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Managing doctors, doctors managing

Research report

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Good working relationships between doctors and managers are critical for the safety and quality of NHS care. Yet recent reports have referred to a 'gulf' between the two groups and to the growing risk of clinicians disengaging from management. This research uses a detailed survey of doctors and managers at board and middle-management levels of NHS acute trusts, along with interviews and a focus group, to understand their views on the current state of the doctor–manager relationship in the UK, the pressures it is coming under, how it has changed, and the outlook for the future. Looking back on a survey from 2002 by the same authors, which identified similar themes, allows the research to examine what has changed over a decade of political turmoil, what has not, and where policy-makers and NHS leaders might look to improve the pivotal relationship between doctors and managers in future.

This work builds on a narrative review of the literature, which is published alongside this report and can be accessed at www.nuffieldtrust.org.uk/publications/doctors-managers

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Key points

- Good working relationships between doctors and managers are critical for the safety and quality of NHS care. Yet recent reports have referred to a 'gulf' between the two groups and to the growing risk of clinicians disengaging from management. We carried out a survey of doctors and managers at board and middle-management levels of NHS acute trusts, along with interviews and a focus group, to understand their views on the current state of the doctor–manager relationship in the UK, the pressures it is coming under, how it has changed, and the outlook for the future.
- There has been some improvement in overall positive scores of local doctor–manager relationships since 2002 when we did a similar survey. But a growing proportion of respondents believe that these relationships are likely to deteriorate over the coming year. This suggests that these already challenging relationships are extremely vulnerable to further changes in the external political and financial context as they impact on individual organisations.
- As we found in 2002, managers and senior doctors see things differently. At the top of the management structure, chief executives were the most positive overall on a wide range of issues. Clinical directors, the NHS's frontline medical leaders, were least positive. Despite some areas of agreement, especially about wider problems in the NHS, this suggests real differences of perception and widespread concerns about the doctor–manager relationship among people who hold crucial roles.
- There was agreement on several key factors that have made it more difficult for doctors and managers to work closely together. Financial pressures, changes in the role of NHS regulators, and the Health and Social Care Act 2012 created additional strain as managers were pushed to implement more difficult and contentious goals more quickly. A period of stability and calm would do a lot to create space for better working relations.
- The study suggests overall that significant disaffection and frustration persist among doctors who hold clinical director posts. Some feel they have heavy responsibilities, but limited capability to actually influence

anything. There are initiatives in some hospitals to make the role of clinical director a better-defined one with clear objectives and training and support, but these seem not to be widespread.

- Few of the newer initiatives that aim to promote better working relationships between doctors and managers are widely available. They should be tracked and evaluated, and rolled out when they work.
- There is a stark difference in study participants' perceptions of the differences in the relative esteem in which doctors and managers are held by the public. Only 12% of survey respondents considered that NHS managers are respected by the public compared to the 97% of respondents who considered that doctors are.

1. Introduction

The importance of the doctor–manager relationship

The working relationships between doctors and managers have attracted increasing attention as one of the factors critical to the delivery of high-quality, safe patient care. The Francis report in 2013 warned of a gulf between clinicians and management that needs to be closed and urged greater involvement of clinicians in leadership and management roles (Francis, 2013). More recently, Nuffield Trust and NHS Providers (2015) have emphasised the growing risk of clinicians disengaging from the leadership and political direction of the NHS.

The working relationships between those who are trained to provide clinical services and those who manage the organisational and governance structures in which those services are provided have been at the heart of the NHS since its inception. The relationship between doctors and managers has been particularly significant because of the pivotal role that doctors have always played in directing, overseeing and providing those clinical services. Like all relationships in complex health systems, this core relationship has always been influenced by the external political context and by the 'mutual dependency' between the state and the medical profession (Klein, 1990). Working relationships between doctors and managers in the past two decades have therefore not been immune to the growing trend for 'new public management' (Osborne and McLaughlin, 2002) and its managerial challenges to professional autonomy and self-regulation. They have also been affected by the changes in the delivery of health services arising from the increasing dominance of the neo-liberal agenda and its emphasis on marketisation, cost-cutting and competition in public services.

The traditional professional role that doctors have enjoyed in health care settings is one of autonomy, independent judgement, trust and self-regulation. The rise of a more 'scientific–bureaucratic' model of government (Davies and Harrison, 2003) combined with increasing demands from policy-makers and, to some extent, from the medical profession for greater clinician involvement in governance, leadership and management have forced doctors and managers to reconsider their roles in relation to each other, and to go on doing so as new challenges and threats emerge.

In 2002, we carried out a large scale survey of perceptions of doctor–manager relationships with doctors and managers in the acute sector in the NHS. We surveyed chief executives, medical directors, directorate managers and clinical directors (Davies and others, 2003a, b) and found that although there were some areas of agreement between doctors and managers, there were also significant fault lines. Doctors and managers disagreed around key issues, including:

- the influence and involvement of doctors in hospital management
- the quality of managerial staff
- the balance between financial and clinical priorities.

Despite the high political profile of the NHS and the importance of the doctor–manager relationship, few empirical studies of doctors' and managers' perceptions of that relationship have been carried out since that survey (Powell and Davies, 2016). Those that have been done suggest the following key trends (Powell and Davies, 2016):

- That although there have been some shifts in the power balance between doctors and managers, overall, doctors continue to be a powerful group that retains considerable clinical autonomy.
- That open acknowledgement of the shared values and concerns is relatively rare and the more negative perceptions between the two groups are often resistant to change.
- That, in general, NHS managers find doctors a challenging group to manage and report having to use a range of strategies to engage doctors' support at board and directorate level.
- That measures aimed at increasing managerial control over doctors and other health professionals tend not to be met with overt 'resistance' but instead with more subtle forms of resistance by which doctors seek to uphold clinical autonomy despite managerial initiatives.
- That, in general, doctors have been reluctant to embrace managerial roles and find it hard to act in a managerial capacity towards other doctors. The expectations of policy-makers that involving more doctors in management will mean a greater degree of management control over doctors may be unduly optimistic.
- That policy developments over the past decade have created an environment in which both managers and doctors have felt beleaguered and under attack from politicians, the media and the other group (i.e. doctors or managers), and have struggled to fulfil their professional roles. At both collective and local levels, neither group has had the resources to devote to improving their working relationships, despite recognition on both sides that improvements are needed.

Against that background, and acknowledging the significant changes in the political landscape since the 2002 survey was carried out (including the Darzi report (Department of Health, 2008), the change of UK government in 2010 and 2015, the publication of the Francis reports in 2010 and 2013 and the increasing financial pressures on the NHS), we wanted to revisit the issues explored in the earlier survey through new empirical work with doctors and managers and to look at how perceptions of working relationships between doctors and managers at board and middle-management level had changed over time.

Study objectives

The aim of this study was therefore to explore current perceptions of medical and non-medical managers on their working relationships with each other and the factors affecting these relationships, and to assess whether and in what ways these perceptions had changed since the 2002 UK survey (Davies and others, 2003a, b). We also wanted to explore how widespread were initiatives aimed at developing and fostering better working relationships between doctors and managers (e.g. paired learning between individual managers and doctors). In line with the earlier work, we focused on chief executives (board level) and middle managers (directorate level) and on medical managers at board and directorate levels (i.e. medical directors and clinical directors).

Using a combination of survey, interview and focus group methods as outlined below, we explored a range of questions, including the following:

- How do managers and doctors rate the quality of doctor–manager relationships locally?
- How satisfied are managers and doctors with the time, resources and energy devoted to nurturing effective doctor–manager relationships locally?
- What is the extent of agreement between the four role groups on specific aspects of the doctor–manager relationship?
- What do managers and doctors perceive as the main barriers to more effective doctor–manager relationships?
- What changes in perceptions can be seen compared to the earlier survey carried out in 2002?
- What external factors do managers and doctors perceive as having had the most positive and most negative impact in the last five years?
- Which initiatives aimed at improving doctor–manager relationships are available in respondents' hospitals?

Methods

The study used a combination of a survey sent to chief executives, medical directors, directorate managers and clinical directors from acute trusts across the UK and interviews and a focus group with medical and non-medical managers from these categories to allow more detailed discussion of the issues raised by the survey. We summarise our approach briefly here; a more detailed account of our methods is provided in the Appendix.

Survey

The survey combined the questions that had been used in the 2002 survey (Davies and others, 2003a,b) with new questions designed to gauge the perceptions of doctors and managers on the impact on the doctor–manager relationship of more recent policy developments (e.g. the Francis reports of 2010 and 2013 and the Health and Social Care Act 2012). Respondents were asked a range of multiple-choice questions and were provided with free-text comment boxes to expand on their answers. The survey development was informed by a scoping seminar held with doctors, managers and stakeholders from the policy and research sectors and by piloting the survey with seminar participants and others.

The survey was sent out in two phases: an online survey phase in May–June 2015 (to 2,650 recipients) and a postal survey phase in October 2015 (to 817 recipients). We combined responses from the two phases of the survey for analysis. In total, 472 respondents completed the survey: a response rate of 18% across all four role groups. The response rate at board level was 34% for chief executives and 41% for medical directors. The response rate for directorate managers was 13%, while for clinical directors it was 9%.

The overall group of respondents was made up of 59 chief executives (13% of respondents), 131 medical directors (28% of respondents), 132 directorate managers (28% of respondents) and 150 clinical directors (32% of respondents). Around 88% of

respondents worked in England, with the remaining respondents roughly evenly split between the other UK countries. Around 60% of respondents were male. Over three quarters of respondents had a clinical qualification: 60% in medicine, 12% in nursing or midwifery and around 10% in other clinical professions.

Respondents were asked to indicate how they came to be appointed to their leadership or management role (Table 1.1). It was much more common for chief executives than for other groups to have been headhunted from outside the organisation, while it was much more common for medical directors than for other groups to have been headhunted from inside the organisation. Chief executives and directorate managers were more likely than medical directors and clinical directors to have applied from outside the organisation. Applying from inside the organisation was a more common route for clinical directors and directorate managers than for those at board level (i.e. chief executives and medical directors). Around one third of all respondents were in a fixed-term role.

Table 1.1: Method of appointment to this leadership/management role (n=470)

Role	Headhunted from outside this organisation	Headhunted from inside this organisation	Applied from outside this organisation	Applied from inside this organisation	Rotating post	Other
Chief executive	39%	10%	29%	20%	0%	2%
Medical director	12%	40%	13%	34%	0%	2%
Directorate manager	3%	11%	33%	48%	1%	4%
Clinical director	2%	27%	5%	53%	6%	6%

Respondents were asked to indicate whether they currently had clinical commitments and, if so, the rough proportion of their working week that these clinical commitments took up. The majority (57%) of respondents had clinical commitments. Clinical commitments varied by job role: 82% of medical directors and 97% of clinical directors had clinical commitments compared to only 2% of chief executives and 9% of directorate managers. Those most heavily involved in clinical work were clinical directors: 70% of clinical directors had more than two thirds of the working week taken up by clinical commitments (Table 1.2). For medical directors it was most common for their clinical commitments to take up less than a third of the working week (45% of medical director respondents) (Table 1.2) or one to two thirds of the working week (27%).

Table 1.2: Proportion of working week taken up by clinical commitments (n=463)				
Role	Less than one third	One to two thirds	Greater than two thirds	No clinical commitments
Chief executive	2%	0%	0%	98%
Medical director	45%	27%	10%	18%
Directorate manager	8%	2%	1%	90%
Clinical director	3%	25%	70%	3%

Interviews and focus group

The interviews and focus group (Table 1.3) were used to add to the data from the survey by providing the opportunity for discussion in more detail of the headline findings from the online phase of the survey and of the wider issues around the doctor–manager relationship. Interviews were sought with members of the Nuffield Trust's Health Leaders' Panel who had expressed interest in or attended the earlier scoping seminar. Further interviewees were suggested by these contacts. We also invited acute sector members of the British Medical Association's (BMA's) Committee for medical managers to take part. In total, 12 interviews were conducted between June and November 2015, involving 13 individuals. Interviews lasted between 20 and 50 minutes. Eleven interviews were conducted by telephone; there was one face-to-face interview with two interviewees. One focus group lasting 50 minutes was held in November 2015 with nine board and directorate-level medical and non-medical managers from a large London trust.

Table 1.3: Role of interviewees and focus group members (n=22)	
Role	Number
Chief executive	5
Medical director	5
Directorate manager	5
Clinical director	7

The responses from the survey and from the interviews and focus group were non-attributable. To protect respondents' anonymity, in this report we identify direct quotations from the survey and interviews only by the role group (e.g. clinical director) that the participant belonged to. We give quotations from the focus group with the label 'medical manager' or 'non-medical manager'.

2. Findings from the survey

We now present the findings from the online and postal responses combined. Because of rounding, the numbers do not always sum to 100%. The overall proportion of missing responses was low (typically around 5% or lower); missing data have therefore largely been excluded in the calculation of all percentages.

Overall perceptions of local doctor–manager relationships

Chief executives were the most optimistic about the state of doctor–manager relationships and clinical directors the least (Table 2.1). On a scale of 1 to 5 (where 1 was poor and 5 was excellent), around three quarters of chief executives (72%) rated the quality of doctor–manager relationships locally as 4 or more, whereas only half of clinical directors did (50%). Four fifths of chief executives (80%) thought that doctor–manager relationships were likely to improve over the next year, whereas only around a third of clinical directors did (35%). Indeed, over half of clinical directors (51%) thought that doctor–manager relationships were likely to deteriorate over the next year and even one in five chief executives (18%) thought this was so. Moreover, with the exception of chief executives, at least a quarter of respondents in each role group were dissatisfied with the 'time, resources and energy' devoted to nurturing doctor–manager relationships locally. Dissatisfaction was highest in the clinical director group (at 46%). These differences across groups were all significant at $p<0.05$ using a chi-squared test of equality across groups.

