



**UNIVERSITY OF
BIRMINGHAM**

Evaluation of the Wessex Chief Registrar programme

Final report

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University of Birmingham

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Summary

1. Background

- a. Following the Future Hospital Commission (2013), the RCP instituted a Chief Registrar programme in 2016, to provide a 'bridge' between senior medical staff and senior managers (on the one hand) and the junior doctor workforce (on the other).
- b. In 2017, the Wessex Deanery developed a novel approach whereby non-physicians were offered places in the RCP Chief Registrar programme combined with local support. Nine were appointed. The Wessex Deanery commissioned the Health Services Management Centre (HSMC; University of Birmingham) to evaluate this programme.
- c. The aims of the evaluation were:
 - To explore the ways in which Chief Registrars are enacting their role;
 - To assess the effectiveness of the Chief Registrar role, through considering the role of individuals and the contexts in which they work;
 - To recommend future directions in the Chief Registrar role.

2. Methods

- a. The evaluation comprised an online survey of all Chief Registrars and case-studies of four Chief Registrars. The latter entailed audio diaries and interviews with the Chief Registrars and their respective role sets.
- b. All data were transcribed and analysed thematically (using the 'Framework approach').
- c. Ethical approval was granted by the University of Birmingham's research ethics committee.

3. Findings

- a. Online survey:
 - Responses included that Chief Registrars varied in their views on a number of issues including whether the time available for the role was sufficient and the degree to which there was tension between medical and leadership roles. They agreed that they had very good mentoring from medical and managerial leaders, and were very satisfied with their development in post.
 - Chief Registrars reported that their time related to education (28%), operational (19%), service improvement (29%) and other activities (23%).
- b. Key themes from the case-studies:
 - *Support from senior staff*: Chief Registrars valued the mentoring and supervision from senior doctors.
 - *Influence of specialty*: Chief Registrars reported little concern about the diversity of specialties, although there were advantages and disadvantages of this in practice.
 - *Organisational setting*: the type and size of Trust shaped how the Chief Registrar enacted their role and the impacts that were delivered.

- *Medical engagement*: the 'bridge' role was commonplace and there was a significant emphasis on junior doctor well-being.
- *Quality improvement*: this was a common activity but some adopted it as a dominant activity whereas for others it was minimal.
- *Projects*: Chief Registrars had a high degree of autonomy in choosing projects but some were becoming more embedded into organisational structures and processes
- *Enactment of role*: Analysis of the ways that the Chief Registrar roles were enacted suggested that there were some frustrations with processes for engaging with Trusts.
- *Impact*: we could not assess the counter-factual but some positive impacts were observed in terms of improved junior doctor morale, personal development, and collective benefit of a regional network of Chief Registrars.
- *Sustainability*: as the posts were only 1 year, Chief Registrars tried to sustain the impacts. Successive posts and embedding activities into the organisations helped this.

4. Discussion and conclusions

- a. The Wessex Chief Registrar programme was a feasible and successful model.
- b. Its strengths include:
 - A model for non-physician medical leadership by senior trainees;
 - A strong emphasis on medical engagement (downwards to junior doctors and upwards to senior staff), QI, and staff well-being;
 - Developing complementarity between the medical profession and organisational leadership (though this was yet to be realised fully).
- c. Its weaknesses include:
 - A relative lack of integration into organisational decision-making;
 - A frustration with a role which can become overly enmeshed in administrative matters.

5. Action points

- a. Chief Registrar engagement with senior staff needs to be balanced with enhanced operational management capacity;
- b. Clarity is needed in the degree of autonomy of the Chief Registrar role;
- c. Support should be provided for broadening the role of the Chief Registrar beyond physicians;
- d. Support on-going junior doctor engagement (especially regards their well-being). Junior doctor leadership programmes should be developed.
- e. Support the Chief Registrar role with management and administrative resources in the middle of the organisation.

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Evaluation of the Wessex Chief Registrar programme

Interim final report

1. Background

The Royal College of Physicians' Chief Registrar scheme started in 2016. The role was recommended as part of the Future Hospital Commission (Royal College of Physicians, 2013). Its key purpose was to provide a 'bridge' between senior medical staff and senior managers (on the one hand) and the junior doctor workforce (on the other), particularly in the context of the service changes that were envisaged as part of the Future Hospital Commission.

The first RCP cohort appointed in the scheme consisted of 21 Chief Registrars, 1 of them in the Wessex Region. In 2017-18, there were 34 Chief Registrars, 9 of them in the Wessex region (Royal College of Physicians, 2018). Of the 9 Chief Registrars in Wessex, three were in non-physician specialties, and two more were in non-acute settings. The appointment of non-physicians to Chief Registrar roles was regarded as a pilot by the Royal College, and there were no other non-physicians in the cohort.

Table 1: Specialties of the Wessex Chief Registrars (2018)

Rehabilitation Medicine	2
Renal Medicine	1
Respiratory medicine	1
Emergency medicine	2
Trauma and Orthopaedics	1
Anaesthetics	2
Total	9

In the full national cohort 2018/2019, there are 57 new appointments. 6 of these appointments were in Wessex, and of them 3 are non-physicians – 1 anesthetist and 2 psychiatrists. These individuals are working in Trusts which had previously hosted a Chief Registrar. In this national cohort, there is one other Chief Registrar from a non-physician background. The Royal College of Physicians have announced that the 2019/20 scheme will be open to non-physician specialties.

Across England, Wales, and Northern Ireland, the norm was that individual organisations would fund the non-clinical element of Chief Registrar posts. However, in Wessex, some resources were available from the Wessex Deanery (Health Education England), and a regional scheme was developed. Recruitment to the scheme was undertaken at the regional level. In 2017-18, the distinctiveness of the Wessex scheme was threefold: it included non-physicians, there was a local cohort effect (derived from the Wessex Chief Registrars meeting together during the programme with the Deanery), and there was a focus on staff well-being.

The Deanery commissioned an evaluation from the Health Services Management Centre (HSMC; University of Birmingham). The authors of this report had also evaluated the national scheme a year earlier (Exworthy and Snelling, 2017). The evaluation of the first year national scheme in 2016-17 had examined the hours that Chief Registrars devoted to their roles, their priorities and their areas of work.

The evaluation into the 2016/7 RCP scheme identified that the key elements in the success of the first year of the scheme were autonomy, flexibility, and support (Snelling and Exworthy, 2017). In general, there was very little expectation on the Chief Registrars about what their role would be, and as a result, there was considerable variation in how the roles were enacted. For many, there was a focus of service improvement issues; the study's survey across the cohort estimated that 47% of time was devoted to these issues, with 27% on educational issues, and 20% on operational issues, including rota management. Chief Registrars worked flexibly to undertake their role; for example, Chief Registrars used their time flexibly and felt well supported in their roles, at all levels, and particularly by medical leaders. The roles were widely understood to be both training roles, and substantive leadership roles, although again emphases varied.

In recent years, there has been increasing interest, in research and practice, on the welfare and working conditions of junior doctors. Several factors have contributed to this increasing interest: changes in training, particularly through the implementation of the European Working Time Directive and Modernising Medical Careers, the increasing evidence of the effects of environmental issues on patient safety, the contract dispute in 2016 which led to junior doctors going on strike, and the pressures caused by increasing demand and shortages in junior doctors and other NHS staff (Exworthy, 2015).

One of the provisions of the 2016 contract was that each Trust would establish a Junior Doctors Forum (or fora) to advise the Director of Medical Education and Guardian of Safe Working. The membership of the Forum would include junior doctors "elected from amongst the trainees" as well as "relevant educational and HR colleagues as agreed with the group" (NHS Employers 2017, p.39-40). The Forum would have a role in the distribution of any fines levied on the Trust as part of the contract agreement. The contract agreement gave detailed prescriptions of allowable shift patterns. In addition to the hours worked, there are a range of issues that have been highlighted that affect the working conditions, performance, and welfare of junior doctors.

In 2016, Health Education England established an Enhancing Junior Doctors' Working Lives programme. A progress report published in 2018 highlights a range of reported issues and how these are being addressed (Health Education England, 2018). There is a broad range of issues covered, including some structural issues related to training such as Whistleblowing protection, and review of the ARCP process. Other issues relate to operational issues within Trust, including the need to improve induction and mandatory training, improvements to rotas, and addressing the decline in supportive relationship in the training environment.

In 2017, NHS Improvement, NHS Providers and the Faculty of Medical Leadership and Management, supported by a range of other organisations, published a document which outlined actions which could improve junior doctors' working environment (table 2). This guide is not cited in the HEE report. However, it does address issues to be tackled within Trusts and was referred to by a number of Chief Registrars and colleagues.

