

Clinical leadership – a framework for action

Case studies compendium

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.





Clare Boobyer-Jones

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Somerset Partnership NHS Foundation Trust and
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Occupational Therapist |  [@clareboobyerMPH](https://twitter.com/clareboobyerMPH)

My journey

I started as an occupational therapist in 1990, after which I became Head Occupational Therapist, then Head of Therapies in an acute trust. I moved temporarily into a directorate operational manager role and finally had the opportunity to act as Deputy Director of Nursing for the trust. I believe that stepping into these roles allowed me to develop both clinical and operational credibility and raise the profile of allied health professions within an acute, medically driven environment.

The acute trust is currently working in an alliance with the community, mental health and learning difficulties trust, working towards a merger and already have a joint executive board. My role sits under the Chief Nurse for the allied trusts and covers all allied health professionals (AHPs) and psychologists. I sit within the Chief Nurse's care directors team and work alongside the patient care directors for each trust. I am co-located with the executive team, which affords many opportunities for discussion and influence.

On starting in her new role, the Chief Nurse spent six months seeking out all professions within the alliance to understand their roles and the services they provide. She has a good understanding of the breadth of services AHPs provide. With this knowledge, she ensures that there is a voice at the board and advocates for the services.

The turning point

In the acute trust, therapies have played a key part in reducing delayed transfers of care and introducing enablement as an approach to improving patient outcomes. Along with the alliance of the trusts, this meant that there was a good understanding of the value AHPs could bring. The limitation of not having a seat at board is that



although others have an understanding of the profession, we are not always at the right forums to influence direction of services and decisions about workforce and patient care delivery. The Chief Nurse is very good at bringing me into appropriate discussions.

Key barriers/challenges and how I worked through these

The key barriers and challenges are the expectations of others of the role. Many see it as just occupational therapy and physiotherapy. There could also be a tendency in one of the trusts to think the role is just for professional leadership and as such a reticence about including the post-holder in operational delivery decisions. Representing the full range of AHPs in a strategic way is helping to overcome this.

Organisational support to make this happen

It is essential that AHP professions are represented at the right forums in the organisation. Executive and senior clinical leaders need to understand the impact these professions have on patient outcomes, experience and patient flow and it is our job as AHPs to help them develop that understanding.

My top tips

- Be bold and gate-crash politely.
- Approach with solutions to systemwide issues. Work alongside the powerful and large groups, ie nurses and doctors.



Shane DeGaris

**Group Deputy Chief Executive Officer,
Barts Health NHS Trust**

Physiotherapist (not practising) |  [@shanedegaris](https://twitter.com/shanedegaris)

My journey

My clinical background was as a physiotherapist although I am no longer Health and Care Professions Council (HCPC) registered. Following this, my line manager's manager went on maternity leave and so my line manager acted up to cover that role and I was asked to cover the head of therapies role (I was previously working as superintendent physiotherapist).

An opportunity arose to cover another maternity leave role as General Manager in the Medical Directorate. I then progressed to Assistant Director of Operations, Director of Operations, Chief Operating Officer, Deputy Chief Executive Officer and then before my current role at Barts, was the Chief Executive at Hillingdon Hospitals.

The turning point

I made decisions to move laterally/diagonally, sometimes at a lower or protected grade, to continue to make a difference for many more patients than the ones I treated individually as a physiotherapist.

The key to my success was that I sought out and needed support from within my trust(s) to do this (which I had). While I have not worked clinically for a number of years, my clinical background is a very important part of my journey and the leader I am today.

Key barriers/challenges and how I worked through these

There is a challenge in that there is normally only one route to the board of an acute trust for AHPs, compared to nurses and doctors. To work through this, it has been critical that I have moved towards the operational board roles through positions that offered significant operational and general management experience.



Organisational support to make this happen

Trusts need to ensure there is a good system of talent management in place that helps identify and support future leaders from right across the clinical and non-clinical spectrum.

My top tips

- Ensure you gain operational experience.
- Talk to key/influential people within the organisation and tell them your ambitions (CEO/COO, etc).
- Seek out and find others who have followed a similar path to the one you want to embark on.
- Try to get onto one of the mainstream programmes (eg [Aspiring COO programme](#) etc).