Several respondents added additional comments in order to emphasise the variability of relationships, that the onus was on individuals to make the relationships work and that the organisation as a whole did not provide support to improve doctor–manager relationships. Some suggested that managers made more effort to develop relationships than doctors, although other respondents emphasised that there was considerable energy and goodwill on both sides. Many respondents emphasised that both doctors and managers were dealing with challenging workloads, which left little time for engaging with each other beyond immediate operational matters:

> Local doctor–manager relationships vary between individuals, from the very poor to the very good... There are no events, time etc dedicated by the organisation to nurturing relationships. It is down to individual managers or doctors to make an effort. *(Directorate manager)*

> Most managers and clinicians are spending all their time attempting to 'keep the wheels on'. There is almost no time to nurture relationships beyond dealing with day-to-day pressures and firefighting. *(Chief executive)*

In many ways, these results on the overall perceptions of local doctor–manager relationships reflect those from the 2002 survey, which similarly showed that chief executives were the most positive overall about the state of local doctor–manager relationships and that clinical directors were the least positive of all role groups.

There has been relatively little change from 2002 in the within-group percentages on most of these responses (Table 2.1), although it is striking that the proportion of both directorate managers and clinical directors who give a positive rating to local doctor–manager relationships is significantly higher in 2015 compared to 2002 (at 64% of directorate managers and 50% of clinical directors in 2015 compared to 44% and 37% respectively in the 2002 survey). Directorate managers as a group are also more optimistic about the prospect of doctor–manager relationships improving in the next year than the 2002 survey respondents from this group were: in 2002 only 42% of directorate managers expected that relationships would improve but in 2015 this percentage had risen significantly to 67%.

The percentages of respondents in each group who believe that doctor–manager relationships are likely to improve over the coming year have remained steady since 2002 (or increased in the case of directorate managers), with this optimistic view expressed by at least two thirds of respondents in the chief executive, medical director and directorate manager groups. However, it is striking that compared to 2002 the current survey has seen a large increase across all groups in the percentages of respondents who consider that relationships are likely to deteriorate in the coming year. That percentage has almost doubled in the clinical director group (from 26% to 51%), while in the other three role groups the percentages have roughly trebled: from 6% to 18% in the chief executive group, from 13% to 37% for medical directors, and from 8% to 29% in the directorate manager group.

Table 2.1: Overall perceptions of local doctor–manager relationships, 2002 and 2015 results

	Chief executives (n=59)	Medical directors (n=131)	Directorate managers (n=132)	Clinical directors (n=150)	Overall (n=472)
Positive rating for local relationships (4 or 5 on a 5- point scale)	72% (42)	62% (80)	64% (84)	50% (75)	60%*
2002 figures	**76%**	**57%**	**44%**	**37%**	**47%**
Negative rating for local relationships (1 or 2 on a 5-point scale)	10% (6)	9% (12)	6% (8)	19% (28)	12%**
2002 figures	**6%**	**10%**	**11%**	**22%**	**15%**
Those agreeing that relationships are likely to improve in the next year	80% (44)	66% (80)	67% (73)	35% (47)	58%***
2002 figures	**78%**	**58%**	**42%**	**28%**	**42%**
Those agreeing that relationships are likely to deteriorate in the next year	18% (10)	37% (45)	29% (31)	51% (68)	37%***
2002 figures	**6%**	**13%**	**8%**	**26%**	**13%**
Those dissatisfied with 'the time, resources and energy devoted to nurturing effective relationships locally' (1 or 2 on a 5-point scale)	21% (12)	25% (32)	33% (43)	46% (68)	33%***
2002 figures	**28%**	**31%**	**39%**	**44%**	**39%**

Values are the percentages (numbers in parentheses) of respondents in each group who agreed (or gave a correlative rating) with the given statement (missing data excluded). '*' denotes $p<0.05$ for chi-squared test of equality across groups; '**' denotes $p<0.01$ for chi-squared test of equality across groups; '***' denotes $p<0.001$ for chi-squared test of equality across groups.

Perceptions about specific aspects of the doctor–manager relationship

Respondents were asked to indicate the extent to which they agreed or disagreed with a range of statements on aspects of the doctor–manager relationship, using a five point Likert scale (strongly agree; tend to agree; tend to disagree; strongly disagree; don't know/not applicable). To improve the layout of the survey and ease of completion, the propositions were spread across five questions. The findings are presented below in six tables (Tables 2.2–2.7) under thematic headings (for example 'issues of relative power') but to avoid 'directing' respondents these headings and these groupings were not used in the survey itself.

Overall, across all four roles, there were some areas of good agreement about aspects of the doctor–manager relationship. For example, there was widespread agreement (over 80%) that managers and doctors focus together on patient need, that medical staff are of high quality and that managers allow doctors enough autonomy to practise medicine efficiently (Box 2.1). Around three-quarters of respondents overall agreed that 'doctors and managers work well together as a team' and that 'quality and service improvement are undertaken on the basis of partnership and team work'.

Box 2.1: Areas of widespread agreement

Taken across all roles, over 80% of respondents agreed that:

- In general, doctors are respected by the public
- Medical staff in this hospital are consistently of high quality
- Managers and doctors focus together on patient need
- Managers allow doctors sufficient autonomy to practise medicine efficiently

Respondents also agreed on areas of tension in the external environment (Box 2.2): that it was becoming harder to balance financial and quality of care challenges (87% of respondents overall) and that the performance management and regulatory system 'tends to be poorly coordinated and somewhat punitive' (88% of respondents overall). There were also shared concerns about resourcing (Box 2.2), with around half of respondents considering that there were insufficient consultants to provide quality patient care and over half that their organisation lacked sufficient clinical resources.

Box 2.2: Shared concerns about the external context and about resources

- In general, NHS managers are respected by the public (88% disagreed)
- The external performance management and regulatory system for hospitals tends to be poorly coordinated and somewhat punitive (88% agreed)
- The tension between improving quality of patient care and managing costs is increasing (87% agreed)
- The external performance management and regulatory system for hospitals is necessary and proportionate (68% disagreed)
- Within this organisation there are generally sufficient clinical resources (56% disagreed)
- There is an adequate number of consultants to provide quality patient care (52% disagreed)

There was agreement that management do not exert pressure to reduce use of tests or services. Only around a third of respondents overall (35%) believed that management is driven more by financial than clinical priorities. However, there were also many other statements about the doctor–manager relationship that prompted disagreement, suggesting widespread concerns about particular aspects of the doctor–manager relationship (Box 2.3). Overall, significant numbers of respondents were concerned about the balance of power and influence between management and medical staff, the quality of management staff, the confidence of managers and doctors in the leadership capabilities of the other group and about communication between the two groups. Around 65% of respondents considered that managers 'exert pressure to discharge or transfer patients early'. However, there were also concerns about whether doctors prioritised effectively when they made requests for additional resources: less than half of respondents (39%) thought that doctors did so.

Box 2.3: Areas of widespread discontent

Taken across all roles, significant numbers of respondents indicated problems with specific aspects of the doctor–manager relationship:

- Doctors prioritise effectively when making requests for additional resources (61% disagreed)
- Management are good at providing feedback to doctors about service delivery (54% disagreed)
- Doctors view the management decision-making process to be fair (49% disagreed)
- Doctors have confidence in management leadership capabilities (47% disagreed)
- Management staff in this hospital are consistently of high quality (47% disagreed)
- The relative power and influence between management and medical staff is about right (43% disagreed)
- Doctors are good at keeping management informed about service development issues (40% disagreed)
- Doctors are adequately involved in hospital management activities (38% disagreed)
- Managers have confidence in clinical leadership abilities (37% disagreed)
- Management are generally responsive to requests for additional clinical resources (36% disagreed)
- Doctors have sufficient influence on hospital management (35% disagreed)
- Doctors are generally supportive of management decisions (35% disagreed)
- Managers are well versed in clinical activity (31% disagreed)

Differences in views between members of different role groups

Although there were some areas of agreement across the whole sample, there were some significant differences between the four role groups in the focus of their concerns (Tables 2.2–2.7). A striking finding was that clinical directors seemed to hold views that diverged markedly from, and were significantly less positive than, those of the other three groups. For example, on issues of relative power (Table 2.2), clinical directors were significantly less likely than the other three role groups to believe that the relative power and influence between management and medical staff is about right, that doctors are adequately involved in or have sufficient influence on hospital management or that managers allow doctors sufficient autonomy and do not exert pressure on them.

Table 2.2: Issues of relative power

	Chief executives (n=59)	Medical directors (n=131)	Directorate managers (n=132)	Clinical directors (n=150)	Overall (n=472)
The relative power and influence between management and medical staff is about right	70% (40)	68% (88)	55% (70)	44% (65)	57%***
Doctors are adequately involved in hospital management activities	63% (36)	66% (85)	66% (85)	53% (78)	62% n.s.
Doctors have sufficient influence on hospital management	81% (43)	63% (80)	81% (100)	46% (66)	65%***
Managers allow doctors sufficient autonomy to practise medicine efficiently	96% (52)	79% (101)	95% (117)	72% (104)	83%***
Management do not exert pressure to reduce use of tests or services †	78% (43)	79% (99)	68% (82)	61% (87)	70%***
Management do not exert pressure to discharge or transfer patients early†	53% (29)	33% (41)	34% (41)	23% (31)	33%**

Values are the percentages (numbers in parentheses) of respondents in each group who agreed with the given statement (missing data excluded). † These statements were reverse-worded and the percentages have been adjusted accordingly. 'n.s.' denotes p>=0.05 for chi-squared test of equality across groups; '*' denotes p<0.05 for chi-squared test of equality across groups; '**' denotes p<0.01 for chi-squared test of equality across groups; '***' denotes p<0.001 for chi-squared test of equality across groups.

Similarly, clinical directors were significantly less likely than other role groups to have confidence in managers' abilities (Table 2.3).

Clinical directors were also less likely to believe that managers and doctors shared common goals (Table 2.4). For example, only 43% of clinical directors thought that management was driven more by clinical priorities than financial ones compared to around 70% of medical directors and directorate managers and 96% of chief executives.

Table 2.3: Perceptions of staff calibre

	Chief executives (n=59)	Medical directors (n=131)	Directorate managers (n=132)	Clinical directors (n=150)	Overall (n=472)
Management staff in this hospital are consistently of high quality	66% (37)	54% (68)	69% (87)	34% (49)	53%***
Medical staff in this hospital are consistently of high quality	85% (45)	84% (108)	82% (99)	92% (132)	86% n.s.
Managers are well versed in clinical activity	81% (43)	70% (89)	84% (102)	52% (74)	69%***
Managers have confidence in clinical leadership abilities	71% (40)	59% (74)	71% (90)	54% (75)	63%*
Doctors have confidence in management leadership capabilities	79% (44)	57% (70)	59% (71)	34% (49)	53%***

Values are the percentages (numbers in parentheses) of respondents in each group who agreed with the given statement (missing data excluded). † These statements were reverse-worded and the percentages have been adjusted accordingly. 'n.s.' denotes p>=0.05 for chi-squared test of equality across groups; '*' denotes p<0.05 for chi-squared test of equality across groups; '**' denotes p<0.01 for chi-squared test of equality across groups; '***' denotes p<0.001 for chi-squared test of equality across groups.

Table 2.4: Views on goals, decision-making and team-working

	Chief executives (n=59)	Medical directors (n=131)	Directorate managers (n=132)	Clinical directors (n=150)	Overall (n=472)
Hospital managers and doctors are largely in agreement on the overall goals of the institution	93% (52)	82% (102)	76% (93)	65% (93)	76%***
Management is driven more by clinical than financial priorities†	96% (54)	70% (89)	71% (85)	43% (62)	65%***
Managers and doctors focus together on patient need	95% (53)	87% (109)	87% (103)	66% (95)	81%***
Doctors view the management decision-making process to be fair	67% (36)	57% (70)	53% (58)	37% (53)	51%**
Doctors are generally supportive of management decisions	84% (47)	68% (85)	70% (83)	50% (70)	65%***
Doctors and managers work well together as a team	86% (48)	82% (104)	83% (104)	61% (89)	76%***
Quality and service improvement are undertaken on the basis of partnership and teamwork	91% (49)	78% (98)	82% (100)	58% (83)	74%***

Values are the percentages (numbers in parentheses) of respondents in each group who agreed with the given statement (missing data excluded). † These statements were reverse-worded and the percentages have been adjusted accordingly. 'n.s.' denotes p>=0.05 for chi-squared test of equality across groups; '*' denotes p<0.05 for chi-squared test of equality across groups; '**' denotes p<0.01 for chi-squared test of equality across groups; '***' denotes p<0.001 for chi-squared test of equality across groups.

Clinical directors also had a more pessimistic view than other groups about the potential for clinical performance data to improve service management or improve the doctor–manager relationship (Table 2.5) and were less likely than other groups to agree that their organisation was 'characterised by openness, honesty and challenge'.

Clinical directors were significantly more likely than other role groups to express dissatisfaction with the level of resources and with managerial responsiveness to requests for additional resources (Table 2.6). The only area in which the views of clinical directors did not diverge markedly from those of the other three role groups was on statements relating to external context, where there was much greater homogeneity across the whole sample (Table 2.7).

Additional comments from respondents

A strong theme that emerged from the free text comments in this part of the survey from both medical and non-medical managers was the tendency of many doctors to focus solely or mainly on clinical work and to avoid getting involved in initiatives that they perceived as 'distractions from patient care'. Some respondents thought that many doctors took up an overall stance of non-engagement with management issues. As one directorate manager observed:

> Many of the doctors actively distance themselves from the business/hospital management activities and work to maintain the traditional divide between these professional groups.