Table 2: Eight high impact actions to improve the working environment for junior doctors

1. Tackling work pressures
2. Promoting rest breaks and safe travel home
3. Improved access to food and drink 24/7
4. Better engagement between trainees and the Board
5. Clearer communication between trainees and managers
6. Rotas that promote work life balance
7. Rewarding excellence
8. Well-being, support and mentoring

There was an emphasis in the Wessex scheme on Junior Doctors welfare issues. In May, the Chief Registrars collaborated on a conference called 'The Wessex Worksmart.' Also, a number of Chief Registrars worked on common initiatives, particularly those covered in the 'Eight High Impact' changes.

Responsibilities for the junior doctor workforce are complex. Although they are employed by the Trusts where they are working, their training (including placements) is organised by Health Education England, and supported by the relevant Royal College. Within Trusts, trainees are embedded in clinical teams, but often rotate. Employment issues including induction and mandatory training are often managed by Human Resources departments. The junior doctor workforce is often regarded as a single entity, with the danger of overlooking significant differences between individual hospitals, specialties, and stages of training.

The context for the Wessex Chief Registrars in working in the well-being agenda was, therefore, complex. Perhaps more than ever before, there is a supportive policy context and a growing evidence base of the importance of effective management and leadership of the junior doctor workforce.

2. Aims of the evaluation

In discussion with the Wessex Deanery, the following aims of this evaluation were agreed:

- a. To explore the ways in which Chief Registrars are enacting their role
- b. To assess the effectiveness of the Chief Registrar role, through considering the role of individuals and the contexts in which they work
- c. To recommend future directions in the Chief Registrar role.

These aims are similar to those of the evaluation of the 2017 RCP study of Chief Registrars. However, by looking at four detailed case-studies, we hoped to be able to develop a more in-depth analysis of the roles, in the specific Wessex context.

3. Review of evidence

In our first report, we drew on literature specifically about the Chief Registrar role, mainly from America (where the role is termed Chief Resident). This evidence base seemed to offer little guidance, mainly because the role in America was chiefly concerned with educational improvement. For this current report, early discussions with the Deanery and Chief Registrars suggested that junior workforce engagement was a high priority. Therefore, we reviewed the available literature in this area to support our analysis of the scheme. In considering how the roles were enacted, our data also prompted consideration of the (organisational and professional) cultures of junior doctors and the processes of clinical leadership in the middle of organizations.

In addition to the attention given by health service organisations, there has been a significant research interest in issues of junior doctor welfare. In a large study funded by the GMC, Rich *et al* (2016) described how postgraduate training was characterised by an imbalance between work and life, with pressures at work affecting their ability to develop social support and deal with pressures outside of work. Work/life balance and social support were found to be significant in determining the impact of shift patterns on junior doctors (Brown *et al*, 2010). Social support in this study included a sense of 'team spirit'. In an interview study based in Wessex, Price and Luszkat (2017) considered whether trainees felt that they belonged to a team. A variable picture emerged. Although the traditional 'team' of a medical 'firm' was consistently perceived not to exist in practice, it had to varying degrees been replaced by a wider medical team, included those involved in the daily ward round, and a wider MDT which included others involved in patient care. Perceptions of membership of these two teams varied, depending on specialty and department. The amount of time spent with team members was a key consideration. Senior trainees noticed less "'kinship' and social interaction" than more junior trainees. (Price and Luszkat, 2017, p.242).

Gregory and Demartini (2017) used data from GMC training surveys from 2012 – 2015 to show that an adequate workload and a supportive environment are key factors, along with clinical supervision, and feedback in determining trainees' satisfaction. The supportive environment questions were only introduced in the training surveys in 2015, highlighting the recent emphasis on this issue.

In conceptualising the role of Chief Registrars as medical leaders, we have been influenced by two theoretical perspectives. Firstly, the idea of 'cultural complementarity' (Noordegraaf *et al*, 2016) which refers to the extent to which medical cultures and managerial cultures are complementary. In a project aimed at developing medical leadership in a Dutch academic medical centre ('Wonder and Improve'), medical residents were engaged in assessing and improving services. The key finding was that the project relied on professional traditions and professional styles, such as short task focused meetings and the acknowledgement of hierarchy, rather than management styles (including 'management speak').

The training of leadership skills, however, is weakly developed in residency programmes. Medical leadership aimed at establishing well-organised health care is still seen as residual, at most additional. It is 'added' to training other skills, but seen as 'alien' and resisted by groups of professionals (p.1113).

This concept has not been yet been widely taken up in other studies, although the tensions between managers and doctors has been extensively studied over a number of years (Powell and Davies, 2016)

Second, we have also drawn on the concept of 'constrained realities' (Martin and Waring 2013). Their study of clinical leadership in operating theatres suggested that

"professional and managerial hierarchies constrained participants' leadership capacity, and consequently the exercise of leadership rested on alignment with managerial relationships and mandates."

In other words, if distributed clinical leadership is to be effective, it must be working to address problems and implement solutions that are consistent with the priorities within the hierarchies. The study on which this idea is based did not include doctors, but the concept is useful in exploring the roles of Chief Registrars.

4. Methods

Our methods were a development of the methods which had been adopted for the RCP study in 2017. They included an online survey and case-studies.

4.1. Online survey of Chief Registrars

In April 2018, an online survey was sent to all Wessex Chief Registrars (originally 10 but subsequently 9) to garner socio-demographic data and attitudes and perceptions relating to their activities and experiences of the Chief Registrar role. The survey received only six replies,

four of which came from the Chief Registrars in case-study sites. Limited additional data were thus available from the survey.

4.2. Case-studies

With the aid of the Deanery, four case-studies were identified. Each case-study comprised a Chief Registrar and their role set (the key individuals with whom the Chief Registrar relates). Our four cases included one site with two Chief Registrars, two where Chief Registrars were from non-physician specialties, one in a community hospital setting, and one where there had been an appointment in the previous year, so some continuity was achieved. Two of our Chief Registrar case-studies had previously undertaken leadership Fellowships. The case-studies sought to capture the process and impact of Chief Registrars over time and across the organisation.

During the spring and summer of 2018, a total of 19 interviews were conducted, mostly face-to-face but some phone/skype interviews were undertaken when diary pressures prevented this. Interviews were held with the Chief Registrar and their role set (such as the Medical Director, Clinical Director, others involved in their local 'project', and peer junior doctor(s)). Interview questions are included in the appendix. All interviews were audio-recorded (with permission), transcribed and analysed. Two Chief Registrars provided audio diaries for a period of approximately two months, which were also transcribed.

With a small number of cases studies, it will be difficult to achieve anonymity of participants if any identification of sites is given even with pseudonyms. Therefore, no site identification is used, but role identification is.

For this analysis, we wanted to develop the understanding of the enactment of the role in practice, which requires more detailed case-studies than were available in the first evaluation report. In analysing the data, we looked for themes, which allowed some comparison with our previous evaluation, but we were specifically interested in exploring issues in more depth. We drew upon the 'framework method' for analysing qualitative data (Gale *et al*, 2013). All the data were analysed using a combination of *a priori* and emergent themes to reveal similarities and differences between individuals and organisations. The triangulation of multiple data sources generated a reasonably high level of assurance in the findings.

The study was given ethical approval by the University of Birmingham's research ethics committee. It was assigned reference ERN_18-0388 (approved 21 March 2018).

5. Findings

The findings are presented as follows. First, we present data from our survey, which gives a general summary of some key elements of the Wessex Chief Registrars although as discussed above, the sample size for the survey was only six out of the nine Chief Registrars. Second, we present general themes from the across our data including details on several specific issues.

5.1. Online survey of Chief Registrars

By the time of the online survey, Chief Registrars had been post for around 9 months, and so it came towards the end of their post. The general questions asked reflected some themes of our earlier report in terms of time and responsibility. Detailed responses on a 6 point likert scale are shown in table 2 below but the responses do show, as did our first report, that there are significant variations in responses in many areas.

Key conclusions across the cohort were:

- a. There was some disagreement about whether the time available is sufficient for the role but all respondents were in the weakest category of agreement or disagreement.
- b. Similarly there was disagreement about whether time was used flexibly between medical and leadership roles.
- c. All Chief Registrars engaged other junior doctors in leadership and service improvement.
- d. Chief Registrars had very good access to mentoring from both medical and managerial leaders.
- e. All Chief Registrars were satisfied with their achievements in role, but half were in the weakest category of agreement
- f. All Chief Registrars agreed very strongly, or strongly, that they were satisfied with the personal development that they achieved in post.
- g. The area where there was the greatest degree of variation between the respondents was on the degree to which tension between the medical and leadership roles was experienced, which was evenly split between agree and disagree and with almost the full range of responses across the scale (table 3).

