IMWC -- Medical Leadership

Medical Leadership in the United Kingdom

Prepared by

Dr Charles Swainson
Medical Director, NHS Lothian
Edinburgh, Scotland.

UNITED KINGDOM -- Scotland

Policy Framework

Delivering health care through interprofessional teams is recognised in United Kingdom policy documents. For example, *Delivering for Health*, the current key policy document for the NHS in Scotland, describes development of the NHS as an "integrated service" which "will require multidisciplinary team working. We will require collaboration and co-ordination between professionals and across organizational boundaries -- in fact, a partnership approach at all levels to achieve continual improvement in quality and value for money."

Policy aims to support innovation and service redesign by providing the means to extend the roles of health care professionals. New frameworks for role development for AHP's and nurses have been developed across the UK and co-ordinated in the different countries. Emphasis is placed also on the active management of hospital admissions, to improve diagnostic and referral pathways, and to manage discharge and length of stay and also follow-up. None of this can be achieved without a multi-professional approach and partnership. This policy context has given a new impetus to integrated workforce planning linked to pay modernisation, from which benefits need to flow to patients.

Training of Doctors

Modernising Medical Careers is a policy initiative to shorten the training of hospital specialists and to improve the training of general practitioners. The policy is aimed at bringing the UK closer to the European Community, and to replace the large numbers of doctors in training that provide the bulk of NHS services with doctors who are trained. The overall numbers of doctors in training is predicted to fall steadily, as the number of trained doctors increases in proportion. The implementation of this policy recognises also the contribution to be made by other healthcare professionals. It is well recognised that it would neither be cost effective, nor professionally satisfying, to simply replace doctors in training with fully trained specialists. There is therefore a further debate to occur across the UK about the shape of the future clinical workforce both inside and outside hospitals. This will play very strongly into the discussion about multidisciplinary teams and should lead to very different service delivery models over the lifetime of this policy implementation.

Involving Doctors

Improving the health of the population and the delivery and effectiveness of health, integrated with other care services, is dependent on the support and active engagement of doctors. A number of studies in United Kingdom and elsewhere have highlighted the positive link between effective clinical leadership and improved patient care. The current health reforms across the UK all require effective medical engagement to realise the benefits fully. The Kennedy report (2001) highlighted the need for all clinicians in management “to demonstrate the

managerial competence to undertake what is required in the role" and to undertake management and leadership training. To be a competent clinician in the 21st-century requires doctors to be able to manage themselves and their time, work within the team, understand when to lead and when to follow, and to be able to influence effectively by knowing how the system within which they work functions.

Some countries have a history of much greater medical engagement and leadership, where all senior health leaders are clinicians by background. Historically, this has not been the case in the UK and other approaches have been attempted to involve doctors in management. The 1998 Griffiths Report proposed the introduction of general management into the NHS in order to manage clinical professionals and the services they provide. Management control and fiscal responsibility was passed to a cadre of professional managers, who supplanted the previous administrators. NHS managers now have their own institutions, codes of conduct and standards, as exemplified by the Institute for Health Services Management. The notion of accountability has been developed strongly within the UK primarily in response to fiscal and target driven objectives. The language of accountability is now entering the clinical professional arena with the requirement that doctors and nurses can be held to account for their clinical performance and behaviour by their employer.

Doctors in Management

A conscious attempt to balance a rise of managerialism was provided by the development of clinical directors, or doctors in management. The 1991-92 NHS reforms provided for medical and nursing directors on NHS Trust Boards, and this principle has gradually been extended to reformed institutions across the NHS. Clinical directors were conceived as a means of bringing clinicians into the new management style and accepting shared corporate responsibility for clinical service performance and fiscal management. A number of institutions responded positively to the need for engagement with senior clinicians. The first of these was the King's Fund, a London-based charity that recognised the potential strengths of clinician involvement. The King's Fund rapidly developed a series of courses and distance learning modules to support the strategic development of medical leaders. Out of this environment was born the British Association of Medical Managers founded by a former public health consultant. This organisation has grown to be the predominant provider of development and training for doctors in management, and, by representing the interests of these doctors, has secured a strong advisory role. A number of other commercial organisations have since entered the market to provide for the education and training of doctors in management. This by itself demonstrates the strength of medical engagement across the UK.