Table 2.5: Communication issues

	Chief executives (n=59)	Medical directors (n=131)	Directorate managers (n=132)	Clinical directors (n=150)	Overall (n=472)
Management are good at providing feedback to doctors about service delivery	69% (37)	37% (46)	64% (75)	30% (43)	46%***
Doctors are good at keeping management informed about service development issues	75% (42)	56% (71)	59% (70)	57% (80)	60% n.s.
The use of clinical performance data stimulates good practice and strengthens service management	91% (50)	81% (102)	85% (102)	62% (87)	77%***
The availability of clinical performance data improves the doctor–manager relationship	91% (50)	72% (91)	79% (89)	59% (82)	72%***
This organisation is characterised by openness, honesty and challenge	98% (55)	81% (102)	72% (89)	59% (86)	74%***

Values are the percentages (numbers in parentheses) of respondents in each group who agreed with the given statement (missing data excluded). † These statements were reverse-worded and the percentages have been adjusted accordingly. 'n.s.' denotes p>=0.05 for chi-squared test of equality across groups; '*' denotes p<0.05 for chi-squared test of equality across groups; '**' denotes p<0.01 for chi-squared test of equality across groups; '***' denotes p<0.001 for chi-squared test of equality across groups.

Table 2.6: Resource issues

	Chief executives (n=59)	Medical directors (n=131)	Directorate managers (n=132)	Clinical directors (n=150)	Overall (n=472)
There is an adequate number of consultants to provide quality patient care	71% (40)	48% (61)	56% (66)	32% (46)	48%***
Within this organisation there are generally sufficient clinical resources	66% (37)	49% (62)	49% (58)	28% (40)	44%***
Management are generally responsive to requests for additional clinical resources	93% (51)	67% (85)	78% (90)	40% (57)	64%***
Doctors prioritise effectively when making requests for additional resources	48% (26)	30% (37)	40% (47)	43% (61)	39% n.s.

Values are the percentages (numbers in parentheses) of respondents in each group who agreed with the given statement (missing data excluded). † These statements were reverse-worded and the percentages have been adjusted accordingly. 'n.s.' denotes p>=0.05 for chi-squared test of equality across groups; '*' denotes p<0.05 for chi-squared test of equality across groups; '**' denotes p<0.01 for chi-squared test of equality across groups; '***' denotes p<0.001 for chi-squared test of equality across groups.

Table 2.7: External context

	Chief executives (n=59)	Medical directors (n=131)	Directorate managers (n=132)	Clinical directors (n=150)	Overall (n=472)
In general, doctors are respected by the public	97% (55)	98% (126)	100% (127)	94% (139)	97%* ~
The tension between improving quality of patient care and managing costs is increasing	82% (44)	86% (108)	84% (103)	93% (132)	87% n.s.
The external performance management and regulatory system for hospitals tends to be poorly coordinated and somewhat punitive	87% (47)	91% (115)	85% (100)	89% (124)	88% n.s.
In general, NHS managers are respected by the public	4% (2)	8% (10)	16% (19)	14% (19)	12% n.s.
The external performance management and regulatory system for hospitals is necessary and proportionate	16% (9)	25% (32)	43% (50)	36% (51)	32%**

Values are the percentages (numbers in parentheses) of respondents in each group who agreed with the given statement (missing data excluded). † These statements were reverse-worded and the percentages have been adjusted accordingly. '~' denotes Fisher's exact test. 'n.s.' denotes p>=0.05 for chi-squared test of equality across groups; '*' denotes p<0.05 for chi-squared test of equality across groups; '**' denotes p<0.01 for chi-squared test of equality across groups; '***' denotes p<0.001 for chi-squared test of equality across groups.

Others felt that doctors' engagement was more selective and 'fair weather'. The tendency was for many doctors to focus primarily on their own clinical area, as one medical director commented:

> Doctors tend to disengage from difficult decisions and management concerns while engaging with the positive developments. Doctors will accord primacy to their specialty, putting it in front of organisational need.

Another medical director noted:

> Doctors (and I'm one of them) still tend to see a small picture when it comes to additional resources.

A further strong theme was the impact of the external financial and regulatory context on working relationships between doctors and managers. As one medical director explained, the dominance of financial drivers usurped other objectives which clinicians valued:

> This is a financially driven system. Clinicians want to move to a more patient outcome focused quality driven system but the grip of finance prevents this.

This created the daunting challenge of balancing competing objectives and managing multiple constraints:

> Getting the balance between targets, resources and quality right is extremely difficult with political imperatives, unrealistic expectations and quality assurance crude and often unrelated to best clinical practice.

Some respondents believed that the current regulatory system was completely unworkable and needed radical changes. As one chief executive commented:

> The regulatory burden is unsustainable. The CQC regime is breathtaking in its dysfunctionality – it needs to be scrapped and start again.

Others suggested that it was not so much the overall system that created rifts between managers and doctors but the wholesale adoption by managers of external policy and financial targets unchanged and without challenge: "*the drive to implement these initiatives verbatim*" as one clinical director described it. These challenges were compounded in many trusts by persistent problems in capturing and using robust data. Data problems tended to lead to clinicians 'disengaging immediately' and meant that discussions revolved around the inaccuracy of the data instead of the topic at hand.

In summary, the additional comments from respondents provided further insights into the dynamics of local relationships between doctors and managers, with some evidence of many doctors continuing to have a patient or specialty focus rather than an organisational focus and widespread resentment at externally imposed constraints, particularly when these were imposed without tailoring to the local context. Persistent problems of poor data quality served as a distracting focus for many discussions between doctors and managers.

Barriers to more effective doctor–manager relationships

Respondents were asked to consider the three main barriers to more effective doctor–manager relationships. There was considerable alignment between the different role groups (Table 2.8). Across all four role groups, the top three barriers identified were time demands on doctors (60%), the turbulent policy context and associated structural changes (45%) and insufficient resources (40%). The next most significant barrier identified by respondents was time demands on managers: 36% of respondents overall identified this as a significant barrier.

Although there was in general considerable alignment between the role groups, the issue of time demands placed on managers was raised most often by directorate managers and least often by clinical directors (46% versus 24%). Chief executives (70%), medical directors (63%) and clinical directors (64%) identified the issue of time demands on doctors more often than directorate managers did (48%).

Table 2.8: Barriers to more effective doctor–manager relationships

Barriers to improving the doctor–manager relationship	Chief executives (n=59)	Medical directors (n=131)	Directorate managers (n=132)	Clinical directors (n=150)	Overall (n=472)
Time demands placed on doctors	70% (41)	63% (82)	48% (63)	64% (96)	60%
Turbulent policy context and associated structural changes	56% (33)	52% (68)	33% (44)	45% (68)	45%
Insufficient resources	41% (24)	41% (54)	35% (46)	43% (64)	40%
Time demands placed on managers	39% (23)	39% (51)	46% (60)	24% (36)	36%
Lack of communication	19% (11)	32% (42)	36% (48)	32% (48)	32%
The cultural divide between management and medical staff	25% (15)	29% (38)	31% (41)	28% (42)	29%
Lack of trust between management and medical staff	22% (13)	31% (41)	28% (37)	27% (41)	28%

The figures show the percentage (numbers in parentheses) of respondents in each category identifying specific issues as important barriers to more effective doctor–manager relationships. Columns do not sum to 100% as respondents could select up to three main barriers.

Changes in perceptions since the earlier survey in 2002

One of the changes seen between the 2002 and the 2015 surveys was in perceptions of sufficient resources. Respondents in the later survey were much more likely overall to say that there was an adequate number of consultants to provide quality patient care (48% in 2015 compared to 27% in 2002). In the chief executive group, this had risen to 71% of chief executives in 2015 compared to only 32% in 2002. Similarly, in 2002, only 17% of respondents overall and 24% of chief executives thought that their organisation generally had sufficient clinical resources but in 2015 this had increased to 44% of respondents overall and 66% of chief executives. Furthermore, although insufficient resources were still one of the top three barriers to effective doctor–manager relationships identified by respondents in 2015 (as in 2002), the percentage of those who considered that insufficient resources were a barrier was considerably lower in 2015 (at 40%) than in 2002 (at 76%).

Another positive shift seen between the two time periods is that respondents in 2015 were more likely overall than respondents in 2002 to agree that management is driven more by clinical priorities than by financial ones (65% overall agreed with this statement in 2015 compared to 42% in 2002). However, respondents in 2015 were more pessimistic about whether managers exerted pressure to discharge or transfer patients early: 67% overall thought that managers did so compared to only 48% in 2002. For clinical directors, the shift was even greater: by 2015 77% of clinical directors believed this compared to only 45% of clinical director respondents in 2002. Fewer respondents overall considered that 'management staff in this hospital are consistently of high quality' (53% in 2015 compared to 67% in 2002). Clinical directors were particularly negative about the quality of management staff: only 34% rated management staff as consistently of high quality in 2015, down from 53% in the earlier survey. The overall percentage of respondents who considered that 'management are good at providing feedback to doctors about service delivery' also fell between 2002 and 2015 from 63% of respondents overall to 46% of respondents overall. Again, there

was a significant change in the clinical director group between 2002 and 2015: from 51% of clinical directors in 2002 expressing this positive view to only 30% in 2015. In addition, clinical directors in 2015 were less likely to agree that managers have confidence in clinical leadership capabilities: 71% of clinical directors thought this in 2002 but this had fallen to 54% in 2015.

Although the top three barriers to effective doctor–manager relationships identified in 2015 were the same as in 2002 (i.e. time demands on doctors, turbulent policy context and insufficient resources), one of the barriers that did not make the top three seemed to have increased in importance in 2015. Lack of trust between management and medical staff was perceived as a more important barrier in 2015 than it had been in 2002, especially by respondents at board level. In 2015 28% of respondents overall considered that this was a barrier compared to 17% in 2002. Only 9% of chief executives and 13% of medical directors identified lack of trust as an important barrier in 2002, but in 2015 22% of chief executives and 31% of medical directors did so.

The impact of external factors on doctor–manager relationships in the last five years

Respondents were asked to consider which of a list of external factors had had the most positive impact and the most negative impact on doctor–manager relationships in the last five years, and to choose up to three factors in each category.

The top three factors that respondents thought had had the most positive impact on doctor–manager relationships in the last five years were the Francis reports (2010 and 2013), the Berwick review into patient safety (2013) and the Keogh mortality review (2013) (Table 2.9). The three factors that were thought to have had the most negative impact (Table 2.10) were financial pressures, changes in the role of external monitoring bodies and the Health and Social Care Act (2012). One directorate manager commented that, following the Act:

> The whole system is still broken and full of perverse incentives. Competition versus integration, tariff and income versus system-wide transformation, quality and safety versus cost, commissioners versus providers, regulators versus providers, regulators versus regulators, health versus social care.

Several respondents suggested other external factors; for example, several commented on the negative impact that the *"thoroughly negative national media agenda"* had on relationships between doctors and managers:

> The NHS is used as a political football and means of selling newspapers and making headlines which masks the pride we all take in working hard to provide high-quality care for patients. *(Directorate manager)*

There were some differences in perceptions by role group. Chief executives were less likely to identify the Francis reports as having had a positive impact on doctor–

Table 2.9: Factors that have had a positive impact on doctor–manager relationships in the last five years

	Chief executives (n=59)	Medical directors (n=131)	Directorate managers (n=132)	Clinical directors (n=150)	Overall (n=472)
Francis reports (2010 and 2013)	48% (28)	66% (87)	71% (93)	69% (104)	66%
Berwick review into patient safety (2013)	59% (35)	66% (86)	41% (54)	41% (61)	50%
Keogh mortality review (2013)	53% (31)	49% (64)	51% (67)	40% (60)	47%
Establishment of the Faculty of Medical Leadership and Management (2011)	24% (14)	18% (24)	18% (24)	16% (24)	18%
Changes in the role of external monitoring bodies (e.g. Monitor and the Care Quality Commission)	14% (8)	10% (13)	22% (29)	20% (30)	17%
Health and Social Care Act 2012	7% (4)	5% (6)	20% (26)	6% (9)	10%
Social media	12% (7)	5% (6)	5% (6)	9% (13)	7%
Financial pressures	9% (5)	7% (9)	8% (11)	3% (4)	6%

The figures show the percentage (numbers in parentheses) of respondents in each category identifying specific issues as important barriers to more effective doctor–manager relationships. Columns do not sum to 100% as respondents could select up to three main barriers.

Table 2.10: Factors that have had a negative impact on doctor–manager relationships in the last five years

	Chief executives (n=59)	Medical directors (n=131)	Directorate managers (n=132)	Clinical directors (n=150)	Overall (n=472)
Financial pressures	71% (42)	83% (109)	74% (98)	83% (124)	79%
Changes in the role of external monitoring bodies (e.g. Monitor and the Care Quality Commission)	48% (28)	51% (67)	31% (41)	35% (52)	40%
Health and Social Care Act 2012	51% (31)	50% (66)	22% (29)	34% (51)	37%
Social media	19% (11)	21% (27)	36% (48)	31% (46)	28%
Francis reports (2010 and 2013)	27% (16)	9% (12)	8% (11)	11% (17)	12%
Keogh mortality review (2013)	9% (5)	8% (10)	4% (5)	6% (9)	6%
Establishment of the Faculty of Medical Leadership and Management (2011)	2% (1)	5% (7)	5% (6)	3% (5)	4%
Berwick review into patient safety (2013)	2% (1)	1% (1)	2% (3)	4% (6)	2%

The figures show the percentage (numbers in parentheses) of respondents in each category identifying specific issues as important barriers to more effective doctor–manager relationships. Columns do not sum to 100% as respondents could select up to three main barriers.

manager relationships than the three other role groups (48% versus 66–71%) and were more likely to identify the Francis reports as one of the factors that had had a negative impact (27% versus 8–11%). Those at board level (i.e. chief executives (59%) and medical directors (66%)) were more likely to choose the Berwick review into patient safety as one of the factors that had had a positive impact than directorate managers or clinical directors were (41% each). Similarly, in relation to the negative factors, there was a difference between board and directorate levels in terms of perceptions of the Health and Social Care Act 2012: around half of chief executives and medical directors identified the Act as negative in its impact on doctor–manager relationships compared to less than a quarter of directorate managers and around a third of clinical directors. Indeed, directorate managers were much more likely than the other three role groups to say that the Act had had a positive impact on doctor–manager relationships.