Table 3: Responses to online survey questions

	Very strongly agree		3	4	Very strongly disagree	
	1	2			5	6
• I have clear objectives and priorities agreed with the Trust	1		3	2		
• The time I have available for the role is sufficient			4	2		
• I have appropriate access to office facilities.		2	1	3		
• I have engaged other junior doctors in leadership and service improvement.	1	4	1			
• I use my clinical and leadership time flexibly in my two roles.		3	2	1		
• I experience tension between my medical and leadership roles	1	1	1	1	2	
• I have access to mentoring support from senior medical leaders	3	1	2			
• I have access to mentoring support from senior managerial leaders	2	1	2		1	
• I sometimes feel stressed in my leadership role.		2	3		1	
• I am satisfied with what I have achieved in the Chief Registrar role	1	2	3			
• I am satisfied with the personal development I have received in my Chief Registrar role.	4	2				

We asked Chief Registrars to identify the percentage of their time that was spent on educational, operational, service improvement, and other activities. These categories were used in the evaluation of the initial national cohort in 2017. The figures from the Wessex cohort and previous year's cohort are given below (table 4). With small numbers in both samples, the comparison needs to be treated with caution, but there seems to be a shift in activities between service improvement and others. The responses to the question asking for a brief account of the issues being worked do suggest an emphasis on issues of workforce well-being and engaging with the junior doctor body. It does seem reasonable to suggest that the Wessex scheme had a focus in this area that was not so clear in the national pilot scheme a year earlier.

Table 4: Proportion of Chief Registrar role according to key activities

	2017/8 Wessex n=6	2016/17 National cohort n=13
Educational	28.3	26.7
Operational	19.2	19.7
Service improvement	29.2	46.5
Other	23.3	7.1

Chief Registrars were asked to give some brief details of their achievements and setbacks. Achievements covered a range of activities, some of which are discussed below. The theme of engaging with doctors, particularly through establishing or developing medical engagement fora is strong in the summaries. One Chief Registrar selected their own remit which specifically focused on QI (which is discussed later).

In terms of setbacks, issues identified often related to the difficulty of achieving change, because of difficulties in engaging key stakeholders whose agenda may be different, pressure of time and access to key colleagues, and the time taken to establish the role. These factors echo the broad patterns of findings from the 2017 report.

5.2. Context and role

The context in which Chief Registrars operated had a significant effect upon the ways in which they enacted their role during their 12 months in post. This reflected findings from the 2017 evaluation in which we argued that each Chief Registrar was its own distinctive 'experiment', making direct comparisons problematic. However, some contextual factors were pertinent to the Wessex scheme; namely, support from senior staff, speciality influence, and organisational setting.

5.2.1. Support from senior staff

This support was crucial in establishing the credibility of the Chief Registrar post, in maintaining their effectiveness during the year, and in creating ways to sustain the initiative afterwards.

I think there was a lot of support from the executive, OK. And I really do think you need the executive on board to the point that if ever I was in a meeting with some of them and they would say 'well, we've got these Chief Registrars, this should be something they should be doing, that they should be sorting out'. So they were well aware of it, which made a big difference (Clinical director).

All participants spoke highly of the Chief Registrar scheme. Some role set interviewees, for example, argued that they had sought to appoint a second Chief Registrar and/or were considering appointing Chief Registrars in subsequent years. One, for example, noted that although their Trust was under financial pressure, they hoped to appoint another Chief Registrar in the following year.

We're under a lot of pressure but I guess that's my [job], you know. I'm responsible for everything in our Division from finance, to governance, to performance. It was my decision, but no one has disagreed at all. And actually my proposal had been to double the cost to have two, one on each [hospital] site. And it'll be interesting to see whether somebody across two sites works or whether we do try to get two for the year after. (Medical director).

A related issue of senior support concerned the backing and assistance that senior staff gave to the Chief Registrar. All Chief Registrars spoke of the positive contribution of senior staff, especially senior doctors. On the one hand, this was self-interest on behalf of senior staff (to make 'their' initiative work) but it also afforded credibility and legitimacy to the Chief Registrars

as they undertook their role within the organisation. Significantly, one senior doctor spoke about how they (senior doctors) should act as role models for Chief Registrars.

So [the Chief Registrar's] mentor is X who knew all about the scheme... And I thought, great, he'd be a good role model for [the Chief Registrar]. The role modelling also was kind of really important I've found. So I deliberately approach people that I respect (Director of Medical Education).

5.2.2. Influence of specialty upon Chief Registrar effectiveness

A distinctive feature of the Wessex scheme was the extension of Chief Registrar posts beyond physicians, compared to the RCP national scheme. This feature is only distinctive when seen through the context of a scheme and a role orientated to 'medical' issues. As there was autonomy across the cohort to work on specific issues, the structure of the scheme was unlikely to cause problems in itself. Non-physician Chief Registrars for example, did not feel that the training was orientated to issues that particularly affected physicians, who themselves, come from a range of different specialties and contexts. One non-physician Chief Registrar did get involved in physician activities, and there were two reasons for this. First, at least one of the Medical Registrars had been at a hospital before which had had a Chief Registrar, and therefore, there was an understanding about the 'medical' focus of the role. Second, the context of Medical Registrars in particular was pressing, and therefore this group might be considered most in need of support.

I think the trainees at an F1/2 level do have a peer group and I think the Registrars are the ones that are slightly more lost or at risk of being more lost and unsupported and of the specialties I feel that medicine is pushed hardest. Anaesthetics have a lovely department and I get that from I think from other people as well. And actually Surgeons although I think I've engaged with them less I think because they see their Consultants in theatre more than a med reg who might get left to do Ward rounds on their own.... the other big problem here is that people aren't coming here so there's lots of gaps so everyone is quite hard, hard pushed. (Chief Registrar).

Some specialties (such as rehabilitation and emergency medicine) were, it was claimed, more naturally inclined to look broadly across issues and/or involved a higher managerial content. Whilst this may be relevant, we did not specifically look at this aspect. Rather, our interest focused on how Chief Registrars from different specialties worked across the multiple specialties within their Trust. The 'specialty expansion' seemed to have dual effects. On the one hand, the new and different perspective that a non-physician could bring to discussions and issues elsewhere in the Trust was broadly welcomed.

Because [the Chief Registrar] works in [specialty X], they bring the [specialty X] perspective to the medics, and we give the medical perspective to the [specialty X]. (Consultant).

[The Chief Registrar] can look at things from a different angle, something that we don't see... I think it gives a fresh pair of eyes to many of the issues (Junior doctor).

Furthermore, the Chief Registrars' contrasting perspectives could enable new insights:

I have a bit more flexibility and time to do it so this whole idea that I'm neglecting them by doing their Chief Registrar stuff... - I'm an outsider. But it also means I can go to seniors as a slightly anonymous outsider... I can take the message as a group as opposed to some person saying 'I'm bring this message from the group' – they are putting their head on the line, whereas for me I'm not in that system. The medical seniors aren't going to be giving me a job (Chief Registrar).

However, this credibility associated with the role had to be balanced with their clinical responsibilities.

On the other hand, it could be claimed that Chief Registrars from other specialties would not understand the nuances. It is generally easier to communicate with one's own specialty (according to one Chief Registrar). Also, the timing of the Chief Registrar appointment (and the roles that it entailed) in a doctor's training programme meant that the Chief Registrar scheme was seen, by some, as more appealing to some specialties (according to a Chief Registrar), possibly due to the nature of rotations in training.

On balance, the activities which Chief Registrars undertook engaged a range of specialties and delivered numerous benefits to them. Specialty difference seemed to matter less than expected and the credibility of the role more than expected. It was, therefore, instructive to note that one respondent suggested that *"nobody was concerned about"* the difference in the Chief Registrar's specialty (Medical director). Moreover, a senior doctor in another case-study explained the value of moving beyond one's own specialty:

One of the most - [the Chief Registrar] will tell you but learning about the whole business, the whole spectrum of what goes on outside your world, is one of the most rewarding things and leads to the most growth of you as a person, to realise what's different and what's important for other people (Director of Medical Education).

5.2.3. Organisational setting

The selection of case-studies in this evaluation was on the basis of a maximum variety sample. This mean that the organisations we studied were diverse in scale and service provision. It followed, therefore, that the Chief Registrar roles were equally varied.

Two of the case-studies operated over multiple sites, making communication (especially a visible presence) much harder than single site organisations. For example, one senior stakeholders described the adaptations that the Trust made to accommodate the Chief Registrar:

..one is because we have just one big building and [other] buildings over the county... so there was something about how [the Chief Registrar] does that and how do we support [the Chief Registrar] do that across the whole footprint? (Medical Director).

