ATHENA series 2

Creating a Fresh Approach to Healthcare Leadership in the NHS

A Discussion Document

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The Case for a Fresh Approach to Clinical Leadership

Clinical leadership is crucial in taking the NHS forward. The service is about to enter the most austere period in its 62-year history. Trusts and PCTs are likely to become caught up with the need to achieve financial stability in the coming years. The danger is that, despite the failings of numerous foundation trusts (Mid Staffordshire, Basildon & Thurrock, etc.). Trust managers will concentrate the bulk of their efforts on meeting stringent targets at the expense of quality. We believe that the route to securing financial balance in the long-term is through the relentless pursuit of clinical quality. There has never been a more compelling argument to promote clinical leadership. Emerging, there are two very good reasons why the medical component of clinical leadership will be increasingly critical to success in the modern NHS:

- Medical revalidation
- Improving quality and safety

However important the medical part of leadership might be, it will increasingly be important for healthcare organisations to shift their thinking towards a much wider model of clinical leadership, that includes nurses, allied health professionals, general managers, administrators, etc.
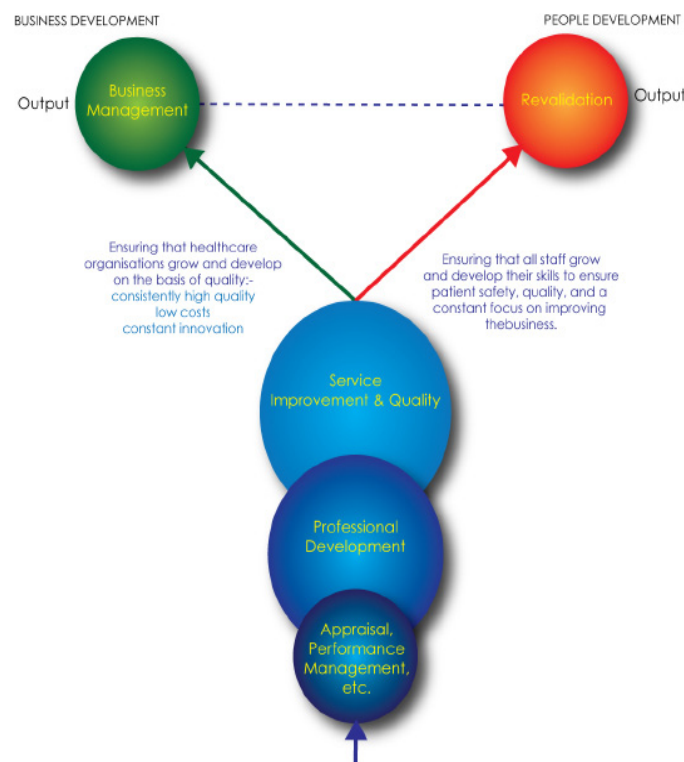

Fig 1: Focus energy onto what is needed for the organisation

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Our belief, quite simply, is that it would be a wasted opportunity to divorce quality improvement from professional regulation. Fig 1, above, shows how business improvement should become the primary focus of healthcare management and leadership. It is our opinion that the primary business activity of a healthcare organisation is the delivery of healthcare. Put simply, healthcare organisations are funded to provide clinical services. Leaders need to re-focus their energy onto activities that raise the bar and deliver better, more efficient, higher quality services. There is a wide evidence base from industry that the pursuit of quality can lead to better financial stability. Although this is known to NHS leaders, it has been sadly lacking in application across the country.

We discuss the two strands outlined above in greater detail in the following paragraphs. The reality is that one cannot be achieved without the other. To deliver effective professional regulation, we will need effective quality and business improvement mechanisms, as described, below.

Medical Revalidation

Starting in October 2010, the NHS in England, Wales and Northern Ireland will begin appointing Local Responsible Officers (LROs or ROs). In Scotland the role of the responsible officer will be specifically combined with that of the medical director on the basis that Scottish medical directors already have responsibility for issues that would be covered by the LRO (such as clinical governance). Subject to successful passage of the legislation through the Westminster Parliament, and the Northern Ireland Assembly – expected in June 2010 – effective from October 2010, all medical doctors practising in the UK will be required to relate to a single responsible officer. This LRO will be personally responsible for the conduct and performance of every doctor linked to them.