Chief executives and medical directors were also more likely than those at middle-management level to identify changes in the role of external bodies (e.g. Monitor[1] and the Care Quality Commission) as having had a negative impact on doctor–manager relationships. Conversely, chief executives and medical directors were less likely than directorate managers and clinical directors to identify social media as one of the negative factors impacting on that relationship.

Many respondents commented that specific reports and initiatives had had both a positive and a negative impact. As one chief executive observed:

> Both the Francis reports and evolving regulation have had contradictory impacts. They have properly encouraged a shared focus on quality, safety and patient experience but have encouraged an unnecessary culture of blame rather than responsibility.

A directorate manager suggested that the financial pressures had had similar mixed effects locally: they had promoted closer working between doctors and managers on 'transformation' projects but, at the same time, they had pitched clinical priorities against financial priorities. Other respondents considered that national reports like the Francis report had made little impact at local level and that they had had most impact, if any, on trust boards:

> Few of these reports have had an actual impact as recommendations take so long to implement, or the resource implications have simply never been considered.
> *(Clinical director)*

One commented that change in their organisation was driven by other factors and that success had resulted from other organisational drivers around culture and values:

1 As of 1 April 2016, Monitor merged with several NHS bodies, most notably the Trust Development Authority, to form NHS Improvement, a new body responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.

> Overall, we do not do things because of external reports. Our culture and values are such that we do things because they are right for our patients, staff and the organisation. So we have made huge progress. *(Medical director)*

Another respondent expressed surprise that "*the increasing pressure from patients for better care, for more information and involvement in their care*" had not been included in the list of external factors. This medical director considered that this had been one of the external factors that had had a positive impact on doctor–manager relationships.

Initiatives to improve doctor–manager relationships

A range of initiatives has been developed in the past decade or so aimed at improving doctor–manager relationships. We were interested in the extent to which such initiatives were widespread. We therefore added a new section to the survey so that respondents could indicate what was available in their hospital (Table 2.11).

Table 2.11: Initiatives to improve doctor–manager relationships

	Chief executives (n=59)	Medical directors (n=131)	Directorate managers (n=132)	Clinical directors (n=150)	Overall (n=472)
Collaboration between individual managers and doctors on quality improvement or service innovation projects	95% (53)	84% (99)	83% (87)	63% (80)	68%
Management training for doctors	86% (48)	80% (94)	63% (66)	79% (99)	65%
Joint discussion events for doctors and managers	79% (44)	58% (69)	66% (70)	51% (65)	52%
Joint training events for doctors and managers	71% (40)	53% (62)	42% (44)	38% (48)	41%
Paired learning between managers and doctors	41% (23)	26% (31)	27% (28)	16% (20)	22%
Joint social events for managers and doctors	29% (16)	24% (28)	19% (20)	14% (18)	17%
'Buddying' or mentoring schemes between doctors and managers	39% (22)	19% (23)	12% (13)	7% (9)	14%
Joint social spaces	25% (14)	9% (11)	10% (10)	5% (7)	9%

All figures are the percentage (numbers in parentheses) of respondents identifying specific initiatives as available in their hospital. Columns do not sum to 100% as respondents could select as many initiatives as were available.

Across all respondents, the most common initiatives were:

- collaboration between individual managers and doctors on quality improvement or service innovation projects (68% of all respondents indicated that this happened in their hospital)
- management training for doctors (65%)

- joint discussion events for doctors and managers (52%)
- joint training events (41%).

However, 65 respondents (14%) did not answer this question. Furthermore, when broken down by role group, it emerged that chief executives were more likely than other role groups to state that such initiatives were available and that with the exception of management training for doctors, clinical directors were less likely than other role groups to indicate that these were available. In particular, clinical directors were less likely to state that paired learning or collaboration on quality improvement or service innovation projects were available.

Several respondents added comments to the effect that none of these initiatives were available locally as far as they were aware, with one clinical director commenting: *"None! I wouldn't have time for them anyway."* One medical director described how there seemed to be 'little appetite' for social events for doctors and managers in their local trust despite efforts to arrange these. More positively, respondents described initiatives that had been successful locally. These included a monthly discussion event for managers and medical leaders comprising a brief presentation *"followed by open discussion and challenge on a variety of topics – clinical, finance and quality"*. However, others commented that structured events were less likely to be productive compared to managers and doctors having *"the time and confidence to seek each other out on an individual basis"*.

Although management training for doctors appeared to be fairly widely available, with around two thirds of respondents stating that it was available locally, several respondents commented that leadership and management training for doctors was not sufficient in itself, particularly when formal courses were generic i.e. detached from the organisation and its particular context and challenges. Respondents suggested that even strong courses needed to be supplemented by ongoing coaching and support to enable course participants to put their learning into practice in their local setting. Indeed, coaching was endorsed by one respondent as one of the initiatives that had made a significant difference locally:

> Individual executive coaching on leadership style and resilience for individual senior clinicians and managers has had a transformational impact upon relationships between senior clinicians and management. *(Chief executive)*

In summary, management training for doctors appears to be available in many hospitals, together with collaboration between individual managers and doctors on quality improvement or service innovation projects. Joint discussion and joint training events are also fairly common. Other initiatives are much less widespread. In particular, joint social spaces (9%) and joint social events are relatively rare (17%) while only 14% of respondents indicated that 'buddying' or mentoring schemes between doctors and managers were available in their hospitals. Of the four role groups, chief executives were most likely to indicate that any of the initiatives listed were available in their hospital.

General observations on doctor–manager relationships

Around one third of respondents used the free-text comments box at the end of the survey. Many respondents reflected on their overall perception of the doctor–manager relationship; Box 2.4 gives some typical examples.

Box 2.4: Overall perceptions of the doctor–manager relationship

- *"Operational management at local level works very closely with clinical teams in my areas and the divide seen elsewhere is not apparent."* **(Directorate manager)**
- *"In general I believe doctor–manager relationships locally are very good but there is a general myth of an adversarial relationship nationally which does not help junior clinicians and managers."* **(Chief executive)**
- *"Everybody cares and wants to do the best. There are misconceptions/misunderstandings on both sides without sufficient time in either group's diaries to clarify. Doctors tend to be 'partisan' – understandably wanting the best for 'their' patients and not getting the big picture of all of the patients. Managers can misinterpret this as being 'empire building' and clinicians misinterpret the response as lack of understanding or lack of care. There is also the culture that a manager can lose their job by not delivering to the externally required imperative whilst doctors lose their jobs by not insisting on the right quality/safety – they shouldn't be mutually exclusive but sometimes they are."* **(Medical director)**
- *"Clinical input into important management decision-making has been progressively eroded due to various pressures and processes, most of which stem from government orders. Much is said about increasing clinical effectiveness in management, but this seldom translates into tangible action beyond ever more bureaucracy and form-filling. Doctors and managers can work effectively and collaboratively together, I have seen it on many occasions, but it requires mutual trust, respect and power-sharing."* **(Clinical director)**

Overall, these assessments were largely positive, referring to effective collaborative working between managers and doctors while acknowledging that there were a range of factors (e.g. time demands, financial pressures, the rapid turnover of managers compared to doctors) that made the relationships more challenging. The overall tone of comments could be described as optimistic but rueful, recognising the common concerns of both managers and doctors to deliver high-quality patient care and regretting the external financial, regulatory and policy challenges that made it significantly harder to meet these shared objectives. Many respondents commented on the negative impact of external policy on local relationships (Box 2.5). Several policy developments (e.g. stringent financial targets) and external bodies (e.g. NHS England) were singled out for particular criticism. For one chief executive respondent, the increased emphasis on clinical leadership had been particularly divisive:

> "I think that the focus on clinical leadership being superior to any other kind of leadership in recent years has had a detrimental effect on the quality and influence of general management.

Respondents also acknowledged that in some cases external policy developments had brought managers and doctors together against a 'common enemy' or to fulfil a 'common purpose' (Box 2.5).

Box 2.5: The impact of external policy on local relationships

- *"In the main there are good working relationships with joint work and decision-making. However the increasing financial constraints and increasing demands on the service are taking their toll on all relationships."* **(Directorate manager)**
- *"NHS England and Health Education England are instrumental in driving a wedge between clinicians and managers. These are pointless quangos with less than optimal leadership. To counter, extraordinary endeavours are called for in the operational settings – however, common purpose is enhancing the bond and trust between the respective disciplines."*
  (Chief executive)
- *"The punitive financial nature of targets set by e.g. CCGs has a negative impact on all NHS establishments. It leads to a deepening of the divide between management and clinicians as NHS trusts strive to maintain financial balance. Whilst all targets should be based on good clinical practice they are inevitably interpreted as being financially driven and this disengages clinicians which exacerbates the manager clinician interface."* **(Directorate manager)**
- *"Poor relationships between doctors and managers are the symptom not the disease in our organisation. The real issue is a mismatch between resource and demand, which inevitably creates conflict and disappointment."* **(Medical director)**

That said, there were a few comments that suggested that the traditional divisions between managers and doctors reported in earlier research and alluded to in recent reports like the Francis report (Francis, 2013) still have some force (Box 2.6).

Box 2.6: Traditional divisions between doctors and managers still evident at times

- *"The managers should be more visible around the hospital rather than communicating via electronic media."* **(Clinical director)**
- *"Managers are seen as agents of the government to deliver targets. Doctors are seen as irresponsible and unaccountable. The above although a cliche also contains more than a germ of truth."* **(Directorate manager)**
- *"The current situation with doctor–manager relationships arises from the 1983 Griffiths report which excluded doctors, nurses and patients (grassroots representatives from all those who would be affected by the inquiry's findings). The consequent 'managerialism' of the NHS follows on from this with predictable results. The single most important change required is for managers to have an ethical and regulatory equivalent of the GMC or NMC. This will align doctors, nurses, managers and the needs of patients."* **(Clinical director)**
- *"When a clinician–manager relationship works well, it is extremely valuable and beneficial to both parties... I am certain that these positive relationships result in better outcomes every time than if either professional tackled it alone. It is extremely frustrating when a lack of trust or a perceived opportunity to 'play the system' means that clinicians provide insufficient or misleading information as to the importance/risk associated with a particular issue in an attempt to secure resources.* **(Directorate manager)**
- *"Most of the senior [managerial] people seem genuine, intelligent people, who initially create the impression that they will solve obvious, long-running problems. A year or so later, it always becomes apparent that nothing will change. ... I suspect that the central NHS organisation gives them very little room for manoeuvre or so much work to serve the machinery of bureaucracy, that they never actually make the decisions that I would expect them to be capable of."* **(Clinical director)**

Box 2.6 (*continued*): Traditional divisions between doctors and managers still evident at times

- *"I find that there are (in any organisation) a few instances when medical staff work extremely well with management. However these are rare. The majority of medical staff are slow to engage with management apart from issues relating to pay, pay awards and revalidation. Most use management to ensure that everything works for them and their patients in a rather parochial view rather than the larger picture."* **(Directorate manager)**
- *"'Managers' is too generic a term. I have a very different view of departmental-level managers – who are strongly integrated into my team and really do see the overall picture and for whom I have the greatest respect and trust and with whom I can work very well – than I do of exec-level managers and those on the tier just below, who I feel are purely driven by costs and internal political manoeuvring and who I feel remain aloof and in a parallel universe to the rest of us."* **(Clinical director)**
- *"The cultural divide between the two groups is vast and it is only now that I am medical director and working closely with senior managers that I can see how big the divide is. The hierarchy in medicine works very differently than that in the rest of the NHS and the values are very different."* **(Medical director)**

Several respondents made suggestions for approaches or changes that could improve doctor–manager relationships (Box 2.7). These centred around enabling clinicians and managers to make service improvements without constraining them with unduly narrow bureaucratic or financial processes, improving data quality and encouraging doctors to see a 'bigger picture' and to develop a shared vision, respect and trust for managers as partners rather than as opponents.

Box 2.7: Suggestions for the way forward

- *"We need teams, supported by coaches to lead continuous quality improvement. They need to be free from over-bureaucratic processes and be empowered to be decision-makers. We are currently locked into a finance-driven system which drives down standards. This is an impossible situation for clinicians. However much leadership and improvement training we deliver, unless people are empowered at the end of it, it is of limited value and potentially demoralising."* **(Medical director)**
- *"This remains a challenging area and a mystery as to why more progress can't be made... Where clinicians work well with managers and have a big picture view of the constraints, real progress is made. Do we have to drop the divide language and start selling the partnership concept?"* **(Chief executive)**
- *"Both sides have huge agendas. Emotional connections and informal networks will help the understanding."* **(Medical director)**
- *"Many doctors see managers as 'the enemy' – the ones who succeed the most are the ones who can put aside their biases (on both sides) and work with each other as people with a joint vision of using the resources there are to best effect for safe patient care. Doctors in my experience are more invigorated by concepts first, details and finance second. They recognise the importance of step 2 but they need to be on board first, details second. And the details need to be right – accurate and up to date."* **(Directorate manager)**
- *"I believe that the divide is artificial and if there is one, managers have responsibility to move it. Industry does not in my experience have the public discussion about who is a manager and who is a technician and who is right. I know there is still some way to go in developing trust around what we need to do. This will not come by media focusing on the differences – we can do that for ourselves!"* **(Directorate manager)**

The free-text comments boxes at the end of the survey allowed respondents to expand on their earlier answers and provided further insights into what respondents perceived about local and national challenges to good doctor–manager working relationships and some of the changes that respondents believed were needed. We used these themes and some anonymised direct quotations as discussion prompts in the interviews and focus group.