Another respondent in this Trust thought that *"there are definitely some drawbacks about having to travel around"* (Director of Medical Education).

Though applicable especially to multi-site, dispersed organisations, communication problems were prevalent among all Chief Registrars. The use of electronic communication (such as WhatsApp) was commonplace.

[The Chief Registrar] has had to collect mobile phone numbers, set up WhatsApp groups and things, that's actually because the juniors often don't look at their Trust emails. So, it's just having an easier way to communicate (Medical Director).

New technological developments are likely to over-take these sort of arrangements in future.

The size of staffing in the case-study organisations also shaped the context in which Chief Registrars sought to engage junior doctors and to undertake QI projects. For one, a community-based Trust, the pool of available doctors was about 30.

...because we don't have a massive pool of trainees to pull from... it's quite difficult for me to ask them to make sacrifices and say 'can you please take some time out of the [training] programme to be a Chief Registrar] because it's a really good thing to do (Medical Director).

By comparison, a large acute Trust might have a pool of several hundred doctors with whom to engage. Even an acute Trust might be faced with a relatively small cohort of junior doctors and (in consequence) a 'tight' rota especially given staff shortages (according to a Junior Doctor). Furthermore, smaller Trusts were more reliant on Chief Registrars given the lack of clinical cover. Such factors led on respondent in the community-based Trust to conclude that:

And so I think when you look at the situation nationally, I think it seems to have fitted in better in acute Trusts or Trusts which have general hospitals and acute teaching hospitals (Director of Medical Education).

The Trust with two Chief Registrars was a very large Trust. The Chief Registrars had different patterns of days for Chief Registrar time. They met together at the beginning of their appointments to agree which areas they were going to concentrate on, and maintained regular contact. They both went to the formal and informal Junior Doctors' Fora.

so when we were both on Chief Reg days we'd generally go to one of the offices and work together on the projects that we were working otherwise you end up duplicating stuff or stuff gets missed and you assume that one person's doing it and they're not, so we've had to keep an eye on who's doing what and coordinate our approach (Chief Registrar)

Finally, the presence of a Chief Registrar previously in one Trust seemed to be a decisive factor in ensuring that the 'second' Chief Registrar was able to settle in quickly, drawing on the legitimacy and visibility generated by the previous incumbent.

5.3. Medical engagement

One of the primary activities of the 2016/7 RCP Chief Registrar cohort had been engagement with junior doctors, in the light of the 2016 junior doctor strike. The 2017 evaluation found that engagement was a dual process, involving Chief Registrars' engagement with junior doctors and senior (medical) staff. Chief Registrars thus had a liaison or bridge role. Medical engagement

remained a key task for the Wessex cohort of Chief Registrars but was also supplemented by a growing concern with nature and quality of communication with junior doctors in Trusts.

The Chief Registrars' 'bridge' role remained a crucial link. The link seemed to operate in a number of ways and at a number of levels. For example:

[The Chief Registrar is] our link as a consultant body to the registrars because we don't meet all the regs. We only see them when they come on-call or a specialty base... [The Chief Registrar] is a good focal point... It's a two-way process and [the Chief Registrar] is the link to the juniors (Consultant).

One danger is that too much emphasis is placed on the Chief Registrar as the 'only' link which could be lost when the post-holder moves on. The issue of sustainability is explored later in the report. Yet, others argued that the role of the Chief Registrar could not be under-stated:

This is a really good Trust I'd say and you might think that I would say that but the people at the top of this Trust are bothered and they do value Junior Doctors... so seeing then the Chief Registrars point of view, it's perfect timing from our point of view to have this role (Director of Medical Education).

Chief Registrar engagement with the junior doctor workforce took many forms, which had been clearly shaped in the aftermath of the junior doctors' strike. Whilst the individuals were seen as transient, their posts were permanent, a distinction that had implications in specific cases (see below). At one level, Chief Registrar saw themselves as "advocates" for junior doctors (according to one Chief Registrar), including for issues which might be seen as minor, but where there is limited focus in the organisation for their being addressed.

So I think that doctors are neglected as temporary staff and the systems aren't adapted to that rotational nature, so [for example] you can't have a locker because not even all the permanent people have lockers..... it's kind of a bit unfair, there's isn't always me but there's always someone in my slot which makes it a permanent slot, for example. (Chief Registrar)

At another level, Chief Registrars were instrumental in creating, supporting and/or developing the structures of engagement such as fora or committees either mandated by the junior doctor contract or as a Trust initiative (according to one Chief Registrar). In some cases, the organisational structures reflected the interests of junior doctors. For example, in one Trust, an advisory committee was oriented towards this group (according to a Chief Registrar). Elsewhere, Chief Registrars were closely involved in junior doctor induction programmes (as indicated by one Chief Registrar). Another example was the meetings organised by the Chief Registrar to aid the engagement of medical registrars with senior (medical) staff (as cited by Chief Registrar). In others, the Chief Registrar was the "conduit" for engagement between junior doctors and consultants (according to a Consultant and a Chief Registrar in different cases-studies). Whilst Chief Registrars saw this role as essentially theirs, they also recognised that this could become a 'tick box' exercise. Probably with the contract dispute in the foreground, engagement structures have developed various strands including consideration of

issues such as work-life balance and well-being (as one Chief Registrar claimed); their issues had been raised with the Medical Director and Director of Medical Education.

Structures for engagement included informal opportunities to meet. Junior Doctors' Fora, for example, were supported by more informal meetings. One Chief Registrar set up monthly breakfasts where a free breakfast was provided with an opportunity to network. This was not engagement in the vertical sense of a 'bridge'. It was just an opportunity to meet with colleagues, and the information exchanged often related to simple issues of organisational life.

We just did the breakfast for the first time and there was someone that showed me an App that I'd never seen before which means they can get all the hospital extension numbers on their phone (Chief Registrar).

Although the dominant focus of engagement of Chief Registrars was with junior doctor workforce, Chief Registrars valued the relationship with senior staff for the benefits that dedicated time, supervision and mentorship that they enjoyed. Specifically, the title 'Chief Registrar' gave them credibility with senior management (according to a Medical Director). Regular (usually monthly) meetings with the Medical Director or shadowing senior staff was, Chief Registrars reported, enormously helpful from a personal development perspective as well as enabling them to fulfil their role. This effect was magnified when the Chief Registrar had prior limited leadership experience.

I spent the whole day with the Chief Exec. I spent the whole day with the chief medical officer. I'd never met the chief exec before (Chief Registrar).

I never had a full linkage with the medical director before... It's been really interesting and I've shadowed [Medical Director] a couple of times and it's been really insightful and by doing that, I've actually had meetings with the CEO and other directors... High level meetings are actually really interesting and they give you a completely different view on how the NHS works and you realise [that] if it's clunky down below, it's much clunkier up above (Chief Registrar).

5.4. Quality Improvement

In this and the previous evaluation, QI has often been a significant component of Chief Registrars' remit. Whilst there is some merit to this (such as in fostering the adoption and implementation of these tools and techniques), there is also a danger that the Chief Registrar role becomes defined (only) by QI. Certainly, the prominence of QI in health-care organisations make it a pressing issue for many. However, it may distract from longer-term and/or more impactful activities.

On the one hand, some Chief Registrars and their role set felt that the Chief Registrar role should be more than QI.

So I think one of the things we have discussed is how you use one with the other. So it hasn't just, by no means has [the Chief Registrar] spent time just on the QI project and [the Chief Registrar] has been quite clever I think in bringing other things in and using them (Medical Director).

On the other hand, some respondents felt that QI should be the focal point of the Chief Registrar's role. In one case-study, the decision for such a focus was taken prior to the Chief Registrar appointment.

... the decision we made last year with my predecessor... was that we would, given that the role was about – the Chief Registrar's role was about looking at QI and quality improvement within the trainees and also promoting it within the entire medical workforce. (Director of Medical Education)

However, QI activity should ideally complement and enhance other activities (such as medical engagement). Indeed, this was evident in several instances across a spectrum of approaches. The minimal approach was evident in the following quote:

And I thought I was going to come in to the Chief Registrar post saying 'I've done quality improvement so now I want to support other people to do quality improvement because I think it's a really good way of doing things' then quality improvement was one of a list of four things on their [the Trust's] agenda and interestingly it's probably been the one I've done the least of (Chief Registrar).

A maximal approach was evident in the QI support which the Chief Registrar tried to establish:

And then one thing that I wanted to do but it didn't really end up flying was a Quality Improvement framework for the junior doctors (Chief Registrar).