Kay Fawcett

**Non-Executive Director,
Derbyshire Community Health Services NHS
Foundation Trust**

Nurse |  [@fussy1958](#)

My journey

I have spent the majority of my career in the NHS, starting my nurse education in 1977 and qualifying in 1980. Most of my clinical work was in emergency care, followed by 11 years in pre- and post- registration education and finally 8 years in executive roles.

After retiring from my executive role, I retained my registration and have carried out a portfolio career for the last 4 years. This has included a non-executive role outside the NHS and roles supporting nurses and trusts across the UK. A few months ago, I decided to apply for a non-executive job within the NHS and was successful in obtaining my role in Derbyshire.

When I stepped down from my executive role I wanted to stay engaged with the NHS. Having worked with non-executives on the board, I realised that my experience would be useful in a non-executive role. This allows me to work part time but still engage in the NHS and support quality in a different way. It's a really responsible role where I'm learning more new skills while applying the ones I already have.

The turning point

The transition from executive to non-executive role has been something I was interested in from the point I retired. I thought it was important to gain some experience outside my executive experience before undertaking a different board role. After four years as a non-executive in a non-NHS but related industry I felt ready to bring all my experience to an NHS role.



Key barriers/challenges and how I worked through these

The key barrier to my taking a non-executive role was actually my own concern that the transition might be hard because I had recently been on a board as an executive. I now realise that choosing the right trust, where there is effective development and support, means that this transition is nowhere near as difficult as I might have expected. I began to recognise that the whole of my career had been a series of different roles and that effective support and development assist with achieving competence in them.

Organisational support to make this happen

- Clarity of thought from the board that is appointing you.
- A supportive trust, with a mix of mature and new board members where open discussion is welcomed.
- Clear development sessions and induction.
- Regular support from the chair.

My top tips

- Choose a trust where you will not be tempted to try to act as an executive. Moving from executive to non-executive in the same trust is likely to be more challenging.
- Recognise that early months in the non-executive role will require significantly more time to make sure you understand the business and processes.
- Take the training and development offered to you.
- Get a buddy non-executive and/or a coach to support your transition.



Dr Claire Fuller

Senior Responsible Officer,
Surrey Heartlands Health & Care Partnership

GP |  [@clairefuller17](https://twitter.com/clairefuller17)

My journey

I am the Senior Responsible Officer for the Surrey Heartlands Health & Care Partnership and lead the integrated care system (ICS). Previous to this, my roles have included Clinical Chair of Surrey Downs Clinical Commissioning Group (SDCCG) and I have been a practising GP since 1995. In my GP role, I worked as a partner before having children and then, following this, returned as a salaried/retainer/locum GP. I have worked as a GP in A&E and provided medical management to a community hospital. I became a clinical lead for the primary care trust at the time of transition to CCGs, and subsequently clinical chair for SDCCG. Following this role, I also worked as Chief Clinical Offer, focusing on developing clinical leadership within the CCG.

I developed a GP Leadership Programme which is now in operation across the Surrey Heartlands footprint, with more than 100 participants to date. This has facilitated the creation of primary care networks across the whole integrated care system. Developing clinical leaders across the sustainability and transformation partnership (STP) more widely has helped us reduce unwarranted variation begin to standardise care.

I have supported the development of pioneering new integration initiatives such as community hubs and [Epsom Health and Care](#) which are succeeding in reducing non-elective emergency admissions by 4%.

The turning point

Becoming CCG Chair launched me into my next leadership steps. The key for me though has been to continue to do clinical practice as a GP.



Key barriers/challenges and how I worked through these

I haven't had any specific barriers however my approach has been to not seek permission and to take opportunities when I have been able to, ensuring ideas are supported by a robust plan.

Organisational support to make this happen

- Listen to clinicians – non-hierarchical, multiprofessional, parity of esteem between mental and physical health.
- Listen to patients.
- Have a plan recognised by clinicians and patients.
- Be clear what you are trying to do.
- Evaluate what you do.
- Don't forget to include the wider determinants of health.
- It's all about relationships.

My top tips

- Always do what feels right – regardless of whether you are in a clinical or non-clinical role.
- Find an external mentor to support you.
- Find your passion then get on and deliver.
- If you have caring responsibilities, don't apologise for this– work/life balance is important, and we are all entitled to this but do not use this as an excuse for non-delivery.



Rachel McKeown

**Director of Allied Health Professionals,
Midlands Partnership NHS Foundation Trust**

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My journey

I am the Director of Allied Health Professionals which is a sub-board position. I am also the Professional and Strategic AHP Lead across the organisation. My role reports to the Director of Nursing.