3. Key themes from the interviews and focus group

The interviews and focus group were carried out to provide additional insights into the headline findings from the online phase of the survey and into wider issues around the doctor–manager relationship. In presenting the findings from the interviews and focus group in this section, we open with a strong theme (Theme 1) that emerged from the interviews and focus group discussions: the variability in doctor–manager relationships between trusts and between different departments and levels within the same trust. We then set out the findings under the following key thematic areas covered by the survey:

- Theme 2: How medical managers and managers perceive each other
- Theme 3: The status of medical management among doctors
- Theme 4: The impact of the external context on doctor–manager relationships
- Theme 5: Public esteem of doctors and managers
- Theme 6: Local initiatives to support doctor–manager relationships.

We close this section with what the participants in the interviews and focus groups thought about the trajectory in doctor–manager relationships since the 2002 survey (Theme 7).

Theme 1: Differences in doctor–manager relationships between trusts and within individual trusts

One of the strongest themes to emerge from the interviews and focus group was that it was impossible to generalise about the state of play of doctor–manager relationships in the NHS as a whole. Most participants in the interviews and focus group emphasised how different doctor–manager relationships were in different trusts and in different hospitals and departments within the same trust. This meant that many felt that it was impossible to generalise about the state of play in doctor–manager relationships in the NHS as a whole, and some were critical of the implicit underlying assumption in the survey that it was meaningful to do so.

The influence of the trust board

Some argued that the cultural tone of doctor–manager relationships within a hospital was very dependent on the approach taken by the board chair, by the chief executive and, to a lesser extent, by the medical director. The relationship between the chief executive and the medical director was seen to be critical, although it could also cause problems if the relationship were perceived as being too close. Where the trust board members and the chair welcomed clinicians in management, it was suggested that it was more common to find that doctors and managers worked well together. Conversely, in trusts where clinical management was more of a 'fig leaf' than a reality then the non-medical managers were perceived to hold all of the power, and relationships between doctors and managers tended to be more oppositional.

Disconnection between the board and divisional or directorate level

However, some participants argued that whatever the ethos that the trust board might try to promote, this did not necessarily filter down to the working practices between doctors and managers at divisional or directorate level. Participants observed that the board was often somewhat disconnected from these levels. Many doctors perceived the trust board as remote and spoke of the board as 'them' as if the board did not include medical managers like the medical director.

Instead, much depended on the individuals in post at those levels and how well they got on with each other. Indeed, it was suggested by several interviewees that it was often the case that clinical directors and directorate managers worked well together while both being opposed to aspects of national policy or to the direction taken by the trust board. One interviewee observed that considerable amounts of work and training had been put in to encourage clinical directors and service managers to work well together but that it was possible that 'upward' relationships between that level and those at board level would be less positive.

Theme 2: How medical managers and managers perceive each other

Interview and focus group participants commented on how they considered that medical managers and managers perceived each other. Comments were focused around whether doctors believed that they shared common objectives with managers and the perception that general managers faced additional challenges in their role compared to medical managers.

Are there common goals between doctors and managers?

Non-medical manager interviewees expressed frustration at the impact of clinical priorities on their ability to do their job effectively: *"I have a lot of inefficient conversations because doctors are too busy to be there or are not really engaged."* Several medical manager interviewees commented that some doctors refused to accept that managers shared a strong passion for improving services for patients:

> "I have to work really hard at getting people to accept that others also put patient care first. They say things like 'I believe you care about patient care [as medical director] but my managers don't care about it.'

One medical manager interviewee commented that a common tendency among doctors (and one that he thought was also suggested by the survey wording) was to assume that 'doctors are right and managers are wrong' and that this ignored both the strong motivation of managers to improve patient care and the tendency for the medical profession at times to cling to traditional ways of working that might not necessarily be in the best interests of patients (as the Keogh review had suggested). This interviewee commented that this was a very difficult challenge for the medical profession as a whole to acknowledge.

Several interviewees emphasised that there was still a 'them and us' perspective from many doctors towards managers, particularly from the 'rank and file' consultants and junior doctors rather than from medical managers. (Relationships between the consultant

body and the junior doctor body and non-medical managers were not specifically covered by the study, which aimed only to assess the perspective of medical and non-medical managers about each other. However, interviewees acknowledged that these other relationships formed an important aspect of the context in which medical managers and non-medical managers worked.) Medical managers reported that they had to be alert to doctors using this kind of 'them and us' language and perspective and that they often had to challenge it. One medical manager expressed surprise at the quotation from the survey that deteriorating finances had reduced clinicians' trust in managers. This medical manager's view was that deteriorating finances were a challenge to be faced together by both doctors and managers. She emphasised that challenging the 'them and us' mantra was an essential part of making progress on engaging doctors in management.

One interviewee commented on the apparent discrepancy between the change in the level of agreement since the 2002 survey with such statements as 'Hospital managers and doctors are largely in agreement on overall goals' and the positive ratings given by many survey respondents to local relationships. The interviewee considered that this might be a reflection of the increasing external pressures on trusts (e.g. the letters sent by the Trust Development Authority (TDA) and Monitor to trusts in August 2015 regarding further cuts) and of how those pressures were perceived. Doctors might see such policy developments as indicative that 'management' were not so aligned with doctors, but that might be different from blaming individual local managers. One interviewee added that medical managers in particular would be aware of the content of these policy letters and would be likely to have a large degree of sympathy with their managerial colleagues. It was suggested therefore that survey respondents might be commenting that a divide was being created between 'management' and clinical staff at national level but that their own local relationships were positive.

General managers: serving two masters?

Managers were perceived by medical manager participants as having to serve two masters, whose requirements were often conflicting. This made the challenge for non-medical managers much harder: they had to deliver the internal clinical strategy (on which they were often aligned with clinicians) and at the same time answer to the external political agenda set by the Department of Health and regulatory bodies – an agenda that was often seen as being at odds with the internal clinical strategy. One medical manager observed that despite the official rhetoric about quality improvement and about the process of external inspection and regulation being one of supporting organisations and encouraging development, the style of the external management in practice seldom appeared to be developmental, constructive or even logical.

One non-medical manager in the focus group expressed the view that she saw the role of non-medical managers as essentially a servant role: *"As a manager I see my role as being to support delivery of our clinical services – we're effectively servants in this."* None of the other members of the group challenged this label, although one of the medical managers in the group augmented it:

> You're teachers as well – a lot of teaching goes on from managers to medics because none of us have had as much training [in management] as you've had.

However, although she saw her role as one of servant, this did not mean that she saw the power as being vested in clinicians. She reflected on whether the NHS really wanted clinical leadership or whether what policy-makers really wanted was agents to deliver organisational goals:

> We say we want to be clinically-led but we don't actually give real power to clinicians. Actually what we're looking for is clinicians to be moulded into the shape of managers to deliver the organisation's goals.

Recognition of additional challenges for non-medical managers

Several interviewees (both medical and non-medical managers) expressed concern about the challenges of the role that general managers held. One general manager commented on the steep learning curve that junior managers (especially those who had not been on the NHS national management training scheme) now faced, with fewer opportunities for training and support compared to her own experience as a junior manager several years earlier.

One medical manager commented that non-medical managers typically had additional job stress and lower job satisfaction than medical managers did and that they appeared to work in a more hierarchical framework on the management side than doctors: managers had to *"jump to the tune of the next one up"*. Non-medical managers also faced additional constraints: nurse managers were usually required to give up clinical duties in order to enter management, whereas many medical managers continued to perform clinical duties and indeed had the option to return to full-time clinical work later if they wished to do so. Another medical manager observed:

> Good general managers are really undervalued. They work very hard, are relatively poorly paid. People are often very unpleasant to them – especially doctors can be really rude. Until you get involved with management you don't realise how hard they work – it's a very stressful job...Often I'll find myself supporting a general manager or a service manager and saying to doctors 'have you any idea how difficult this is?'

Participants recognised that an additional pressure on non-medical managers was that they were required to move organisations frequently to avoid being seen as having a limited perspective and limited experience whereas doctors were allowed to be less geographically mobile, particularly once they had moved out of training roles. Medical manager interviewees expressed frustration at the high turnover of non-medical managers that resulted from this expectation. It took time to build up trust and confidence between medical and non-medical managers through working together and some medical managers became reluctant to put this effort in with one individual who might then leave: *"If you invest in them and then they move on because they've got their career to follow, then you think, 'Well, I'm not going to do that again.'"* The implication seemed to be that mutual trust and organisational knowledge were invested solely

in the short-term relationship between two individuals in that organisation at that time and that no ongoing benefit would be gained by the medical manager's service, organisation or future relationships with non-medical managers – or by the next NHS organisation to which the manager moved.

Theme 3: The status of medical management among doctors

Interviewees had differing views about whether the status of medical management was changing or not. Some interviewees considered that medical management was still an unpopular option for many doctors: they saw it as a role that brought reduced status, additional stress and limited power to influence and improve services compared to being a clinician. Many doctors still saw medical management as a temporary option, from which the individual then returned to the clinical 'fold', rather than seeing it as a proper career choice with appropriate rewards. Several medical manager interviewees referred to general managers during the interview as 'the professional managers': this may suggest an important distinction in how medical and non-medical managers are perceived. It may suggest, for example, that medical managers are seen as retaining their primary medical identity rather than adopting a professional managerial one. Interviewees considered that many doctors still had a tendency to blame 'managers' and to perceive managers as a group comprised of non-medical managers alone. Doctors were often slow to acknowledge that their own manager (e.g. the clinical director) was a doctor. If doctors did not like the medical director, then that individual would be 'lumped in' with the managerial group.

Increasing status for medical directors and some chief executives

However, other interviewees countered these perceptions and believed that although medical management had historically been seen as unattractive for doctors, this perception was now changing. One commented that they had had no difficulty in filling medical manager posts in the past two decades and that the regional development programme for medical managers was oversubscribed. Interviewees considered that the creation of the Faculty of Medical Leadership and Management had been a positive development, although it was suggested that so far it had had greater influence at junior doctor level than at senior doctor level.

Some interviewees believed that the changing perceptions had partly been influenced by the growth of an 'elite' group of knighted NHS CEOs who were seen as 'influential hard-hitters' with successful large organisations and considerable influence with policy-makers. Interviewees commented that the role of medical director now seemed to be acquiring greater status: some doctors were now willing to move trusts in order to take up a medical director post and more doctors were considering a chief executive role. Interviewees perceived that the medical director role was changing: previously it had been seen as a token role on the board and one focused on dealing with difficult doctors and with clinical governance; it was now seen much more as a parallel role to the chief executive. It was noted that some medical directors now had 'deputy chief executive' job titles and that it was often the medical director who acted up in the role of chief executive when that post was temporarily unfilled.

However, interviewees acknowledged that many doctors continued to believe that those who chose to take on a medical director or chief executive role were either brave or foolhardy: these roles were seen as risky in that they were high profile and often of short duration but with the additional disadvantages of attracting less money, reducing

the opportunity of gaining a clinical excellence award, and attracting less respect from peers and the public.

Interviewees considered that individual hospitals could work hard to create a positive and motivating culture to encourage doctors to take up management roles but that they could not do this independently of the national NHS culture or of contractual and financial disincentives.

Clinical directors: continuing challenges with the role

Interviewees discussed changes in the role of clinical directors. Interviewees commented that in the past the role of clinical director had been seen as a 'Buggins' turn' role: a rotating role that fell on the most senior member of the department who might or might not have had the skills needed to perform the role or indeed the desire to do so. This was thought to have contributed to difficult relationships between clinical directors and their managerial equivalents in the past. Although there remained hospitals where this was the usual practice, in some hospitals the role of clinical director was now seen as a specific choice for doctors who wanted to take on management responsibilities and they were given support and training to enable them to meet specific objectives. Interviewees emphasised that this was not universal: some hospitals had much better developed career development schemes and support structures for clinical directors than others. There was no national framework for clinical director posts and appointment to these posts was not always through open competition. Indeed in some hospitals, doctors continued to expect that it would be the most senior individual who would automatically get the post of clinical director, and there was some consternation at the idea of strengths-based recruitment processes.

In those hospitals in which clinical director posts lacked an adequate support structure, interviewees perceived that clinical directors could feel that they had a considerable burden of responsibility but without power: individuals were appointed to the role but not given detailed objectives or the support and training to enable them to meet them. The tendency was to expect individuals to learn by the traditional medical model of being seconded and getting on with it: *"He says sensible things at meetings, we'll make him clinical director".*

Thus, these doctors in clinical director or divisional director posts had to give up some clinical time (which could be considerable in the case of divisional directors) and therefore reduced their chances of gaining a clinical excellence award later – yet there was often little mentoring, monitoring or career progression for these posts. Instead of doctors seeing medical management as an integral part of their role and one that they could commit to, it was often seen as an unrewarding 'add-on'. Medical managers were often not taught key management skills like how to manage performance in other doctors. This led to gaps and omissions in what clinical directors did in that role; this contributed to frustration on the part of the individuals holding those posts, and for the non-medical managers with whom they worked. The medical peers of individual clinical directors often did not respect the clinical director and had a limited understanding of the role. Indeed, one interviewee commented that the role of clinical directors had regressed in the local hospital to a post whose main role was to be the medical 'voice of veto', while managers took all the blame for failure to implement service changes. This hospital had therefore introduced the post of medical divisional director, each having a manager who reported to the divisional director.