Each case-study was adopting a different approach, reflecting their capacity, resources and traditional approaches. Yet, the challenge of this dual task of QI and engagement was apparent, as well its implementation:

Historically, our junior doctors have been, yeah, very engaged because of their audit and everything... but actually a key thing is how we get them engaged in more than just they're wanting to tick their box? (Medical Director).

We were very much more interested in harnessing our juniors to get them involved in quality improvement because no other mechanisms were engaging trainees (Medical Director).

As well as leading QI projects and developing a framework for others, there were opportunities to engage in wider projects, bringing leadership and followership to initiatives. In one initiative, for example, to have regular 'Board rounds', medical input was difficult to secure because of commitments elsewhere. A suggestion was to introduce a laminated document at the bedside that staff and patients could use to communicate up to date information, specifically about preparing for discharge.

So, I decide to try...[to]introduce this patient passport as a means of gathering the data needed for the [board] round, so that could then be used as the senior clinician input at the board round and improve communication with the patient. And then, give them the opportunity to have real-time feedback about the quality of their stay, whether there were any issues they could perceive that would delay their discharge or stop them going home or anything they felt could help them to get home. ...So, that was implemented a couple of weeks ago, it's a bit of a challenge to get it embedded in the culture of the ward rounds (Chief Registrar).

5.5. Chief Registrar projects

The work of Chief Registrars tended to focus on a limited number of discrete projects during their post. These projects were mainly hands-on activities rather than the coordination and facilitations of medical engagement which we discussed in the previous section. Chief Registrars liked the operational detail and clinical focus which projects gave them.

Basically, my projects - I was going to aim to do projects that were generated locally, as it were, as I didn't really want to come in with big ideas (Chief Registrar).

However, the projects also generated issues which needed to be balanced against the feasibility and logistical necessity of one person, working about 40% for one year (with limited support). For one Chief Registrar, these constraints shaped their approach:

So at the beginning of the year, we came up – well, I came up with three projects I wanted to do and I tried to be as realistic as possible knowing that 40% is not a lot of time (Chief Registrar).

The balance by which Chief Registrars and their role was undertaken and largely achieved can be considered in two ways. First, Chief Registrars, in conjunction with their supervisor and mentors, had a reasonably high degree of autonomy in 'choosing' projects with which to become involved. However, such autonomy needed to be balanced with an increasingly structured approach to aspects of the Chief Registrars' work. For example, whilst many Chief Registrars were actively involved in QI initiatives, Trusts had on-going programmes for QI including training, implementation and action. One year posts for Chief Registrars did not always allow them to be able to become fully integrated into QI activities or complete a cycle of implementation, for example. Yet, some projects did contribute to the personal development of the Chief Registrar, in acquiring new skills and competencies.

None of the things that I started from the beginning were things that I would have thought of to do naturally. They're very outside of what I initially thought I would end up doing (Chief Registrar).

So I do have autonomy and I find myself seeking permission at times and there was a key moment when I told myself 'actually until I get asked to step back, I haven't probably pushed far enough' (Chief Registrar).

Clearly, Trusts which had had a Chief Registrar previously, did not necessarily imply a hand-over of specific tasks or projects to the incoming Chief Registrar.

Second, there was a danger that Chief Registrars could become heavily involved in operational issues. For example, whilst rota development and implementation remains a crucial issue, some Chief Registrars were careful not to become too closely involved. Although some did, others felt that it was more appropriate to provide leadership and oversight to the process. The following quotes illustrate the contrasting experiences.

There are a lot of logistical issues. So there's been a lot of rota problems which I specifically distance myself from... I don't see it as my role because there is a rota structure in place. I'm not a medic so I don't work that rota which is a slightly other issue (Chief Registrar).

So what happened with the Medical Registrars is that they had an issue with their rota so I tee'd it up for a meeting with the appropriate people. I went along to that because I decided in that situation, it would be good to have someone to chair it and make sure no-one kills each other (Chief Registrar).

So we initially tried to implement a rota... [to aid patient discharge]. But there was a fair amount of resistance within the department from a couple of people who quite vocally resisted (Chief Registrar).

Projects, particularly perhaps projects in the area of staff well-being required a good deal of time and effort to engage with others in the Trust, outside the medical workforce. This process provided learning opportunities, as it brought the Chief Registrars into contact with parts of the organisation that they had not experienced before. It also brought some realisation of the difficulties of engaging junior doctors in important issues that concerned them.

I went to this engagement group and I was the only junior doctor there ... the first session was 3 hours, no junior doctor's going to be allowed randomly off the ward for 3 hours, maybe 1 hour. And they had approached it by going round various different departments and asked people for feedback on what we could be doing better. And we've had, well I've been to two of those meetings now, they've had a third which I was unable to go to (Chief Registrar).

5.6. Enactment of the Chief Registrar role

We present some examples of Chief Registrars projects, not to demonstrate the merits (or otherwise) or particular activities *per se* but rather to illustrate the challenges and tensions that emerge in doing so. Together they illustrate some key themes of the posts; that they were mainly concerned with staff engagement and well-being, that they combined learning by doing and additional management and leadership capacity, and that they enhanced through informal leadership and activity the formal mechanisms of Trusts. However, some frustration was also evident because the roles required a lot of personal activity and administration, and required engagement with administrative functions in Trusts that might have been more responsive. Further, there are also many aspects of the issues beyond these accounts but these are the perspectives relating to the Chief Registrars and their role set. The examples are followed by extracts from Chief Registrar diaries, which support the final point of some frustration.

Example #1: Staff engagement and well-being - Junior Doctors' awards

Chief Registrars ran Junior Doctors' awards in two case-studies. Both had a very high impact and helped to raise the profile of the Chief Registrar role.

In the first case-study Trust, the response was positive:

One big thing that we did which was a bit of an ad hoc thing was to run an annual junior doctors award thing. We... sent an email out to all the consultants and all the junior doctors in the hospital saying 'these are the categories for [example] rising star, team player, leadership,

every little counts awards for the junior doctors within the department' and that got a massive response, a much greater response than anything else. And seeing [that was done] in the capacity of Chief Registrar, I think that has kind of cemented [the] role at the end of the year, which was really nice because we literally ran it over two weeks. We gave them a week to put the nominations in, finalise them and then presented them three days later. Got the Chief Operating Officer to come and deliver the awards, which was great, because it gave it authority... So I think that [it] significantly raised the profile of the role.

In the second case-study site, a similar awards day was managed by the Chief Registrar, combined with a poster display.

What I was trying to achieve was two-fold. One was the junior doctor awards, that they could be recognised, appreciated and given something in recognition of that. It opened up to, sort of, gratitude to everybody, even those not nominated, and then I also thought I would use the day to display to everyone else in the Trust some of the stuff that the junior doctors are doing. Because I think there is a low level of awareness about the junior doctors, who are all doing audits for quality improvement projects. ...And allowing them to share that information I felt really could be more useful to everybody, because you could see what other people are doing, link communication networks, share information, spread your information wider.

[W]e had lots of visitors through the day, looking at the posters. And a couple of the non Executive Directors, the CEO. The Medical Director came up... I was really pleased that the award nominations did include representation from most specialties. So, yes, I just felt that it was a fantastic day. It was really nice to have done it.

Example #2: Learning from Excellence

'Learning from Excellence' was taken up by at least two Registrars. This title refers to the scheme developed in Birmingham, and it has other 'brands' in different Trusts.

So the idea is that anyone can recognise it and say 'oh that was great' and write it down and there's four questions, essentially, it's who's nominated, what area do they work in, what did they do that was excellent and .../ what was it about this that was excellent. But it's about trying to delve a little bit deeper.... And then the idea is that the person gets it, they're acknowledged for it, they can learn and reflect from it, the line manager gets it and can appreciate them as well, so there's a small set of learning. But the big idea is the fact that they can look at them all as a group and therefore say what is it that works well in our division, let's delve a bit deeper.

In this case, the scheme had been set up before the Chief Registrar arrived. The role that the Chief Registrar was able to bring was promoting the scheme to clinical departments, and acting as a role model.

I went into (department) and said 'can I run an appreciative enquiry session in theatres' and they said it was absolutely fine, I've had no training in this, apart from reading around and I wouldn't say it's top of my skillset actually facilitating. I'm an organiser. I'm not so much of a facilitator or presenter, but I took a load of them and I chatted to staff, on the ground staff, they sent in three or four, because (the department was) still running, so you're getting a few people and we sort of ran it three times, half an hour each time with different groups, kind of coffee in hand, and chatted through 'here's a few of them, what is it that you see coming out from them' we need to get more people with more training to try and be drawing out what we can from these.