I found that having the title of director, has helped elevate my position. It also opens doors so that I can influence at a strategic and board position level both internal and external to the organisation. The seniority of my role reflects the organisation's desire to raise the profile of AHPs within the trust and more widely within the system.

The turning point

Having held head of service and head of therapy posts previously, I had reached a glass ceiling professionally. As such I progressed in senior operational, quality and transformational roles outside AHP professional and operational leadership. This was instrumental to being successful in the Director of AHPs position.

My clinical profession is represented through the Director of Nursing at the board. Diversity of AHP professions is difficult to represent without specialist professional knowledge and this can result in potential opportunities for AHPs being lost, despite excellent working relations with the Director of Nursing.

Key barriers/challenges and how I worked through these

- There is a lack of professional AHP roles or opportunities to progress at senior and strategic level beyond band 8b/8c. This results in the potential to lose talented individuals from senior clinical leadership. There has been some improvement with opportunities from NHS England and NHS Improvement. These national roles also provide essential peer support.
- There is a lack of a clear leadership pathway for AHPs.



- I personally left the professional AHP leadership pathway as could not progress further. My ambition was always to be a director of AHPs, however due to lack of opportunity I started to follow senior leadership outside AHPs, until this recent opportunity arose.

Organisational support to make this happen

Midlands Partnership Foundation Trust recognised the value of AHPs to the organisation's success and so invested in the director of AHPs role. Recognising AHPs diversity and ensuring their voice is heard at board raises the profile, and unique contribution AHPs make to Midlands Partnership Foundation Trust.

My top tips

- Keep positive, always offer AHP solutions to system-wide challenges.
- Think creatively and differently as our training has facilitated.
- Keep options open, AHPs can lead within and outside their own professions.
- Be prepared to do something different if there are limitations to AHP leadership roles.
- Senior operational roles/national secondments/transformational roles enhance the knowledge and experience you bring back to AHP leadership.



Pippa Nightingale

**Chief Nurse,
Chelsea and Westminster NHS Foundation Trust**

Midwife |  [@pippanightinga3](https://twitter.com/pippanightinga3)

My journey

My journey into senior leadership began as a clinical midwife for over 10 years and then as a consultant midwife. From here I progressed to Head of Midwifery, then Director of Midwifery. Following this I became the Clinical Director for Women's Services and then was successfully appointed Chief Nurse, along with my role at the sustainability and transformation partnership (STP) as senior responsible officer (SRO) for maternity services.

The turning point

Personally, I naturally progressed through the various clinical roles. I was fortunate to have leadership training and development outside the organisation. I also had a supportive mentor and coach who helped me along my leadership journey.

It's important to recognise the importance of networking and having a wide-reaching clinical professional community. Management/leadership can be a lonely, challenging place sometimes; external networks are essential. It's also important to understand the balance of leadership and management and to identify your followers.

Having a professional voice at the board is essential, I am a firm believer if you are not contributing you should not be there, choosing your battles well as not all battles can be won!

Key barriers/challenges and how I worked through these

Self-belief and professional identity was a challenge I had to work through. This was helped by leading multiprofessional groups of nurses, midwives and AHPs.

Other challenges I have had to navigate have included:

- work-life balance



- board and non-executive director politics and practices
- self-conflict of not being directly clinical and having patient contact but understanding you can still influence care
- maintaining clinical credibility.

Organisational support to make this happen

All the organisations I have worked for have supported me to grow my leadership potential by supporting me to have leadership training. The organisation also supports talent spotting/management and role shadowing.

My top tips

- Be yourself and be authentic, open and honest as well as passionate.
- Keep your professional network close: we all need support at times.



John Quinn

**Chief Operating Officer,
Moorfields Eye Hospital NHS Foundation Trust**

Pharmacist |  [@john-quinn-68b97029](#)

My journey

I started my career as a hospital pharmacist at Northwick Park Hospital where I was a resident and undertook my MSc in Clinical Pharmacy. I had a good training and grounding there which set me up for a career as a clinical pharmacist specialising mainly in cardiology. After a period in academia undertaking research into the education of clinical pharmacists, I started my career in pharmacy management eventually becoming a chief pharmacist. In that role I was good with budgets and strategy, hence got more involved in corporate projects supporting the trust more widely. That was how I got noticed as someone who may have the potential in a more senior role.