Although consultants working in NHS Trusts have always been 'employed' by the NHS, and since the 1990's have been professionally accountable to a medical director, there has been a strong sense in some quarters that they have clinical autonomy, and are somehow outside the traditional employment structure. This is, of course, false and in law they have always been bound by the same employment conventions as every other employee. The new regulations make it explicit that another doctor will be responsible for their conduct and performance.

In primary care in England, most GPs are independent contractors who

are commissioned by their PCT to deliver services, so there is no direct employer/employee relationship. However, they will still be required to relate to a responsible officer, probably working within the PCT and related to the performers list – and the RO will need to have particularly acute skills and acumen in dealing with this constituency.

It is likely that the majority of responsible officers will be medical directors. The guidance from the Department of Health in England, who have taken the lead on revalidation across the UK, is that responsible officers should be board level appointments. Whoever takes on the role, they will need sophisticated systems to provide them with the information they will need about every doctor linked to them. It is expected, therefore, that systems of appraisal, clinical governance and performance management will be put in place to provide responsible officers with the assurance they will need. Where problems are identified in relation to an individual doctor, the LRO will be expected to work with them to put things right as far as possible. In practice, this will probably mean that clinical directors will do most of this on behalf of the LRO, working with appropriate colleges and/or faculties. The LRO will make the necessary recommendations to the General Medical Council (GMC), through the Board of the responsible organisation, whether individuals should be revalidated each year. The GMC will make the final decision about revalidation, not the LRO, but their decision will more than likely be guided by the specific recommendations they receive from Trusts.

Most responsible officers will be medical directors of large and complex organisations. Even in relatively smaller NHS trusts, they may be responsible for dozens of consultants and specialty doctors (so-called SAS grades). In larger organisations, including teaching trusts, health boards (in Scotland, Wales and Northern Ireland), LROs may be responsible for many hundreds, even more than a thousand individuals. In many mental health and community Trusts, even where the numbers of doctors may be small, they are often spread out across large geographical areas. It will be an impossible task for LROs to form an accurate judgement about the conduct and performance of each doctor without support. This must come from effective governance and assurance systems, and from competent colleagues working within and managing them. The reality is that for the most part, LROs will need to delegate many of their day-to-day duties to colleagues within the organisation. Decisions about individuals will be at their most effective when they are made by colleagues who are 'expert' in the candidate's own specialty, and who work as lead clinicians, clinical directors, and the like. In a sense, therefore, clinical directors will need to become 'deputy' or 'associate' responsible officers, acting directly on behalf of LROs

in respect to their own colleagues. In many cases, this will mean new powers and responsibilities – extending their roles above and beyond those that they currently have.

Improving Quality and Safety

Quality is variable across the NHS. Despite successive government attempts to raise the bar, the NHS often defaults to chasing targets, which for the most part appear to be about finance and performance, rather than the actual quality of clinical services. It is, for example, more important for a clinical team to be seen to achieve success in terms of treating the patient within the Department of Health target of 18 weeks (referral to treatment time), than it is to ensure that they receive the best quality clinical care, appropriate to their condition.

Evidence suggests, however, that those organisations that focus their energies on finance and cost reduction strategies rather than improving quality actually see costs increase over time, whilst quality falls. Conversely, those that focus on improving quality see quality improve over time, while costs fall in the longer term (in fact, costs rise in the immediate, before stabilising and then reducing over time). This wisdom is well known to the NHS, and is actively promoted as part of the work of the NHS Institute for Innovation and Improvement, and taught on the NHS Management Training Programme. Despite this, it is the culture that the default setting for many NHS trusts seems to be to tackle targets first, and quality second.

This culture was heavily criticised in the recent Mid Staffordshire Inquiry, where it was demonstrated that senior NHS managers took their eyes off the ball and allowed clinical systems to deteriorate to such an extent that hundreds of patients were put in harm's way. In many cases, patients died.