The success of the scheme in individual departments seemed to depend on the support of the manager, and having champions using the scheme. This championing activity, crucial though it is, competed with other priorities. It is not 'formal' leadership in the same way as attending meetings or communicating in writing.

it may well fall off my list of priorities with other things but I had wondered if to just give myself a couple of half a days maybe sitting in the surgical coffee room in the surgical ward and one sitting in the theatres coffee room and just maybe over a lunchbreak, sort of, as people come in say 'do you know about [the scheme]'

Experience of using the scheme also led to awareness of difficulties in the details of the reporting process.

Example #3: Learning by doing - Hospital at Night

The Chief Registrar in this case-study Trust helped to develop and implement a 'hospital at night' scheme in a short space of time which has already started to deliver positive results. The process of learning 'how' to design and implement schemes such as this was also a practical lesson.

So what Hospital at Night does and what it does elsewhere is it brings all the night people together as one team led by a coordinator who filters all their bleeps essentially and so they can get on with their work. So we set about kind of doing that, so I spoke to... my supervisor, and she had it on her radar as well and I had it on my radar, so then we sort of said 'look, let's just do it', so we put a team together with the people who we thought would be useful and just built it from there and I went to a Hospital at Night, ..conference ..to gather

some information and what we really feel is that you need a permanent staff member as the lead for it, i.e., not me.

So through that they've nominated a lead for out of hours care is what they're called a consultant lead who now I sort of work alongside with on that project. And it started on 1st March – So I think that's because – and this is something that I've noticed – is the consultant who .. I'd nominated to be the lead, he very – he just does things, you know, he's very good at just getting things done... And I've tried to pay attention to that because I want to learn how to do it! ..So I think having that character in charge of the whole thing was what it needed...I think that points to sort of how you get things achieved and implemented as a leader, it's not always you doing it, it's working through and with other people, yeah.

So we did get it up very quickly but we quickly decided to start it in essentially quite a skeleton form just so we had something that you could then build on... We have done quite well in that space of time and there's loads that could make it better and it will continue and it will need to improve, but [the junior doctors] are ...so appreciative of it, because .. there was something like a 75% reduction in number of bleeps the medical F1 got overnight, so all that time they were spending answering a bleep they're now spending with patients doing their work and they just love it.

Example #4: Enhancing the role of Contract Junior Doctors' Fora

In three of the case-study sites, a key element of the Chief Registrars' role relates to the Junior Doctors' Fora, that were set up after the Contract dispute in 2016. In two cases, in addition to the formal forum, there is an informal one. In one Trust, the Chief Registrar chaired the formal meeting.

In one case-study Trust,

“[w]e were fortunate the Junior Doctor Forum was already in existence when we started, so we've really championed that as the Chief Registrars coordinating the meetings, making sure that the right people are there in terms of the Director of Medical Education, the Guardian for Safe Working, representatives from HR. It's usually an opportunity for celebrating and promoting good practice. So, junior doctor awards that people have voted for are distributed during those sessions, and if there are any particular updates, for instance, more recently there was a change in the distribution of study leave and questions around what would be appropriate use of the study budget.

In another Trust, the personal responsibility for organising meetings took an unlikely turn, which illustrates how personally involved the Chief Registrar was in the meeting :

"I had the food ordered, I'd emailed everyone and told them it was happening and as I went to walk out the hospital on Monday morning via the canteen, which is where the doctors' mess was, which is where the meeting happens, the whole area was sectioned off because of sewage leaks so there was like a public health warning and barriers and they wouldn't allow us access for the meeting room. So as you can imagine, in my post-night shift brain state on Monday morning that was not a problem I was well prepared to deal with. So I went to find my boss ... [and] we spoke through the other options with, trying to find an alternative meeting room, which proved impossible at the last minute. We looked through everything that was available and the rooms were either too small for the capacity or they wouldn't allow us to bring the catering which I'd always get for the meeting. So in the end we cancelled the meeting and I emailed everyone to let them know that it was cancelled, which I didn't feel particularly good about because it has been a very regular meeting, it has been very well attended, I think people like coming to the meeting so it was quite disappointing to have to cancel it."

Example #5: Operational frustrations - bleeps

In this case-study Trust, there had been a problem with bleeps for some time, because there were not enough of them. The Chief Registrar recounts the challenges of resolving a seemingly straightforward operational issue.

They knew they needed more bleeps, they said they were getting more bleeps. It was going to happen in December, then it was going to happen in January and then I went up to a meeting and [the relevant manager] said 'oh look, all the bleeps are here' and there was this big pile of boxes and this was at the beginning of April. And he said we are going to roll them out at the end of April. And I said 'you have them there while I am missing bleeps every shift, why are we not rolling them out before?'

And I think that was actually a safety concern. But this is where I don't have the power to say 'you can't possibly do that' but also don't have the seniority to decide myself whether it's reasonable to push it or not push it. So what I did was come back to [two senior doctors] ... and I know them, they understand on the ground problems and the urgency of actually having bleeps. And I said to them 'are you aware the bleeps are physically here, but they're still intending to roll them out in a month's time?' Because I thought if they were aware, they do have the seniority to say 'I understand all the issues and I appreciate that it is going to take a while'. [We had an] e-mail Saying 'we need to test them in a controlled environment.... they all need to be tested', but ... he's not clinical I ... don't think he appreciates, he said 'oh you've all been managing for 6 months'. .. But there are the occasional times when actually that would be a disaster and if he's not clinical he thinks 'oh, you're managing to get hold of each other eventually, so that's fine' without realising that actually there could be an airway issue. They came out at the end of May. But at least it wasn't me that went home lying awake at night.

In interviews and diary entries, there was a consistent pattern in which Chief Registrars' autonomous activity (which they valued) entailed some disconnection from the organisation's structures and support activities. So, for example, organising activities often meant sending out emails, arranging rooms and catering, liaising with colleagues to ensure adequate attendance, discovering which departments and managerial colleagues needed to be involved, negotiating for minor changes, walking around seeking opportunities for discussion, waiting for meetings to progress discussion, all part of the minutiae of the activities of management and leadership. These activities took up a lot of time in roles that had limited capacity. These issues are reflected in these diary excerpts:

So, today I feel slightly like I have rushed around all day. But, thinking about it, I was thinking I don't really know what I've done. But actually, what I've done is manage to spend the day speaking to a representative from each department in plastics, orthopaedics, paediatrics, medicine and general surgery, with a view to trying to encourage junior doctors to display their posters next week at the junior doctor celebration event.

I've been struggling a little bit with a couple of processes... I was just trying to sort something out that was relatively simple, could do it basically on my own without any help, and just needed a few bits from certain people. So, I ordered what I needed, gave the relevant things to the people I needed to get a completion from, and thought very little of it. Then someone stepped up, who thought I needed to get their permission and they wanted to ask more about it, get more details, which I shared.. they wanted input into costs, numbers, choices. And then it just added delays, because they wanted this information. They suggested that they wanted a say. They were – you know, there's delays just in the communication, which often is done by email because we're not seeing each other face to face. And they maybe asking other people for input.

I've generally been the glue for the meetings if that makes sense. So I've sent reminder messages out and I've offered to buy people coffee and sort of taken orders if you like, so you know, who wants what, and that initially was helping to make sure that everyone turned up. But now I think when I don't do that people do forget because they're busy and it does sort of pass them, slip their minds and pass them by, and then it doesn't really end up being as valuable because it's not very well attended. I don't think that means people don't want to go or they don't find it useful, I think that's just a reflection of how busy people are

These five examples and diary entries illustrate some key themes of how the roles were enacted.

5.7. The impact of Chief Registrars

A major evaluative challenge of this (and similar) studies is the counter-factual; that is, understanding what would have happened if the Chief Registrars were not in place, as noted by several respondents (according to the Chief Registrar and Director of Medical Education in one case-study). Added value was, however, evident.

So I think that it is a really good Trust and this has added to that, you know. The Chief Registrar programme has just added to a situation which was already quite good and has made it better now as well (Director of Medical Education).

Many of the specific projects and task related to the Chief Registrar post had yet to reach fulfilment or fruition, so again evaluation on this point was premature. No cost-benefit analysis was undertaken (as one Chief Registrar claimed). While we do have plenty of examples of organisations without a Chief Registrar, it is hard to trace the pathways by which the intervention influenced the observed outcomes. Such outcomes may be seen in a myriad of ways and often over extended periods of time.