Improving services as a key motivator for medical managers

Interviewees suggested that a significant disincentive to doctors becoming or remaining managers was that it was difficult to gain a sense of achievement in making service improvements happen: the complexity of service change worked against easy or quick 'wins'. That made management potentially a much more frustrating role than that of providing patient care and medical managers (unlike managers) usually had an 'exit clause' of being able to return to full-time clinical work. The survival tactic that many doctors adopted was to focus on their clinical role and on doing their best for the patient in front of them:

> They're thinking 'I have two years general training and five years specialty training and I'm going to see a patient and make them feel better and I'm going to feel so much better about it. The other bit – there are other people higher up the food chain who have 'swallowed the pill' or 'gone over to the dark side' who can lose sleep over that stuff – I'll just do my bit'.
> *(Medical manager, focus group)*

One interviewee, a medical director, commented that *"Every potential clinical leader I've seen asks 'Will I genuinely be able to make change in my service – financially and clinically?'"*. This suggested that this issue was a significant motivator for many potential clinical managers and potentially a source of frustration and of conflict with general managers.

One interviewee described how the local trust managers and medical managers had to address the issue of a cadre of 'injured' former medical managers who had been appointed to leadership positions and asked to 'sort out' complex organisational challenges without the right support and coaching. These individuals had then 'retired hurt' from those management roles and reverted to full-time clinical work. It was harder to develop effective doctor–manager relationships against the background of this organisational history.

Theme 4: The impact of the external context on doctor–manager relationships

Participants identified a number of factors in the wider political and financial context that had a strong influence on doctor–manager relationships.

Tensions between financial and quality of care targets

Participants noted that almost all survey respondents had agreed that the tension between improving quality of care and managing costs was increasing. Interviewees commented that some trusts were under such pressure to meet the demands of regulatory bodies that it would be difficult to sustain any relationships and that poor relationships between doctors and managers would be only one consequence of this. The impact on the relationships between doctors and managers of the implementation by managers of central policy varied. Managers were not always blamed for the content of national policy, although they might be blamed if they were perceived not to have stood up strongly enough to pressure from the Department of Health and regulators: *'This is mad – you should say it's mad.'* Some participants suggested that increasing

external pressure could exacerbate existing difficulties in troubled organisations, whereas in stronger organisations, doctors and managers might be brought closer together by the challenge of surviving and 'doing the right thing' despite the external pressures.

Some interviewees suggested that the NHS was not currently working as a system: that the system was fundamentally broken, and 'a mess', with a lack of medical and political leadership and little certainty about what was needed to fix the system. One interviewee commented that that they would therefore have expected the views expressed in the survey to be significantly more negative. Medical managers felt frustrated because the instability in the system made it harder to get a grip on financial management and on quality issues. Many wanted greater autonomy at divisional level and yet some trusts were increasing board control over trust processes because the financial penalties for failing to deliver on external targets were so great.

External regulation

Interviewees commented that the external regulatory context affected the doctor–manager relationship in a range of ways. Responding to the requirements of external monitoring bodies took time from other service improvement initiatives and from providing clinical care and it could be divisive in the assessments reached. The burden of data collection for external monitoring was resented by many and the data that were collected were often perceived as not relevant to scrutiny of genuine problems. Thus, the process of external regulation was seen as both intrusive and irrelevant and was perceived to detract from the shared goals of improving services. In addition, the external regulatory system was criticised for being too broad-brush: a whole organisation might be branded as 'inadequate' and yet few people working in the organisation believed or respected that assessment. Doctors would recognise that there were areas of inconsistent or lower standards but did not believe that these merited a 'whole organisation' label.

Interviewees also commented that the rhetoric about the regulatory system was at odds with how it operated in practice. The rhetoric spoke of the need for collaborative working as a system and yet the regulatory system itself was deemed to be incoherent and fragmented. Furthermore, the regulatory bodies did not take a systems approach to monitoring or regulating but only considered aspects or components in isolation. Interviewees perceived a gap between the developmental and quality improvement approach that the Care Quality Commission (CQC) leaders espoused and the manner in which many CQC inspections were carried out in practice: at times the approach seemed to be one of 'catching people out' and 'making sure that people aren't hiding things'. Interviewees noted that the regulatory system was sometimes used tactically by trusts or by individual managers to justify a course of action ('I don't want to do this but I have to for regulatory reasons') and that such tactical alignment with regulatory bodies could cause additional resentment between doctors and managers.

Lack of unified medical leadership bodies

Interviewees commented on the issue of whether the lack of one medical leadership body contributed to the difficulties in doctor–manager relationships. Interviewees (both medical and non-medical managers) commented that some doctors used the different bodies tactically when this was helpful to advance their cause (e.g. *"The Royal College/the deanery says I shouldn't have to")*. One medical manager described having to go through these objections one by one with the doctors that she managed in order

to discuss what the relevant rulings actually said. Some medical manager interviewees commented that the increasing power and influence of specialty associations had fragmented the medical profession further and given a focus to resistance to some initiatives. For example, one of the challenges encountered in the Future Hospital Commission[2] had been resistance from some specialists to the idea of working as generalists:

> You can forget this – we're not generalists, we're specialists – we've spent the last ten years improving [name of specialty], you're not going to railroad this through. *(Medical manager, interview)*

One non-medical manager argued that it was too easy for managers to blame medical bodies:

> I think that [blaming the GMC, the Royal Colleges etc for constraints on what managers can do] is an excuse – it's easy to hide behind that. We and other organisations manage to work around that – the contractual and regulatory constraints – and largely do what we want to do. There's usually a way of getting to where you need to be...The system doesn't like centrally driven changes so even if those bodies got together, people wouldn't like it.

However, another non-medical manager argued that medical bodies like the GMC and the BMA could do more to support trusts and to provide strong medical leadership to encourage doctors to take up new ways of working. For example, the GMC could impose restrictions on the length of locum working (and hence encourage the take up of substantive posts); greater endorsement by the GMC of reports into new ways of working from organisations like The King's Fund would make it harder for doctors to resist these changes.

The impact of external reports

There were mixed views from interviewees about the survey headline finding that put the Francis reports (2010 and 2013), the Berwick review into patient safety (2013) and the Keogh mortality review (2013) as the three most positive external factors that had had an impact on doctor–manager relationships. Many thought that these reports had had either little impact or a negative impact. For example, one participant pointed to the fact that the Keogh review had led to the departures of nursing and medical directors from many trusts and suggested that this had been unhelpful to doctor–manager relationships. Some interviewees thought that the reports had had a positive impact in raising the profile of the importance of adequate staffing levels and their impact on safety but that they had not necessarily had an impact on doctor–manager relationships as such. One argued that the earlier Darzi (Department of Health, 2008) report had been more influential than these later reports in shifting the focus from

2 https://www.rcplondon.ac.uk/projects/outputs/future-hospital-commission

financial management to quality of care. Several commented that the large number of recommendations (290) contained in the Francis report had led many to perceive the report as 'ridiculous' and impractical and had undermined its potential impact. One interviewee commented that in the past doctors may have seen reports like this as a way to 'bash' managers (e.g. 'now we will get a management that prioritises quality') but considered that this response was now unlikely as quality had now been on the agenda for a long time.

Theme 5: Public esteem of doctors and managers

No interviewees expressed surprise regarding the survey finding about the lack of respect for NHS managers from the public compared to high levels of respect for doctors. All interviewees appeared very aware of this phenomenon and of the poor press that the media gave to NHS managers. One commented that there had been little shift in the overall public respect for the medical profession in the three decades since he had qualified as a doctor, although another interviewee suggested that the cuts in the UK economy might reduce the support for doctors from the wider public, even if not from current patients. Interviewees noted that this lack of respect for NHS managers was at odds with the increasing tendency for them to have higher degrees in management and with the fact that the NHS graduate management training scheme was highly competitive.

Interviewees who had dual roles commented on how they perceived that they were given a different reception by members of the public and from the media depending on whether they described themselves as a doctor or a nurse or as an NHS chief executive. Some described anecdotes in which NHS manager colleagues used alternative job titles at social events because they did not want to state that they were an NHS manager. Interviewees commented on how 'name and shame' departures of senior managers (e.g. chief executives or medical directors) helped to discourage clinicians and non-clinicians from aspiring to senior posts.

Tabloid scrutiny was one of the factors perceived to deter junior managers from taking a senior management post: *"Why would I want to put my family through that?"*. Several interviewees commented on the public perception that NHS managers were always seen as non-clinicians: medical managers (like medical directors) were not seen by the media and the public as managers but as doctors. Interviewees perceived that trusts often made use of this differential reception when responding to press coverage of adverse events: it was more common for trusts to put forward the medical director or director of nursing than a non-clinical manager as the trust's spokesperson. There appeared to be greater readiness on the part of the public to accept that an error could not have been avoided if it was described by a doctor, whereas if a manager was describing the event they were assumed to be 'covering something up'.

In the same way that medical managers were perceived as invisible to the press and public, it was suggested that regulatory bodies like the CQC contributed to the negative press that NHS managers received: when reporting on an organisation that had received poor inspection ratings the standard terminology was to say that the organisation was 'badly led'. This appeared to blame managers for organisational failings. System failures were therefore seen as the fault of 'managers' even though doctors and other clinicians may have contributed to disrupting the system, either in clinical roles or as clinical leaders.

Medical manager interviewees suggested that the medical profession was partly responsible for the poor press that managers received: the medical profession had fostered this negative view of managers over several decades and the press *"just keeps churning it out"*. One interviewee described concerns that colleagues had expressed that the government was 'feeding' the media this negative narrative about NHS managers as a way of deflecting public criticism of NHS policy away from the government itself.

Theme 6: Local initiatives to support doctor–manager relationships

Participants discussed the survey findings about local initiatives to support doctor–manager relationships. One interviewee expressed surprise that only 41% of respondents had joint training for doctors and managers locally, while another interviewee commented that the figure of 14% for buddying and mentoring arrangements between doctors and managers seemed low. The interviewees commented that survey respondents may have been thinking of formal arrangements only. Conversely, several interviewees considered that the figures for paired learning (22%) and for management training for doctors (65%) were higher than they would have expected; they wondered to what extent there was respondent bias in that survey recipients working in organisations that engaged clinicians well might have been more likely to have completed the survey. One interviewee suggested that the actual figure for management training for doctors ought to be considerably higher still, since it was important for all doctors to have some training in management.

Theme 7: The trajectory in doctor–manager relationships since the 2002 survey

Participants commented on several factors that they thought had had an impact on doctor–manager relationships since the earlier survey carried out in 2002.

Changes in junior doctors' training

Changes in junior doctors' training since the previous survey were considered to have been mixed in terms of the potential impact on doctor–manager relationships. On the one hand, younger doctors had more exposure to training about management and leadership skills throughout their training – although some interviewees believed this was still not sufficient and that undergraduate medical training required greater exposure to management training – and so were more likely to possess a grounding in these skills compared to those who had qualified earlier. However, several medical managers expressed the view that the clinical training that junior doctors now received (under changes to working hours and educational requirements) was not as thorough and as extensive as it had been in the past. This meant that newly appointed consultants had less clinical experience than their predecessors and, therefore, many found the early years of being a consultant stressful as they tried to consolidate their clinical skills and experience. Those who might have felt able to consider clinical management positions in the past were likely, when under pressure, to fall back on developing their clinical skills rather than seeking to extend their management skills.

Changes in the social contract for consultants

Another development observed by interviewees was changes in the 'social contract' for consultants: one interviewee suggested that the majority of consultants in secondary care now saw themselves as being employed to provide a service to that trust, rather than being hosted by the organisation. It was thought that this was more likely to make

them identify with the organisation and to engage with the organisation to provide the best possible service to patients. However, non-medical managers commented that consultants still held considerable power compared to managers (particularly in hospitals that had problems recruiting consultants) and that some expected to be treated differently from other staff groups in ways that impeded smooth working (e.g. in relation to carry-over of leave): *"They don't see themselves as working for the hospital, but in the hospital"*.

Growing emphasis on quality and safety

Interviewees commented that the growing emphasis on patient safety in the past decade had been useful in engaging clinicians with managers and that there was now a greater emphasis on the need to improve systems rather than isolated aspects of quality and safety. However, drives to reduce costs at the same time had 'muddied the waters', had led to considerable cynicism about the motivation behind the initiatives and had made it harder to introduce system improvements.

The emphasis on clinical leadership

Another policy development discussed was the growing emphasis on the term clinical leadership. One medical manager suggested that the adoption of this term by policy-makers had been unhelpful: the term could be interpreted as placing the emphasis on the clinical aspects and on leading other clinicians. That risked the majority of consultants concluding that they were already performing that role and indeed that representing other clinicians was a key component of that role. Instead this medical manager perceived that what had been intended by the term 'clinical leadership' had been the different concept of clinical engagement in management and in how the system functioned. The leadership intended had not been leadership of other clinicians (with the risk of taking on that perspective alone or of fighting the corner for a particular specialty) but leadership of the service in the broadest sense. In similar vein, one interviewee commented that the 'modernisation' agenda had given insufficient thought to what leadership would look like as part of that long-term vision.

New organisational structures

Interviewees commented on how newer organisational structures that had been introduced in the past decade had affected doctor–manager relationships. One interviewee described how service line management had been introduced in their hospital: it had taken considerable effort to change to this new way of working and to shift some responsibility from the board to the service line, but increasingly the team working between service manager, matron and clinical director was becoming tighter and more effective. The early leadership development programme had seen a lot of 'them and us' rhetoric between doctors and managers, but this was starting to shift.

The impact of new communication technologies and social media on doctor–manager relationships

Interviewees considered that changes in communication technology since 2002 had made sharing of information better (e.g. one medical manager welcomed the fact that NHS England provided regular email updates), but had also brought disadvantages. The pace of decision-making appeared to be faster, with corresponding reductions in the quality of decision-making. There was also the risk of conducting protracted discussions online. In some circumstances this could lead to misunderstandings between doctors and managers and could delay resolution of problems compared to face-to-face discussions.