I took on general management roles in addition to being chief pharmacist, which got me skilled in this with the safety net of my professional role. I then left that organisation to become a divisional manager leading large divisions in a major London teaching hospital. This helped me develop my leadership and management skills further until I was ready to apply for executive roles.

I am currently Chief Operating Officer with responsibility for clinical operations, performance, emergency preparedness, private practice and service improvement.

The turning point

My first non-pharmacy role was Associate Director of Operations for clinical support which I was able to undertake while still being chief pharmacist. This was an excellent way into a corporate leadership role.

Key barriers/challenges and how I worked through these

It is difficult in some clinical professions to progress, as you have to leave behind your own clinical profession in a way that medics or nurses do not need to do. I have



managed to keep my professional links either directly through managing as a pharmacist at the same time as having a leadership role or managing pharmacy in my portfolio. Recently though, I keep involved in my profession through working with my professional body and supporting leadership in the profession.

Organisational support to make this happen

I received access to leadership programmes, in my case The King's Fund and executive coaching, both of which were invaluable.

My top tips

- Get involved in beyond your remit and support your organisation more widely.



Dr Jagjit Sethi

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Consultant Clinical Scientist (Audiology)

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My journey

Current roles: Clinical Director (CD), Consultant Clinical Scientist (Audiology), Head of Hearing and Balance Services and Lead Healthcare Scientist for Berkshire Healthcare NHS Trust. National role as Past President for British Academy of Audiology and working with the NHS England Chief Scientific Officer on various projects.

My career started at the Royal London in Whitechapel and, as with most professionals in audiology, I just fell into it. The eldest child of a migrant family from India, we found ourselves orphaned at an early age, so after doing my A-levels, I left education to support my family. I always wanted to work in healthcare so when a job came up for a trainee medical technical officer (MTO) in audiology I thought, here's a way in. I applied for it, thinking I would try it out for a year and then see what I really wanted to do. Over 30 years later, I am still in audiology! It has been a long journey, which has required being continuously inquisitive, tenacious and having a lot of fortuitous luck along the way.

My first role was as a trainee MTO at the Royal London with a salary of £3,000 per year where I gained my certificate in medical physics and physiological measurements. As with everything in the NHS, our jobs were reinvented and relabelled as physiological measurement technicians. Slowly, over time, I was promoted through the ranks eventually to Chief Audiologist for Neuro-Otology at the Royal National Throat, Nose and Ear Hospital, London. Working with leading clinical scientists and audio-vestibular physicians stimulated my thirst to expand my knowledge and skills further. So, I took voluntary redundancy to study for a master's in audiological science and attained my Certificate of Audiological Competence. I travelled around the country learning from leading clinical scientists, eventually securing a job as Head of Clinical Audiology at Countess of Chester Hospital.



Over the next 11 years I developed my passion for quality improvement and honed my managerial and leadership skills. Not one for standing still for too long, alongside my day-time job I went on to attain a doctorate in audiology from NOVA South Eastern University, Florida. In 2008 I moved to Berkshire where, alongside my substantive role as Head of Service, I took on national roles including working with NHS England and the Royal College of Physicians to develop the United Kingdom Accreditation Service accreditation for Improving Quality in Physiological Services, being the Neurosensory Sciences Professional Lead for National School of Healthcare Science (NSHCS), then President for British Academy of Audiology and now working with Chief Scientific Officer on Action Plan on Hearing Loss and Healthcare Science Patient Group Direction project.

The turning point

It's difficult to pinpoint one event and I'm not entirely sure I am there yet. The key has been gradual self-determination and grit. Part of the CD role is ensuring your profile and reputation continue to grow in the organisation; this is something that has not come naturally to me and I continue to work on it. It took me numerous attempts before I was fortunate to be given the CD role. While it is not a board role, I do have a voice at senior level and am able to inform decision-making.

There is a long journey ahead as I learn the executive language, way of working and cultures. It is important to develop relationships which go a long way in ensuring support at executive meetings. This can at times feel a bit like an MP canvassing to secure votes before the discussion has taken place. On reflection, I suppose it's a bit like moving abroad; you need to learn the language and the local way of doing things if you want to be accepted!

Key barriers/challenges and how I worked through these

Traditional roles, such as nurse, doctor and more recently AHP, have supportive networks and well-trodden paths to executive roles; however, this is not yet well embedded for healthcare scientists. Quite often you can be overlooked and funnelled towards operational promotions. Despite having transferable skills and related evidence of my achievements, feedback from unsuccessful interviews was that I lacked breadth of experience and was too clinically focused.

