners (the two PCTs). They established a formal project board which included commissioners, service managers and senior clinicians from the acute and mental health trusts. This represented an opportunity for the clinicians to work on an authorised body responsible for redesigning services across existing boundaries. Two years of painstaking negotiations commenced. The consultants were fearful that this might threaten their existing clinics and they raised a number of objections. According to one leading consultant, the perception was that ‘everything had to be moved out of the hospitals ... this caused a huge upset with the clinics’ [9:3]. The commissioners, keen to redesign this service area and fearful of losing the special funding, at one point threatened to put the new service out to tender if cooperation was not forthcoming. This illustrated the newly emergent power of the commissioners.

Outside of the project board, ‘We, the consultants from these different clinics, began to meet in secret’ [9:3]. The clinicians initially used their meetings to establish a uniform approach to memory assessment, bringing together knowhow and methods developed by the geriatricians and psychiatrists. Under the leadership of a senior psychiatrist from the mental health trust, the consultants negotiated between themselves and reached a working understanding which resulted in the new memory clinic being established for initial diagnosis while cases could be triaged so that onward referral for treatment could be made to the existing clinics. As a leading hospital consultant noted, ‘we were slow to progress over the past two years because there were big personalities involved ... throughout there was quite a bit of tension’ [42:3].

Thus, the process of clinical leadership moved through a number of phases. Initially clinicians sought greater attention from managers and commissioners in order to raise the profile of memory services and win more funding through taking advantage of the new National Dementia Strategy. What followed was then a difficult phase of inter-professional mediation and accommodation, as the implications of a more integrated service and the priorities of commissioners became more apparent. Whilst some clinicians appeared at times to be simply negotiating to protect the status quo, over time this grew into something more positive as the different consultants – geriatricians and psychiatrists – learned to work together to make the new service configuration work more effectively. Thus, clinical leadership in this case had both a pro-active, initiating element and an emergent, more reactive element.

A positive outcome was that geriatricians and psychiatrists forged new relationships. Nonetheless, some senior clinicians remain unconvinced and cautious. They see an element of ‘propaganda’ with [the commissioners] ‘wanting to show the Department of Health that they have implemented the National Dementia Strategy ... maybe I am paranoid but I see them closing down dementia services outside the memory clinic’ [24:7].

The work of these senior clinicians in the service redesign process reveals the situation-dependent nature of the leadership of service redesign. In a context where prestigious clinicians, working within powerful institutions with world-renowned reputations faced determined commissioners, the leadership required to bring about change which was perceived to threaten professional investments in existing clinics was very considerable. The challenge in this context was much higher than was the case in the Northern case where apparently similar changes were implemented in a far less problematical way. As in the Northern case, clinicians in this part of London did not initially have an institutional forum for engaging in a more comprehensive approach to service redesign.

Notably, this did not entirely prevent clinicians from thinking about how services could be better integrated, or from showing cross boundary leadership of an informal and emergent kind. They found opportunities to improve interfaces between services, often establishing direct contacts with other clinicians even though the formal management systems were fragmented and difficult to work with. For example, the London consultants involved in the memory service found a way to share a nurse post between the new memory service and one of the existing geriatric clinics. This resulted in shared learning between hospital nurses in geriatric clinics, psychiatric nurses working in the new memory service and general nurses dealing with dementia through the acute hospital [59: 19]. The nurse leading the new memory service worked with her opposite numbers in the community mental health teams to clarify guidelines for when patients should be referred on from the memory service [29:10]. Likewise, the lead nurse in a geriatric outpatient memory clinic worked with community nurses from the hospital trusts; and the third sector dementia advisors became linked-in to the new memory service to improve their understanding of how the geriatric outpatient’s service could continue to support patients [59:9, 14]. These instances of cross-boundary collaboration reveal the emergent and dynamic nature of clinical leadership.

## **Discussion and conclusion**

These two cases allow insight into the nature and size of the challenges facing the idea of clinical leadership in practice. While at national policy level there are constant calls for clinical leadership as a fix for numerous problems facing health services, it is evident from the cases reported here that delivering it on the ground can be hugely problematical. This research sheds light on the nature of the challenges confronting potential clinical leaders. In the domain of dementia services at least, it became clear that the NHS offers limited authorisation and incentives for the exercise of clinical leadership beyond tight institutional boundaries.

A number of key themes emerged from the conversations and narratives surrounding the concrete instances of service redesign which we studied. A first and overarching theme was the *nature of the context* in which leadership was to be played out. We have already noted above the complexity of the multiple power structures in the London case made attempts at service redesign far more difficult and prolonged than in the Northern case.

Further themes concerned the importance of *sources of legitimacy or authorisation* to act across established boundaries, the significance of *different levels of action* – national versus local – within the NHS, and the impact of *decentralised managerial and governance arrangements* within the purchaser-provider framework of the NHS. In both cases, the prompt and the initial legitimacy for cross-boundary action stemmed from the National Dementia Strategy. There was some important clinical input from local level to this national strategy, indicating the possibilities for local clinicians to influence the broader context of possibilities within which they work. However at ‘local’ level in both cases, it was evident that there were deficiencies in managerial and governance arrangements that made it difficult for clinicians or managers to take service redesign forward.