Some managers commented on the positive impact that they perceived that social media had had on their own work: for example, they were able to network more easily with managers outside their own organisation. Most interviewees did not think that social media had had a major impact on the doctor–manager relationship; in part this was thought to be because of a cohort effect in that many of the social media 'enthusiasts' were younger doctors.

Some interviewees did think that social media had had an impact on doctor–manager relationships because of the influence on doctors' contract negotiations of a highly vocal minority active on social media. Others observed that the 'silencing' of some voices on social media could be obscuring the views of some doctors who were not wholly opposed to aspects of government policy.

Recent developments

Several interviewees wanted to emphasise that they considered that the last year had seen an increase in the external challenges that had an impact on relationships between doctors and managers. Many commented that it was hard enough to establish mature relationships between doctors and managers in times of organisational stability but that now the increasing regulatory and financial pressures and rising expectations of clinical care were making it significantly more difficult. Some interviewees suggested that 2015 had been a particularly difficult financial year and that the second half of the year since the general election in May 2015 had seen a step-change in the external pressures on trusts. Recent comments from the Secretary of State for Health on junior doctors' and consultants' contracts and patterns of working were thought to be damaging doctor–manager relationships.

Participants also emphasised that CEOs in England were facing conflicting objectives: chief executives were expected to answer to NHS England on quality and safety issues while also answering to Monitor and the TDA on financial targets. Although there were differing views among participants about the extent to which such pressures were 'contained' largely at board level, many thought that these messages 'pressed down' from the board and affected managers and health professionals at other levels of the organisation. At board level, some interviewees saw signs of clinical involvement in the recent 'pushback' from some trusts against central policy directives in the six months since the May 2015 general election. Interviewees considered that this resistance had been louder and more coherent than had been the case previously; participants suggested that this was indicative of a greater cohesion between non-clinical managers and medical managers in opposing central government policy than previously.

4. Discussion

In this section, we return to the list of questions we set out at the start of the report and consider what the study findings show in relation to each of these.

How do managers and doctors rate the quality of doctor–manager relationships locally?

A striking finding here was that, across the whole group, over half of survey respondents (60%) gave a positive rating to local doctor–manager relationships. However, chief executives were more optimistic about the state of doctor–manager relationships and clinical directors the least, both in terms of the current state and also in terms of perceptions of whether the relationships were likely to improve or deteriorate over the coming year. Many interview and focus group participants emphasised that local relationships were highly variable (between different trusts and within different hospitals and departments in the same trust) and that perceptions of local relationships were not necessarily indicative of overall perceptions at the broader level. In other words, individual doctors and managers often got on well with each other at departmental level while holding more oppositional views about other tiers of medical or non-medical management or about the overall policy direction set by the Department of Health and its counterparts in the devolved countries.

How satisfied are managers and doctors with the time, resources and energy devoted to nurturing effective doctor–manager relationships locally?

Research in health settings (see for example Degeling and Maxwell, 2004; Bartunek, 2011; Kaissi, 2014; Kreindler and others, 2014) suggests that the creation and effective maintenance of effective working relationships between diverse groups in complex organisations like health services are likely to benefit from specific attention, effort and resources, including dedicated time to foster communication and collaboration, to develop systems and processes that function well for multiple groups and to develop shared 'meanings' and objectives. One respondent objected to our separating out the nurture of doctor–manager relationships as a specific activity and suggested that this should instead be integral to daily working life:

> "I struggle with the concept that time and resource should be committed to specifically 'nurture' relationships. Surely these are key to everything we do? *(Chief executive)*

However, many respondents (at least a quarter in each role group) agreed that insufficient time and resources were devoted to this important goal and many noted that the onus was on individuals to make the effort. This points to a disturbing gap in current arrangements: if organisations are relying largely on individuals to make this fundamental relationship work, then it seems likely that in hard-pressed

organisations (in which the need for such relationship-building may be even greater), there will be little spare capacity, and perhaps few incentives, for individuals to make up this shortfall.

What is the extent of agreement between the four role groups on specific aspects of the doctor–manager relationship?

There was considerable homogeneity across the four role groups (i.e. chief executives, medical directors, directorate managers and clinical directors) in their perceptions about aspects of the external context. There was also widespread agreement across the four role groups:

- on the high quality of medical staff
- on the shared focus of managers and doctors on patient need
- that managers allow doctors sufficient autonomy to practise medicine efficiently.

Despite these areas of widespread agreement on shared goals and on the continuing autonomy of doctors, there were many other responses that suggested widespread concerns about aspects of the doctor–manager relationship. These pointed to concerns about:

- the balance of power and influence between management and medical staff
- a lack of confidence on the part of managers and doctors in the leadership capabilities of the 'other' group
- poor communication between the two groups around decision-making and service development.

These point to significant ongoing challenges in the working relationships between doctors and managers.

What was particularly striking was that the perceptions of clinical directors were significantly more negative than those of directorate managers, medical directors and chief executives. The gulf between the perceptions of chief executives and clinical directors was particularly stark, with chief executives consistently holding views that suggested that, in the main, doctor–manager relationships were working well, with doctors and managers in agreement on overall goals, respectful of each other's expertise and communicating effectively supported by clinical performance data. In contrast, the equivalent snapshot across the clinical director data was suggestive of a much more troubled relationship characterised by poor communication on both sides, insufficient resources, a lack of understanding of respective roles, a lack of trust and confidence in the other group and concerns about respective power and influence.

It is possible to interpret these differences as suggestive of differing perspectives at board level from those at departmental or directorate level: what might be described as the more 'global' view of an individual with oversight and responsibility for the whole organisation as opposed to the perspective of those at the front line or 'sharp end'. It is possible that a degree of 'social desirability' bias (Bowling, 1997) may be operating here – that is, that chief executives were keen to portray their organisation in a positive light (despite the guaranteed anonymity of all reported study data) or that they were used to providing a 'positive narrative', whereas in contrast clinical directors may have felt that they had nothing to lose in 'telling it like it is'. The board/directorate level

split is not consistent, however: on many questions, chief executives were significantly more positive about the doctor–manager relationship than their medical peers at board level (i.e. medical directors) were. For example, while 81% of chief executives thought that doctors have sufficient influence on hospital management, only 63% of medical directors did. It therefore appears that this difference in perceptions is explained to some extent by a non-medical and medical manager divide, with particularly dramatic differences in perception between chief executives and clinical directors.

These findings about clinical directors from the survey were borne out by comments made in the interviews: interviewees described how in some hospitals there was now a defined structure and training and support for clinical director posts, but emphasised that this was not universal and that in many hospitals the clinical director role continued to be seen as a frustrating 'Buggins' turn' role of 'responsibility without power'. Earlier research (see, for example, Forbes and Hallier, 2006) has also identified that this group struggles with the challenges of feeling excluded from both management decision-making processes and from their own clinical peer group.

What do managers and doctors perceive as the main barriers to more effective doctor–manager relationships?

Across all four role groups, the time demands on doctors were perceived as the greatest barrier to more effective doctor–manager relationships, followed by the turbulent policy context and insufficient resources. We added a new barrier, 'time demands on managers', to the list in the 2015 survey and this was the next most significant barrier identified by respondents. Perhaps unsurprisingly, directorate managers were significantly more likely than clinical directors to identify this as a barrier. It is interesting that although 60% of respondents overall chose 'time demands on doctors', a much lower proportion, only 36% of respondents overall, chose 'time demands on managers'. This may suggest that respondents regarded clinical roles as significantly more subject to time pressure than management roles, a perception that may be at odds with the 'extreme jobs' in which many NHS managers work (Buchanan and others, 2013). It may also suggest that hands-on clinical work is perceived as (or thought to be perceived as) higher priority than the management activities that underpin the provision of those clinical services.

What changes in perceptions can be seen compared to the earlier survey carried out in 2002?

A decade is a long time in the NHS. Interviewees gave a strong sense that the years since the 2010 election had seen a marked increase in organisational turmoil and financial stringency and that these had had a negative impact on doctor–manager relationships. They also noted several factors that they thought had had an impact on doctor–manager relationships in both positive and negative ways since the earlier survey:

- changes in the junior doctors' contract
- changes in the 'social contract' for consultants
- the growing emphasis on quality and safety
- the emphasis on clinical leadership
- new organisational structures and new communication technologies (including social media).

Despite this turbulent background, we noted that although the results from the survey on the overall perceptions of local doctor–manager relationships broadly reflected those of 2002, with chief executives the most positive overall and clinical directors the least positive, the proportion of directorate managers and clinical directors (the groups that were least positive in 2002) who gave a positive rating for local doctor–manager relationships had increased significantly from 2002.

This suggests that there may be an overall trend of improving local relationships. However, a disturbing change from 2002 is that there has been a large increase across all groups in the percentages of respondents who consider that doctor–manager relationships are likely to deteriorate in the coming year. This suggests that these core relationships are extremely vulnerable – and vulnerable in the short term – to changes in the external context as it impacts on individual hospitals. As survey respondents and interviewees observed, the existing financial and workload pressures were already sufficient to undermine relationships that were under strain and made it difficult to find the 'head-room' to tackle problems with service delivery and with routine processes; further financial and workload pressures could only exacerbate the problems.

Another worrying trend is the deterioration in the perceptions of many clinical directors about the doctor–manager relationship. Of all four role groups, clinical directors had the least positive views of the doctor-manager relationship both in 2002 and in 2015. Furthermore, we observed that the views of clinical directors on many of the specific aspects of the doctor–manager relationship (e.g. the quality of management staff and the tendency of managers to exert pressure to discharge or transfer patients early) had become significantly more negative by 2015 compared to 2002.

Perceptions of the main barriers to effective doctor–manager relationships were largely unchanged from 2002: across all four role groups the top three barriers in both surveys were time demands on doctors, the turbulent policy context and associated structural changes and insufficient resources. However, more respondents in 2015 identified lack of trust between management and medical staff as an important barrier. This is a disturbing trend, particularly as among those indicating this were chief executives: the group who tended in 2002 and 2015 to hold the most optimistic views about the doctor–manager relationship.

What external factors do managers and doctors perceive as having had the most positive and most negative impact in the last five years?

Out of a list of factors, respondents singled out three high-profile reports (the Francis reports of 2010 and 2013, the Berwick review into patient safety (2013) and the Keogh mortality review of 2013) as having had the most positive impact on doctor–manager relationships in the last five years. There were some differences between the role groups, with, for example, chief executives less likely than other role groups to say that the Francis reports had had a positive impact. Combined with comments made in the survey and in interviews, it appears that these reports were thought to be helpful in terms of doctor–manager relationships because they had helped to raise the profile of the quality and safety of care (on which clinicians and managers shared a common focus) and to 'legitimise' a managerial focus on these aspects alongside the achievement of financial targets. As such, the reports were considered to have provided a 'common agenda' that both managers and doctors could support. However, some interviewees were sceptical about the impact of high-level reports and several suggested that the large number of recommendations in the 2013 Francis report had undermined its credibility and impact.

The external factors perceived to have had the most negative impact on doctor–manager relationships in the last five years were financial pressures, changes in the role of external monitoring bodies like Monitor and the CQC, and the Health and Social Care Act (2012). Of these three, the role of Monitor and the CQC attracted considerable additional comment from survey and interview participants. Many felt that the burden of data for external reporting was disproportionate and that the external regulatory and performance management system as a whole was intrusive, divisive and a distraction from genuine service improvement. Some suggested that the problems were exacerbated by a significant gap between the official rhetoric about the developmental role of such scrutiny and the reality of inspections on the ground which many experienced as fault-finding and lacking in mutual trust.

A striking finding was that after the top three negative factors, the next most negative factor was social media (with over a quarter of all respondents identifying this as a negative factor). From comments made in the interviews it appeared that the negative impact of social media was perhaps felt more at the national level than at the individual trust level. Participants pointed to the uses that had been made of social media in spreading information and enlisting support in contract negotiations and political campaigns, and some expressed concern that social media could prove a divisive mode of communication with dominant voices prevailing and 'silencing' dissenting views.

We were interested to note that the establishment of the Faculty of Medical Leadership and Management in 2011 was not perceived as one of the major positive factors in improving the doctor–manager relationship. It is feasible that the Faculty's creation might have helped to raise the profile or even the status of medical management among doctors and that its support for training in management skills for doctors might have been perceived as having a positive impact on relationships between doctors and managers. It may be, as some participants suggested, that it is yet too soon for the Faculty to have had a major impact or that it is most well-known among junior doctors, who were not participating in this study.

Which initiatives aimed at improving doctor–manager relationships are available in respondents' hospitals?

A range of new initiatives have emerged in the past decade or so aimed at enhancing effective working between doctors and managers through diverse ways, whether through enhancing doctors' management skills, encouraging joint working on service improvement projects or facilitating joint discussion or joint training events (Spurgeon and others, 2011). We found that although survey respondents indicated that management training for doctors was fairly widespread and collaboration between individual doctors and managers was a feature of most organisations, other initiatives like paired learning or 'buddying' or mentoring arrangements between managers and doctors were relatively rare.

As with the other findings from the survey, we found that chief executives were consistently more likely to state a positive view: in this case, that the initiatives to improve doctor–manager relationships listed in the survey were available in their hospital. One possibility is that this indicates that chief executives (with the advantage of a board-level perspective) had a more comprehensive overview of what was available locally than other role groups did.

Alternatively, it could be another example of the tendency of chief executives in the survey to lean towards a more positive narrative. The latter possibility is suggested by the fact that the perceptions about what was available locally differed between chief executives and medical directors, suggesting that this was not a simple case of greater awareness at board level.

There is some emerging evidence (see, for example, Atkinson and others, 2011; Greener and others, 2011; Spurgeon and others, 2011) that such initiatives can help to forge greater understanding between doctors and managers and to encourage collaboration around organisational issues. It may be that the benefits of such initiatives need to be more widely known and that additional resources and support would help to spread these approaches from hospitals that have found them useful to more organisations.