How do you break the glass ceiling without opportunities? Since secondment opportunities were limited, I seized opportunities wherever they presented



themselves. I took on additional roles both internally and outside the trust including working with the National School of Healthcare Science, project leading the trust's five-year strategy refresh and other divisional-level projects. I then took on the presidency for my professional body, which led me to work with Chief Scientific Officer on the national stage. Despite gaining all these experiences, it still took a number of attempts at interview to become a CD: an indication of the need for perseverance and to continually seek development opportunities.

Organisational support to make this happen

Prior to my CD role, several talent management conversations suggested I needed more breadth of strategic experience but unfortunately no opportunities were available internally, so I looked outside the organisation.

My top tips

- Reflect on who you are and want to be. Know what's truly important to you. Know your true potential and go for it.
- Never give up trying, no matter the obstacles. If you want it badly enough you will get there. Just dare to dream, you never know it might just happen.



Dr Amar Shah

**Chief Quality Officer,
East London NHS Foundation Trust**

Consultant Forensic Psychiatrist

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My journey

I am the Chief Quality Officer (CQO) at East London NHS Foundation Trust (ELFT), a new role for the organisation and unique one in England. I think I'm the only CQO for a provider trust in England, although it's a fairly standard role in healthcare providers in the US and was recommended in the [Keogh review in 2013](#)¹ as a way for trusts to increase their focus on quality.

I'm also a clinician, a consultant forensic psychiatrist, and still practise clinically. For me, personally, my journey hasn't really been about aspiring to the board or climbing the ranks. The work has led me there, and my purpose in being at the board now is to support our efforts to continuously improve. The principal reason trusts exist is to provide high quality care for the population, and so it feels intuitive that boards should seek to bring some expertise on quality into the boardroom.

I am still learning about how to be most effective in the role, as is the board, particularly with regard to the interplay of my role with the chief medical officer and chief nurse's responsibilities. For me, it's a sign of the board's commitment to quality that they value the insight and experience on quality management I bring to board discussions and decisions, and it adds to the multitude of reasons why I love working at this organisation.

The turning point

When I finished my clinical training in 2012, I started working with our Medical Director at ELFT to plan and prepare for a new approach to quality. The two years of preparation drew mainly on skills I've honed outside the NHS, as well as within the NHS. I've spent 20 years helping run a charity in the UK, and I bring a lot of my

¹ www.nhs.uk/news/medical-practice/keogh-review-on-hospital-deaths-published/



learning from that sector to my efforts to inspire and engage our staff around quality improvement.

I'm not sure the trust would have appointed me to the Board if we hadn't built belief that quality improvement really worked, helping us harness the best that everyone has to offer in helping us achieve our mission. I didn't set out to achieve a board role – the position or power isn't important for me. The work is my passion and having someone at the board to guide and provide expertise on quality is now critical to helping us achieve our mission as an organisation.

Key barriers/challenges and how I worked through these

With the kind of whole organisational transformation work that I lead, there are many, many challenges, and also many, many sources of joy and inspiration. The key for me has been to not get overly influenced by either the successes or the challenges, and always play the long game. See the best in everyone and roll with resistance. Resistance is a good indicator of missing relevance, so keep experimenting with different messages and routes until you find something that resonates.

As a fairly young (39) medic in a board role, I do wonder what the future holds. I haven't exactly followed a traditional pathway, either through my training or after, and am in a fairly unique role. However, I'm confident that if I hold onto what brings me joy in work, the future will continue to offer new and exciting possibilities.

Organisational support to make this happen

I am immensely grateful for the trust the organisation placed in me, as a relatively unknown and junior doctor just post-training, to lead our quality improvement programme across the trust. Key to this was having a senior sponsor who could champion my work, unblock barriers and give me license to disrupt the system, so that I could try new things and learn as I go.

My top tips

- Take some time to really understand what brings joy to you at work and find a way to hold on to this. Aspiring to the executive or board is great, but isn't an end in itself.
- Focus on your own agency to influence behaviour and culture, as these will be the most important requirements to be effective in an executive role.