That said, there are some logical arguments which do point to positive outcomes of Wessex Chief Registrar. Some of these were similar to those in the cohort of national Chief Registrars (Exworthy and Snelling, 2017) but some were more nuanced and others reflected the evolution of these medical leaders. For example, several respondents spoke of the faster sense of change that Chief Registrars wrought. Medical engagement or establishing (QI) projects were, it was claimed, quicker as a result of the facilitative effect of Chief Registrars upon those involved. This indicates that respondents were using an (implicit) 'theory of change' model which foresaw positive impacts. Only a few comments were made relating to the negative impacts of Chief Registrar; however, the sample was biased as they were more likely to be in favour of this role anyway.

The impacts of the Chief Registrar role needs to be understood in the context of the aims and expectations that stakeholders had beforehand. In some case, for example, this seems to have been minimal. The aims seems to have been mostly implicit.

I don't think anyone was expecting Chief Registrars to come across massive, massive changes (Chief Registrar).

The proximal, measurable impacts of specific projects or functions attracted more attention than more intractable issues (according to a Chief Registrar and Clinical Director in different case-studies). For example, one Medical Director spoke of the observable improvement in morale among junior doctors in one hospital site where the Chief Registrar worked.

I can see quite a difference in morale and sort of general feedback compared to [other hospital site] and I do think that the Chief Registrar has enabled that (Medical Director).

In another example, the influence of the Chief Registrar upon senior management was apparent from one senior clinician:

I think they'd [senior management] would see [the Chief Registrar] influencing management (Senior doctor).

Such improvements were not always apparent, however, as one Chief Registrar explained.

If I were to talk about the softer options... actually if I improve the morale of people working in the wards, are those people we are more likely to retain and people are more likely to work full-time or a higher percentage rather than dropping down... If I can save one doctor out of 50 for giving up and leaving the profession. That would be millions and millions or if you upset us all for the next 10 years – but I'm not going to be able to calculate that (Chief Registrar).

The growth in personal development and leadership competency of Chief Registrars themselves was often cited. Though such changes are hard to measure in the short term, statements from respondents are corroborative. For example:

I feel [the Chief Registrar] grew and grew up and out a lot here (Medical Director).

And I guess, as [the Chief Registrar] develops and [the Chief Registrar] becomes more familiar with [him/her self] shall we say, [their] leadership would then change. And I can see it changing anyway with the things [the Chief Registrar's] introducing (Clinician).

Such growth did entail moving “out of [the Chief Registrar's] comfort zone” (Medical director).

Related to this individual growth was the collective benefit of Chief Registrars working across organisation. The formation of well-being day for doctors was the result of such collaboration, and though it lay outside the specific remit of Trust-based Chief Registrars, it showed the added value of a dedicated resource to focus on (in this case) well-being and morale of the medical workforce.

5.8. Sustainability of the Chief Registrar programme and its impacts

A specific challenge of the Chief Registrar role and their role set has been its sustainability in terms of the post itself but also the benefits that it has generated. It may be problematic to ensure the continuity of the impacts and outcomes that the Chief Registrar, as a one year post, had managed to create.

Although many Chief Registrar posts have been replaced for 2018-19, funding has inevitably been an issue. Despite a widespread keenness for the concept of Chief Registrars, some respondents noted that there was a dearth of suitable individuals.

We just do not have a suitable candidate in the Trust to do this [next year] (Medical Director).

Given this situation, Chief Registrars were (even more) keen to ensure that ‘their’ projects were completed and the impacts were delivered by the end of their post.

So the fact that there is no-one to take over what I'm doing puts me into the position where I need to make absolutely sure that my initial plans of any project that I do should get incorporated into the current fabric of current practice (Chief Registrar).

One year posts did hamper somewhat the opportunity to establish lasting, sustainable mechanisms. As we found in our previous report, the one year posts were a 'learning curve' involving three or four phases. Some found the lack of clarity in their role "a bit disorienting" (according to one Chief Registrar) but this period usually lasted about a quarter to a third of the year. For another Chief Registrar, the initial period was harder:

For the first two or three months, I was bogged down with the stress that we have to come up with a really good project and make this worthwhile (Chief Registrar).

The Chief Registrar in a Trust which had hosted a Chief Registrar previously found that they "settled into it quite quickly, certainly compared to a lot of my colleagues." Thereafter, the pattern and flow of work assumed familiar patterns as one Chief Registrar explained:

I came into my job thinking I want to understand the problem. I am going to spend the first few months trying to understand what's going on. And then the next window of time is about making changes and now I'm in the kind of last third of trying to make things sustainable (Chief Registrar).

For such reasons, some respondents suggested that an induction of 4-6 months before taking up the post might be required. An alternative would be a two year appointment (although there was very limited support for this).

If we are going to continue with the one year model, there isn't much room for a ramp up period, so it would be really helpful to have perhaps a four to six month period prior to the actual onset of [the post] (Medical Director).

My advice is that once you know you've been appointed, you need to actually start that straightaway. You become the Chief Registrar before you've even started your post effectively (Clinical Director).

To sustain the benefits of any individual activity or project, or even the Chief Registrar post itself, there needed to be a stronger integration of the role in organisational systems and processes. Generally, this was apparent all the case-studies. However, overall, the case-studies highlight a familiar tension between the autonomy of the Chief Registrar to determine the work programme for their post and the challenges that come from being more embedded within the organisational structure. One senior clinician recognised the benefit of better medical engagement through Chief Registrars but also noted that:

What the individuals.. make of it beyond that remit, which is a definite role now, they can make of it what they will but I certainly envisage that freedom reducing as that role becomes a bit more embedded [within the Trust] (Director of Medical Education).

Another senior stakeholder spoke of the need to embed the learning into the organisation, by avoiding the individual dimension of the post-holder. Whilst this would be difficult in one iteration of the Chief Registrar scheme, it does point to a recognition within the organisations of its sustainability.

How does this [the Chief Registrar scheme] outlive both of us [Medical Director and Chief Registrar] and carry on, with somebody who's really interested and who is in a position to have the time to do it? (Medical Director).

From the beginning, we made a decision to build sustainability into this... we really worked on making this [initiative not]dependent [on the Chief Registrar] and not even dependent [on the Chief Registrar role] ... It was more kind of a principles before personalities type of approach (Medical Director).

Clearly, there are some aspects of, say, QI programmes which can be made sustainable in relatively short periods but longer-term perspective seemed to be prevalent in many interviews. Indeed, some spoke of the value of the Chief Registrar scheme to the longer-term and wider application of medical leadership within NHS organisations.

I get a sense that now leadership and medical management are much more, I suppose, valued, for their own intrinsic value rather than as a stepping stone towards something that actually mattered (Medical Director).

The significance of such points were not lost on Chief Registrars themselves:

Well, you have to be everything, don't you? You have to be, at one end, a good manager and then at the other, a good clinician as well and everything in between (Chief Registrar).

6. Discussion and conclusions

6.1. Distinctive features of the Wessex Chief Registrar programme

There were three distinctive elements of the Wessex scheme, that it includes non-physicians, that there is a local cohort effect, and that there is a focus of staff well-being. These elements are discussed below.

First, the inclusion of non-physicians in the scheme seemed to be a natural extension of the Chief Registrar scheme that is managed by the Royal College of Physicians. Physician specialties are themselves a broad church. The job description for the 2018-19 cohort stated that applicants should be enrolled in a “medical specialty training programme that *ideally* includes internal medicine.” The guidance for the 2019 cohort has, as noted above, removed this and Chief Registrar posts in the Royal College of Physicians scheme can come from any specialty. The term “Chief Registrar” is not protected, and other schemes may emerge. We heard of some Trusts that have used the term without specific sessions, and in one of case-studies, a Clinical Director said that the Chief Registrar is

“our most senior trainee if you like, so regardless, would always be a Chief Registrar, if you like, within our department.”

As the Chief Registrars have a high degree of autonomy, the ‘Physician’ context seems of little formal relevance. However, the medical specialties, and particularly the acute medical organisation of hospitals, do have a high profile in terms of their centrality to the Trust’s operational priorities and problems, which were addressed in the Future Hospital Commission report. Through the sponsorship of the Royal College of Physicians, the scheme has grown threefold in three years, and will now be open to all specialties. In terms of the future

orientation of the post to medical specialty issues, we found that there were advantages and disadvantages of a non-physician Chief Registrar, but as the roles have had high autonomy, it is the person more than the role which is likely to be the decisive factor. In our sample for example, two Chief Registrars had previously done leadership Fellowships, and were able to bring their experiences into the Chief Registrar role.