Other countries, with similar managerial and leadership arrangements to the UK, e.g. Italy, France, Denmark, are embarking on similar strategies to engage clinicians. The Royal College of Physicians of London has recently published an

important contribution *Doctors in Society: Medical Professionalism in a Changing World* (2005). This document describes a set of values, behaviours and relationships that underpin the trust that the public have in doctors. It recommends strengthening leadership and managerial skills, better interprofessional education and training, developing other clinical leaders, and managing medical careers more effectively to transmit medical values.

The UK has now a strong culture of managerial leadership within the NHS that is unlikely to change. The managerial cadre recognises the importance of medical leadership and clinical engagement in achieving clinical outcomes as well as access and other targets. Senior managers recognise only too well the importance of engaging clinical leaders in controlling costs, and many would acknowledge that senior clinical leaders can propose more radical solutions and carry them out with support. Development of clinical leadership therefore needs to go hand-in-hand with non-clinical leadership. Senior clinical and managerial leaders are undertaking some joint activities including shadowing and mentoring, working in teams and joint development. Doctors are beginning to understand the importance of a corporate role and the accountability that goes with true leadership. Few doctors would opt out of a corporate position where it was evident to them that this was for the general good of the organisation, but this can be a difficult ethical tension for many. The majority of clinical leaders are part-time and have to continue to work with clinical colleagues and in multi-professional teams. An ability to defend an unpopular corporate position, or to drive unpopular reforms even when these are clearly in the best interests of patients, need strong support from other professional clinical leaders and from non-clinical leaders.

<u>Doctors in Teams</u>

The role of doctors within a team environment appears to depend on the context. In surgical specialties, the surgeon is regarded as the team leader or director, ensuring that the professional roles of others are directed towards a safe and successful outcome for the operational procedure to be performed. The style of this leadership role varies enormously from openness, collaboration and willingness to learn, through to complete autocracy and a climate of fear. Both may be equally successful in terms of short-term patient outcomes but carry different risk profiles.

Doctors often assume that they will be the leaders of the team, and other health professionals are often willing to defer to that view. Culturally, doctors are in this position because of their perceived high status, strong public support, high earnings, and years of study and accumulated knowledge. Many doctors expect and want to be leader of the team. Putting aside that mantle is not an easy or trivial decision, and will not always find favour with other members of the team. The Royal College of Physicians approach to medical professionalism tends to reinforce the role of doctors as leaders, but also supports the notion of followership within teams. Within some professional groups however, the idea of

doctors as team leaders is not acceptable, for example in community psychiatry or mental health teams. Other health professionals believe that they have a truly autonomous role, and therefore it is uncertain how the team is led or service development takes place in these circumstances. Clinical leaders from those professions are required to demonstrate effective leadership and contribution to the development of team objectives and team development.

Training and Development

The British Association of Medical Managers (BAMM) has led the drive for greater recognition of medical managers for the past decade and has developed a 3 stage leadership development programme (Fit to Lead). Development for majority of medical leaders has been remedial, episodic and individual. There is no employer driven continuous programme based on a competency model but this will change as the NHS Institute for Innovation and Improvement develops a scoping study and project to enhance engagement in medical leadership.

The effectiveness of team working to improve patient safety has not been formalised in the NHS but is partly evident in the way in which modern services work. This is particularly obvious in emergency services but is very widespread. Improved patient outcomes and reduced risks have been demonstrated for acute heart attack when multidisciplinary teams have redesigned acute care and abandoned a traditional medical model. Many services for patients with long-term conditions e.g. renal dialysis and transplantation, provided by multi-professional teams although often led by doctors, have demonstrated improved outcomes. However, the NHS does not have strong culture of quality improvement through measurement or the use of basic statistical methodology. The introduction of collaborative learning models and quality improvement by the Modernisation Agency in England from 1996-2005 represented a startling break with tradition. This programme was undoubtedly successful but patchy, and has failed to become embedded in the service. Quality improvement through basic methodology, the learning of “lean” or other quality improvement methodologies, that were well known through the general business or management literature has yet to catch on in the modern NHS. Improvements in patient safety are unlikely unless these methodologies are widely adopted, a position strongly endorsed by the Institute for Health Improvement, Boston and exemplified in their published work.