Arlene Wellman

**Chief Nurse,
Epsom & St Helier University Hospitals NHS Trust**

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My journey

My journey towards executive level leadership began in 2008 when I attended the first 'Towards Strategies for Successful Women' programme during which I was able to explore my strengths and weaknesses. This excellent programme challenged me to develop my strategic thinking in preparation for progress as a leader in the NHS.

I have been a matron and senior matron in elderly care nursing and continued to improve my education, successfully completing an MSc in Clinical Healthcare Practice in 2011. I gained significant strategic leadership experience by undertaking a secondment to the position of divisional nurse.

I was fortunate to be selected to undertake the National Clinical Leaders Network, Eminent Leaders Development Programme in 2012, which was aimed at black and minority ethnic (BAME) clinicians with the capability to develop into regional and national scale roles.

The turning point

Obtaining a scholarship with the Florence Nightingale Foundation gave me the exposure needed to be aware of what was available strategically.

Key barriers/challenges and how I worked through these

Key barriers were/are integrating with an established board. Gaining support through coaching and accessing support from NHS Improvement and NHS England have supported me with this.



Organisational support to make this happen

I have been fortunate to have worked in organisations, and with senior nurses, who supported my continuing education and professional development through funding for courses and coaching and mentoring.

My top tips

- Seek opportunities to shadow board members.
- Get a coach and/or mentor to help support you to work through identified gaps in your knowledge/experience.



Michael Witney

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My journey

I have been practising as a clinical psychologist for over 30 years. I studied and worked abroad before joining the NHS in 2001. I have worked in two NHS trusts, the second being Oxleas. I made a lateral move to Oxleas in 2009 – similar role and at the same pay band. About 18 months after joining Oxleas the opportunity arose to apply for the role of director of therapies. This was a fantastic opportunity.

My experience in the role has been very positive, and my portfolio of responsibilities has increased and diversified over time. I am a full member of the trust executive team and, quite rightly, I am expected to make a contribution across all areas and not just limit my focus to my particular portfolio. I report directly to the Chief Executive, which is very important as it gives a status to the role that is highly prized. It also gives direct voice to therapists in Oxleas, who are the second biggest professional group after nurses and account for about one-third of the clinical workforce. In Oxleas, in terms of my leadership responsibilities, I am seen as equal to my nurse and medical director colleagues who are also line managed by the Chief Executive.

The turning point

Once I had been in the director role for a number of years, it was recognised that the role of director of therapies was a central feature of our structure in Oxleas, but I was not a member of the trust board. Given this, I started attending the board of directors in 2016 in an 'in attendance' capacity. This means that I am not an 'executive'/'voting' director on the board, but I am noted as 'in attendance'. However, there is the expectation that in all respects (except for being a voting member), I am an equal member of the board and that I participate in the same way as my board colleagues.

Having the Director of Therapies attending the board was highly valued by the therapist staff group – they had always felt irked by not being seen as equivalent to



nurses and doctors. There remains a slight concern among therapists that I am not a voting member. I also attend a range of board sub-committees.

Key barriers/challenges and how I worked through these

Firstly, I think it is really important to be personable. While it is important to raise concerns, 'fight your corner', etc, it is really critical that this is done in a polite, reasoned and collaborative manner. It is very important to be principled, but also willing to compromise and to consider the organisational goals as a whole. I think a key principle is that, as a director, you are required to not limit yourself to your narrow portfolio, but to consider broadly how you might contribute to helping the organisation resolve the challenges it faces and move it forward to the achieve the strategic goals it has set for itself.

Organisational support to make this happen

As a director who has a clinical background, I think it is important to support senior clinicians to remain in direct clinical practice, if at all possible – I continue to have a half day when I am working clinically in a service, providing frontline treatment to patients. This helps you remember your core skills and training, but also is essential when talking with your clinical colleagues about their work. It is very grounding and helps further the link between the board/executive and clinical practice.

I am one of the few directors who has a caseload of patients for whom I am clinically responsible in Oxleas. This adds huge value to conversations we have at the board/executive about a range of matters that impinge directly on practitioners as I have at least some current, active and direct experience of the clinical environment.

My top tips

- Be willing to be a 'can-do' type of person, while recognising your limitations.
- Be willing to 'go the extra mile', take on tasks and responsibilities beyond a narrow range and be helpful to colleagues for the good of the organisation (and ultimately to help patients).
- Show leadership – be willing to take on new challenges. Offer support to new ideas, be open and willing to explore doing things in a different way to help the organisation achieve its goals.

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