What the study does not tell us

The potential for non-respondent bias is a feature of all studies: are those who take part in the study typical or atypical and in what ways? Were survey respondents more likely to be drawn from the ranks of the enthusiastic or conversely from the ranks of the disengaged and disaffected? The response rate at board level was a healthy 34% for chief executives and 41% for medical directors, suggesting that non-response bias is unlikely to be a significant issue for these groups. The picture among directorate managers (13% response rate) and clinical directors (9% response rate) is more uncertain, although the fact that we used two methods to reach survey recipients (an online survey and a postal survey) should have dealt with any issues that might arise from using either method in isolation. Over three quarters of survey respondents had a clinical qualification (60% in medicine and around 20% in nursing, midwifery and other clinical professions). This is in line with the fact that the majority of NHS staff with management responsibilities have a clinical qualification (Nuffield Trust, 2015) and so this element is unlikely to have introduced an undue clinician-perspective bias. It is possible that there may be differences between the four countries of the UK, arising from their different policy contexts, but the majority of survey respondents worked in England and so it was not possible for us to assess this.

Focus group participants came from one London trust. Interviewees were drawn from a range of trusts but were all involved themselves at national level with the Nuffield Trust or with the British Medical Association Committee for medical managers or were contacts of those individuals. This may have given those participants particular perspectives on the doctor–manager relationship. Nevertheless, the main role of interviewees and focus group members in the study was to provide additional insights to aid interpretation of the headline findings from the survey and therefore these broader perspectives were particularly valuable.

Finally, in exploring any phenomenon, there is always a trade-off to be made between breadth and depth. We have sought to explore broad overall perceptions of the doctor–manager relationship at board and middle-management level at one point in time and to compare these with a similar survey conducted around a decade before. We have complemented these findings with more detailed discussions. Studies with other groups (e.g. doctors in training) of perceptions of the doctor–manager relationship would yield further insights.

Improving doctor–manager relationships

The study provides a rich picture of perceptions among medical managers and non-medical managers at board and directorate level about the challenges (and sometimes the rewards) of their working relationships. It is clear that although the description in the Francis report of a 'gulf' between managers and doctors may be too broad a description to reflect the more nuanced reality within individual trusts and departments, there are nevertheless many areas that need to be addressed to ensure that doctors and managers are able to work together effectively, and in ways that acknowledge and value their respective roles and skills. The broad progress that has been made (as evidenced by the increased proportion of participants reporting positive relationships at local level in the 2015 survey compared to the 2002 survey) is also under significant threat from the severely challenging economic and political context, with large numbers of participants concerned that these relationships are likely to deteriorate in the next 12 months. It is clear that it is widely perceived that the current financial and political context (for all its potential benefits in bringing the parties together in a time of 'adversity') is detrimental to effective working and to developing and nurturing sound relationships for the medium and long term.

In this final section we highlight some areas that our data would suggest require urgent attention from policy-makers and from the bodies that represent managers and doctors.

Firstly, although there has been some improvement in overall positive scores of local doctor–manager relationships compared to 2002, a growing proportion of respondents from all four role groups (including the largely optimistic chief executives) believe that these relationships are likely to deteriorate over the coming year. This suggests that these already challenging relationships are extremely vulnerable to further changes in the external political and financial context as they impact on individual organisations. The evidence that a degree of organisational stability and a sustained period of appropriate resourcing without radical policy change is essential if complex health care systems are to deliver high-quality cost-effective and safe services has been aggregating for some decades (see, for example, Smith and others, 2001; Institute for Healthcare Improvement, 2008; Edwards, 2010; Walshe, 2010) and yet policy-makers at government level seem unable or unwilling to heed this evidence.

Four years on from the Health and Social Care Act it is clear that the appetite for subjecting the health service to repeated and often-conflicting challenges has not diminished. The recent volte-face by national NHS bodies in England and the belated embrace of collaboration over competition (Alderwick and Ham, 2016), while welcome in some respects, seems likely to presage further disruptive reorganisation. We are not hopeful that the service is about to be given the period of calm that seems essential if doctor–manager relationships are not to be undermined further in the next year or so.

Secondly, one aspect of the external political context that respondents singled out for particular critique was the regulatory and performance management 'system'. We use inverted commas here because many respondents emphasised that it was not a system. Instead it was perceived by many to be a collection of poorly coordinated bodies and processes that dumped what were often perceived as conflicting objectives on acute trusts.

These objectives and the associated data reporting requirements, many felt, led to acute trusts having to prioritise 'feeding the beast' over the development and sound implementation of local structures and processes that would actually deliver those objectives of safe, high-quality care in the medium and longer term. These findings suggest that there is an urgent need to streamline the regulatory and performance management arrangements to ensure better coordination and a genuine emphasis on learning and data to support improvement (Dixon-Woods and others, 2013; Walshe and Phipps, 2013).

Thirdly, it is clear from looking at the findings from the 2002 and the 2015 surveys that there continues to be significant disaffection and frustration among medical managers at clinical director level. Some participants pointed to initiatives in some hospitals that have sought to make this role a better-defined one with clear objectives and training and support. They emphasised the desire of many doctors to 'make a difference' to their local clinical services, and described (as earlier research has done, e.g. Hallier and Forbes, 2005) how this motivation can be eroded when clinical doctor roles for many individuals turn out to be characterised by multiple responsibilities and little genuine influence. Some suggested that the continuing lack of a national framework for clinical director posts was unhelpful as it contributed to the variable levels of interest in and organisational support for clinical director roles in many trusts and added to the sense that the role was not well integrated into medical career structures. It may be that a national framework for clinical director posts might prove useful in reducing the variability and in providing a focus for the spread of successful initiatives more widely.

Fourthly, we observed that few of the newer initiatives that aim to promote better working relationships between doctors and managers were widely available. Although management training for doctors was common (although, perhaps surprisingly for 2015, not universal), other approaches like 'buddying' or mentoring schemes between managers and doctors or even shared social spaces or social events were uncommon. We heard of successful initiatives like tailored coaching and tailored management training in which participants were supported in managing 'real life' organisational challenges in their own organisations but we also heard from many respondents that workload pressures often prevented engagement with those opportunities that were available. This situation is likely to require a range of interventions at national and local level, including robust evaluation of emerging initiatives and active facilitation to spread those approaches which prove positive to a wider number of organisations.

Finally, one of the striking discrepancies in perceptions of doctors and managers that emerged from the study was participants' perceptions of the differences in the relative esteem in which doctors and managers are held by the public. Only 12% of survey respondents considered that NHS managers are respected by the public compared to the 97% of respondents who considered that doctors are. Many participants commented on the 'bad press' that NHS managers got from politicians, the media and, at times, from regulatory bodies like the CQC. Some suggested that the medical profession had historically helped to foster this negative public impression of managers. Interviewees added comments that referred to NHS managers feeling obliged to conceal their roles on social occasions and to those with dual identities (health professional and NHS manager) often emphasising their health professional role as this tended to receive a more positive response. We also heard many comments (from medical and non-medical managers alike) to the effect that the role of an NHS

manager had become more difficult in the past decade, with less support and training and greater organisational challenges at a relatively junior level than had been the case for earlier generations of NHS managers.

The fact that NHS managers work in a role that is subject to persistent negative media stereotyping (Buchanan and others, 2013) is likely to have several important impacts on doctor–manager relationships. It is likely to increase the stress of these roles for the managers themselves, and that may impact on their personal resources, creativity and ability to work constructively with other groups, including doctors. It may add to the risk that many doctors may see management as a low-status role (particularly in comparison with clinical medicine) (Russell and others, 2010). This may affect doctors' willingness to work constructively with general managers or with medical managers. It may also further reduce the status of medical management, leading to a further 'vicious cycle' of disengagement of the majority of doctors from such roles and the sense that those doctors who do enter such roles are no longer clinical peers but have 'gone over to the dark side'.

All of these effects are likely to add challenges to constructive working between doctors and managers by increasing the sense of 'them and us'. Addressing these problems is likely to be complex and to require a multi-faceted approach. As several participants commented, there are vested interests for some politicians (and some parts of the media) in using managers as an 'easy target' to blame for the shortcomings of government policy and many suggested that it was no accident that negative media reports of NHS managers were so prolific. It is hard to see how complex organisations can be expected to thrive in challenging times in the face of such widespread public denigration of a large group of staff.

5. Concluding remarks

The significant efforts made by many managers and doctors at local level to make these important relationships work may not be enough to counter the effects of the increasingly hostile external context that informs these relationships. If improving working relationships between doctors and managers is an important strand of building a strong service for the future (as we believe it is), then NHS managers – both medical and non-medical – need to be valued, equipped with the necessary skills and resources and provided with a context that enables them and the clinical services that they manage to flourish. Evidence from the medical and non-medical managers in this study suggests that there is a long way to go.

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Technical appendix

A brief summary of methods is given on in Section 1 of the report. Here we provide a more detailed account of our methods.

The study used a combination of a survey sent to chief executives, medical directors, directorate managers and clinical directors from acute trusts across the UK and interviews and a focus group with medical and non-medical managers from these categories to allow more detailed discussion of the issues raised by the survey.

Survey

The main aim of the survey was to update the findings of the earlier large-scale survey carried out in 2002 with chief executives, medical directors, clinical directors and directorate managers in UK acute trusts (Davies and others, 2003a, b; Rundall and others, 2004). The survey therefore included the questions that had been used in the 2002 survey. We also devised new questions to gauge the perceptions of doctors and managers on the impact on the doctor–manager relationship of more recent policy developments (e.g. the Francis reports and the Health and Social Care Act 2012). These questions built on the narrative review of the literature carried out early in the project and on a scoping seminar conducted with doctors and managers together with stakeholders from the policy and research sectors early in the study, where we discussed the findings from the narrative review and outlined the main areas of the proposed survey. As in the 2002 survey, some of the survey questions were constructed to provide a parallel view of managerial staff and clinical staff. For example, there were questions that asked about perceptions of the quality of medical staff and their leadership capabilities and these were matched with questions about managerial staff.

The survey included demographic questions, multiple-choice questions to assess perceptions of a range of aspects of the doctor–manager relationships and free text comment boxes to allow respondents to expand on their answers. A five point Likert scale (strongly agree; tend to agree; tend to disagree; strongly disagree; don't know/not applicable) was used to assess the strength of agreement with a range of propositions. The draft survey was piloted with medical and non-medical managers (including five medical and non-medical managers who had attended the scoping seminar) and with academic researchers. Minor adjustments were made to the wording and format as a result.

The survey was sent out in two phases: an online survey phase in May–June 2015 and a postal survey phase in October 2015. We used a 'managed email communication' service from a leading UK-based provider of health care databases for the online survey phase and this provider's external mailing house service for the postal phase. In the online survey phase, an email inviting recipients to complete the survey was sent to 2,650 recipients: all those with an email address listed on the database as chief executives, medical directors, clinical directors and directorate managers in acute trusts in the UK. Two follow-up emails (nine days and 21 days after the initial email) were sent to all recipients to encourage non-responders to complete the survey. The postal survey was sent once to 817 recipients: all chief executives and medical directors in acute trusts across the UK and a random sample of 10% of clinical directors and 16%

of directorate managers in acute trusts across the UK. The postal survey mailing was identical in content to that of the online survey, but had minor formatting changes to reflect the hard-copy format and included a reply-paid envelope. The covering letter with the postal survey instructed recipients not to complete the survey if they had already completed the online survey.

We combined responses from the two phases of the survey for analysis. In total, 472 respondents completed the survey (a response rate of 18% across all four role groups):

- 13% of the total respondents (59) were chief executives
- 28% (131) were medical directors
- 28% (132) were directorate managers (or similar)
- 32% (150) were clinical directors (or similar).

The response rate at board level was 34% for chief executives and 41% for medical directors. The response rate for directorate managers was 13%, while for clinical directors it was 9%. Analysis involved compiling descriptive statistics (e.g. on the extent of agreement or disagreement with statements). Chi-squared tests were used to determine the statistical significance of differences across the four role groups. Free-text comments were analysed thematically.

Interviews and focus group

The interviews and focus group (Table A1) were used to add to the data from the survey by providing the opportunity for discussion in more detail of the headline findings from the online phase of the survey and of the wider issues around the doctor–manager relationship. Interviews were sought with members of the Nuffield Trust's Health Leaders' Panel who had expressed interest in or attended the earlier scoping seminar. Further interviewees were suggested by these contacts. We also invited acute sector members of the BMA's Committee for medical managers to take part. In total 12 interviews were conducted between June and November 2015, involving 13 individuals. Interviews lasted between 20 and 50 minutes. Eleven interviews were conducted by telephone; there was one face-to-face interview with two interviewees. One focus group lasting 50 minutes was held in November 2015 with nine board and directorate-level medical and non-medical managers from a large London trust.

Table A1: Role of interviewees and focus group members (n=22)

Role	Number
Chief executive	5
Medical director	5
Directorate manager	5
Clinical director	7

Interview and focus group participants were provided in advance with information about the study and a brief document summarising the headline findings from the online phase of the survey. A semi-structured interview format was used, with questions modified to suit the role of the participant/s. The interviews and focus group were recorded with the permission of the participants. The interview and focus group recordings were analysed to draw out key themes.

About the authors

Alison Powell is a Senior Research Fellow at the University of St Andrews. Her research interests lie in knowledge mobilisation, organisational change and quality improvement in health services. She is particularly interested in the impact of national and local policies on the delivery of care, the role played by professional identities and boundaries, and initiatives to increase the effective use of research. Prior to entering research 16 years ago, Alison held a variety of posts in and around the NHS including working in operational NHS management, working as a midwife, and supporting national policy negotiations on doctors' terms and conditions of service at the British Medical Association.

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