Despite some attempts to institute ‘network boards’ real power was seen to reside with the established individual trust boards – most notably the mental health trust boards in these two cases. These bodies found it difficult to support thinking and developments concerned with integrating services across trust boundaries. Another source of power that was wielded for a particular purpose was the commissioners (PCTs plus local authorities). In both territories the commissioners pushed strongly for a service redesign around a single referral pathway into a new memory service. This followed the recommendations of the National Dementia Strategy. The issue here was the tendency for commissioners to focus on implementing the letter of the national strategy at the expense of understanding the complexities of onward referrals from the single point of entry, as patients with different combinations of physical, cognitive and psychiatric symptoms needed to be referred on to a wide range of different services. In both cases, clinicians found they had to take informal leadership in making links between such services function effectively. It was notable that this was accomplished more easily and more quickly in the Northern case than in the London case. In the latter, there was a more complex pattern competing service providers and there were more consultants – both geriatricians and psychiatrists - with international reputations who feared for, and wanted to protect, their extant clinics, whilst also wanting to establish an effective pattern of onward referral to meet patient need.

In the northern case where different contextual conditions applied, the narratives revealed a less stark stand-off and less overt conflict between commissioners and clinicians. But there was still a perceived restricted scope for clinical leadership, which can be understood in terms of further themes of the *lack of awareness of service integration issues* within established trust boards and their tendency to *exclusion of clinicians* from strategic decision-making. It was in this setting where clinicians of different levels and in different specialities complained of being excluded from local initiatives and service changes. It was here too where complaints about a lack of awareness of the whole picture were more prevalent. The explanation could be that as power was more evidently in the hands of the senior managers of the

trusts, they tended to fail to consult their clinicians when making service changes and so conflict became more covert.

By focusing on a narrative analysis of how services are constituted and changed the two cases reveal that, in the main, local actors are 'normally' expected to confine their activities to their allotted spheres of influence. Large scale vision and change stemmed from national strategy. This helped legitimise action for change but even this was rarely enough unless very specific local funding mechanisms were seen to prompt shifts in priorities. To a considerable degree the clinicians in both health economies saw a gap between the policy rhetoric about the need for clinical leadership and the everyday governance structures and practices in their localities.

However, despite the barriers and blockages noted above, the cases also reveal how, leadership can to varying degrees be exercised by clinicians. While formally authorised redesign of services is often restricted to particular parts of services rather than the complete chain of the patient experience, there a number of instances were uncovered where clinicians tried to take a lead and in some instances succeeded in so doing. Usually this was consequent to significant action by commissioners but, nonetheless, the exercise of emergent clinical leadership was important. The cases suggest that aspirant clinical leaders need to seize opportunities when they are offered – or even only half offered. They also need to acquire rather an unusual degree of understanding of diverse institutions beyond their own familiar boundaries. Even this is not enough. They also need to lead by convincing and reassuring professional colleagues that there are alternative ways of working. When there is an opportunity to recast services, the challenges to existing professional domains may prove threatening and the work of clinical leadership needs to involve addressing these threats in a productive way. Through such a process for example, we found clinicians working with dementia patients develop their awareness and skills by learning how to hold in mind both a medical model for dementia and the relevance of person-centred therapies of group work and activity-based interventions.

In the near future, two developments in particular may prove influential. First, it may be that the national-level attempts to embed new 'clinical leadership competences' such as the Medical Leadership Competency Framework and the Clinical Leadership Competency Framework [28] will act as catalysts to raise the level of ambition, to legitimise and normalise the expectation of seeking service redesign, as well as contributing more self-evidently to towards the development of the requisite capabilities. Delineating competences will not, of itself, make much of an impact on the problems identified here, but in the process of developing these competences in practical situations, the process may serve to raise expectations while confronting and de-legitimising traditional ones. Second, the new Clinical Commissioning Groups introduced into NHS England are explicitly designed to prompt clinicians to take the lead and to approach their role in a new way. Our research suggests that there is an emerging caucus of clinicians providing secondary care services who have learned a considerable amount about the complexities and realities of leading service transformation in spite of the factors that make it difficult. They have begun a shift in focus from the individual patient encounter to thinking about what is needed to provide integrated health systems that meet the needs of an entire patient group. This kind of learning could be made available and built on by those clinicians who are taking up leadership roles within these new commissioning bodies. This, in turn,

offers the opportunity for fresh thinking about the effectiveness of care. This reflects the wider general point that while the 'solution' does not reside in mere structural reforms, emergent clinical leadership is possible opportunities if clinicians have prepared themselves and are willing to take advantage of opportunities in ways similar to those described throughout this article.

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