The Health Foundation, a London-based charity, has pioneered work in partnership with IHI and a number of NHS Trusts, including NHS boards in Scotland. IHI has led a major programme across the USA to reduce avoidable deaths and injury to hospital patients. This work utilises well-known business tools for quality improvement which depend on accurate and continuous measurement within clinical services. Some of the initial benefits appear to be quite dramatic in terms of reduced frequency of certain types of critical incidents affecting patients, and the challenge will be to find a process for making this more generalised across the NHS. The initial results demonstrate that the

introduction of quality methodologies is feasible within the NHS and acceptable to a wide range of clinicians.

There is a slow growth in the development of specialist roles within teams for nurses, operating department practitioners, anaesthetic practitioners and specialist therapists all undertaking roles previously undertaken only by doctors. The drive for this has been the changes in working time conditions for doctors in training (European Working Time Directive and New Deal), the requirement to improve access, and the slow growth of medical specialists within the UK (compared to other countries).
Medical professionalism embraces leadership and managerial skills. Doctors should create a national voice for medicine and act as national advocates for patients within the UK. Doctors' decisions have both clinical relevance for patients but also management consequences that they need to be aware of. Management skills may become gradually incorporated into fitness to practise requirements, a position supported by the medical profession and generally. Doctors bring specific skills from their training, their ability to conduct and implement research findings that benefit patients and services, and the advocacy role they can adopt in response to patient needs.

NHS staff survey results continue to support the importance of doctors as leaders within the NHS. Public opinion polls still place doctors at the top of people most trusted by the public, despite the high-profile inquiries and General Medical Council investigations reported very fully by the media. The British Medical Association remains a powerful negotiating force for doctors earnings and conditions; hospital consultants have a new contract which certainly places more emphasis on direction by the employer, but at the cost of a 23% average rise in pay. The new contract negotiated for general practitioners incorporates also measures to ensure that population is well treated and achieves high standards, but again at a nearly 30% increase in average earnings and no loss of independence. Doctors remain a very privileged group in that sense. There is little doubt that the generous treatment of doctors within the NHS has given rise to enviable comparisons with other staff groups with far less generous pay settlements. Doctors clearly have role in supporting the NHS as an organisation in return for the considerable benefits derived from employment.

A scoping study from the NHS Institute revealed widespread support for the development of a systematic and coherent approach to ensure that doctors acquire management and leadership skills at key stages in their training and careers. A leadership competency framework needs to be seen as part of a wider strategy where doctors are engaged more effectively in the planning delivery and transformation of services. This requires close working with medical professional and regulatory bodies as well as those representing employers, government and the independent sector. The NHS has commissioned a project to create a culture of greater medical engagement in management and

leadership. This will include identifying and disseminating examples of best practice of such engagement and developing an integrated competency framework, including education that can be agreed by all stakeholders. Clearer links with management and leadership development in other health professions are seen as essential. A number of reviews are in preparation including evidence for the links between medical engagement and service performance, and the role of doctors as managers and leaders within a pluralistic and integrated health and social care system.

NHS Scotland is now in the second year of a leadership development programme for the next generation of clinical leaders across all professions within the NHS. NHS boards were asked to identify 1-2 promising candidates and to ensure that they were given working development opportunities both during and after the programme. However the funding for this programme is time-limited and it is not yet clear how this effort will be continued. The Scottish Association of Medical Directors, together with senior nursing director colleagues, and emphasise the importance of developing coherent clinical leadership skills. They believe that potential leaders should be identified at ward or directorate level. The process of appraisal and development of personal development plans should lead to development opportunities, including managerial or administrative roles, secondment, project work and training. Careers should be planned so that there is a future pipeline of clinical leaders across the professions who can aspire and compete for Board level appointments as well as other leadership opportunities within the NHS, the medical Royal colleges and societies, the postgraduate, education sector, and other institutions that support the NHS.

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