Second, the Wessex scheme in 2017-18 had a clear local cohort context. There was step change in the number of Wessex Chief Registrars from 1 to 9. As with the issue of the non-physician Chief Registrars, the context of this distinctive feature has changed and the number of Chief Registrars has reduced to 6 in 2018-19. The Chief Registrars in this study felt that the Wessex cohort was useful. There were two WhatsApp groups, one for the national scheme and one for the Regional one. As one Chief Registrar explained, *“having that local support network has been really valuable”* especially as there was some similarity in the issues being addressed.

So we could update people as to what we were doing, if we had questions about particular issues that we came up against, so how would you deal with x, y or z then we could get a consensus or a selection of ideas of suggestions or even some people go ‘oh I’ve already had this problem, this is who I spoke to and it’s already been dealt with this way in this department.’

The planned quarterly meetings often ran into challenges of scheduling. Unlike the national training events, dates were not in diaries early, and where there was a date that was close to a national training event, there was a sense that the time lost to training was excessive.

The benefits of a regional scheme, in terms of changing the culture towards one where junior doctors were engaged and valued was recognised. However, there was some frustration that the numbers for the next year were lower than the previous one.

I think the Deanery were amazing for frontloading it and for funding it and for being so far ahead of the game and trying – and I just thought the culture is going to change so quickly because everyone is going to move from a hospital with a Chief Registrar to a hospital with a Chief Registrar (Chief Registrar).

Third, the focus on well-being did strike a chord with the Chief Registrars, and with organisations. One Director of Medical Education explained:

I’m absolutely clear that’s what we, as a Trust need, is clear engagement with the junior staff through the Chief Registrar... My feeling is that the NHS needs this and the Trust needs this.

This role for the Chief Registrar differentiates these posts from others, such as QI Fellowships, facilitates sharing of learning in specific issues and initiatives, and helps create some common structures in junior doctor welfare in Wessex (such as in the awards schemes). It also offers the Chief Registrars some profile with junior doctors, senior managers and other clinicians, which may encourage junior doctors to consider a Chief Registrar post in the future. The focus on well-being offers a clearer argument for the value of the post, as many of the projects that have been pursued by Chief Registrars simply were not being undertaken by others (such as the

junior doctors awards, and connecting junior doctors to evolving programmes of rewarding excellence). The regional conference was widely regarded as being successful. Engagement of junior doctors, at all grades, including through supporting specific well-being initiatives, seems to be a process that requires continuous effort, and credible medical leadership. Given the peripatetic nature of many junior doctor posts and the apparent lack of a clear leadership structure Chief Registrar activity in this area across the Deanery has significant potential.

6.2. Empirical contributions

This evaluation demonstrates the strength of the Chief Registrar model to enact medical leadership. The Wessex Chief Registrar programme in 2017-18 moved away from the original intentions of the RCP scheme although it was attached to the RCP programme. It did so in two ways, by being mainly although not exclusively concerned with staff well-being, and by appointing non-physician Chief Registrars. Therefore, the strength of the model was irrespective of specialty or organisational type.

Whilst the sample of respondents in this study had an inherent bias, our data is broadly supportive of the previous Chief Registrar evaluation. Chief Registrars were seen as legitimate medical leaders and appropriate arbiters between junior and senior doctors, and within and between specialties.

However, there do appear to be on-going challenges in the implementation and delivery of this model. In many respects, these are similar to those found in the 2017 study. Clarity of the role remains ill-defined, seeking a balance between (broadly) medical engagement and quality improvement. In addition, the Wessex scheme revealed a growing attention to junior doctor well-being. Whilst these foci are not mutually exclusive, they do challenge post-holders on the basis of two days per week (40% whole time equivalent). The autonomy, which many chief Registrars have tended to enjoy, may become constrained as their roles become more embedded within organisational structures and processes. Although this could make the posts less attractive to prospective Chief Registrars, it might also underline the legitimacy and support which the posts could (and in most cases, do) enjoy from senior echelons in the organisation.

However, the skills and competencies of these nascent medical leaders were in need of on-going development before and during their Chief Registrar posts. One such area of development would be the work on staff well-being. As few other actors are working in this space, the Chief Registrar plays an increasingly pivotal role as a dedicated individual, with some organisational legitimacy and access to resources (mainly influence and facilitation) to effect change in this area. Their role in promoting and encouraging discussion and action in this area is welcome but daunting. Yet, the challenge of Chief Registrars (and indeed their entire role set) will be to achieve significant cultural change in shifting long-held professional traditions, styles and customs (Noodegraaf *et al*, 2016).

6.3. Theoretical contributions

The theoretical frames (which we outlined earlier in this report) are useful to help interpret the study's findings. First, 'cultural complementarity' refers to the extent to which the 'work practice' of Chief Registrars in frontline medical leadership complements organizational routines and processes. (Noordegraaf *et al*, 2016). As nascent medical leaders, Chief Registrars needed to balance professional and managerial logics. This "inter-weaving" involved a sense of organising and of coping with organisational imperatives. They could not ignore wider pressures from (say) clinical teams, departments and care groups. However, Chief Registrars remained heavily dependent on the existing decision-making infrastructure within their organisation, especially among doctors. In this study, there were limited signs that Chief Registrars were moving beyond their model; for example, the appointment of non-physicians as Chief Registrars. Equally, some were involved in multi-disciplinary activities regarding QI (specific programs and training).

Second, 'constrained realities' is a parallel concept which refers to the norms and structures of organisations which constrain (and sometimes enable) the enactment of leadership (Martin and Waring, 2012). There is often a gap between leadership in practice (as often revealed in heroic accounts) and the day-to-day practice, as illustrated by "reactive administrative duties" and "frustration" (Martin and Waring, 2012, p.370). This conceptualization of leadership seemed to reflect somewhat the experiences of Chief Registrars in this study. As medical leaders in the 'middle' (as well as being nascent), Chief Registrars were having to enact more informal leadership 'downwards' to junior doctors. Though not universal, there was a frustration among Chief Registrars with aspects of leadership, management and administration processes. This included, for example, difficulties in arranging meetings, seeking permission to display posters, and inaction between monthly meetings. Chief Registrars were often working with the details of medical engagement (though less so with QI) and yet, in reality, only had about one day per week (20%) to do so. Limited logistical support hampered their efforts. Acting as a bridge or liaison, the Chief Registrar was sometimes poorly aligned with existing organisational structures and had limited support (from, say, an equivalent general manager). However, in some cases, we did identify areas where this alignment was much stronger and relationships had developed well. Therefore, with the further, on-going development of the Chief Registrar, there is a strong danger that the raising of expectations that issues such as staff well-being might be addressed by Chief Registrars (among other initiatives) may be dashed without broader cultural change in the medical profession and NHS organisations. In the longer-term, the role of the Chief Registrar might well prove a fruitful vehicle for this agenda. Currently the Chief Registrar role involves a high level of minutiae but without a clearer connection into the middle level machinery of the organisation (rather than liaison and engagement with senior staff), the longer-term agenda may be confounded. As the Chief Registrar role becomes more embedded, this danger might increase.

6.4. Key points from this evaluation

The Wessex Chief Registrar programme was a feasible and successful model.

Its strengths include:

- A model for non-physician medical leadership by senior trainees;
- A strong emphasis on medical engagement (downwards to junior doctors and upwards to senior staff), QI, and staff well-being;
- Developing complementarity between the medical profession and organisational leadership (though this was yet to be realised fully).

Its weaknesses include:

- A relative lack of integration into organisational decision-making;
- A frustration with a role which can become overly enmeshed in administrative matters.

6.5. Considerations for further action

- a. Chief Registrar engagement with senior staff needs to be balanced with enhanced operational management capacity;
- b. Clarity is needed in the degree of autonomy of the Chief Registrar role;
- c. Support should be provided for broadening the role of the Chief Registrar beyond physicians;
- d. Support on-going junior doctor engagement (especially regards their well-being). Junior doctor leadership programmes should be developed.
- e. Support the Chief Registrar role with management and administrative resources in the middle of the organisation.

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8. Appendix

Interview schedules

These were semi-structured qualitative interviews based on the following topic schedules:

Chief Registrar interviews examined:

1. Career pathway of Chief Registrars
2. Prior awareness of and training for (potential) leadership role
3. Opportunities and challenges of Chief Registrar role (time, skills etc)
4. Professional development opportunities of Chief Registrar
5. Relations with senior Trust staff
6. Role in supporting junior clinical staff
7. Achievement in the role (eg. links to patient experience)

Role set interviews examined:

1. Organisational culture which might support Chief Registrar
2. Wider impact upon Trust systems and processes including quality and patient safety
3. Business modelling to support Chief Registrar implementation
4. Impact on training of juniors and workforce transformation
5. Impact of local variations in contract
6. Relevance on Chief Registrar role to patient experience

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