The safety record in the NHS is poor. It is – arguably – no worse than other – comparable – health systems elsewhere in the world. However, it is still somewhat poor. Various studies have shown that somewhere in the order of 11% of NHS patients suffer serious harm as a result of clinical error (Vincent et al). Of this cohort, an estimated 8% of them die. And, it is thought that around half of these deaths could have been avoided.

This will never be put right as long as clinician leaders are torn between doing the 'right thing' by their patients, and doing the 'right thing managerially' by their employers. The vast majority of clinical errors are the

result of poorly performing systems; communication, team-working, leadership, over-stretched staff, misunderstanding instructions, etc. All could and should be solved through more effective clinical leadership. Innovation, improvement and safety need to form the core agenda for every clinical leader working in the NHS.

There is a real danger that revalidation will be seen simply as a box-ticking, jumping through hoops, regulatory thing. If it is perceived as nothing more than an attempt to identify and weed out poorly performing doctors, it will fail. The NHS needs to view revalidation as an opportunity to tackle the wider issues of patient safety and quality. For NHS organisations themselves, this is a chance to shift the focus away from finance and targets and back to the real business of healthcare – delivering high quality clinical services. For medical managers, it's a chance to step up to the plate and take on real challenges that could result in better NHS services for patients all over the country.

Medical Revalidation is just the start. It is expected that over time it will be extended to include other clinical professionals and even managers. Getting it right now, it could be argued, will save time and effort in the coming years, and will pay huge dividends to the service.

Getting the Structure Right

In the new world, after October 2010, NHS organisations will need to face up the fact that in order to deliver both revalidation and an improvement in quality, they will have to simultaneously focus on two broad themes – the 'business' of healthcare, and 'maintaining professionalism'. This is highlighted in Fig.2, below.
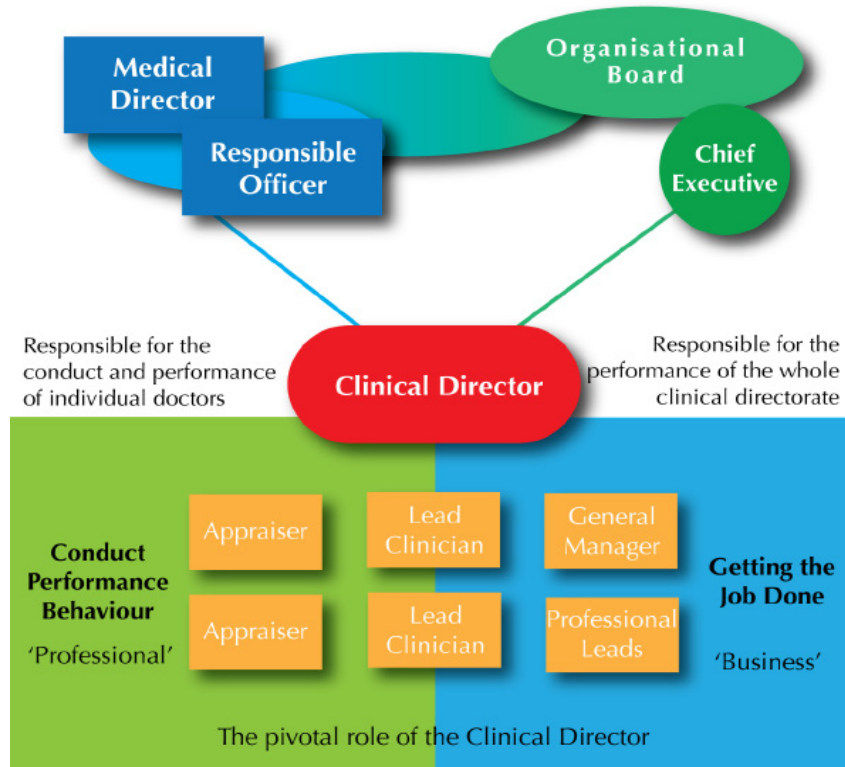

Fig.2: Two broad themes emerging in the new NHS

For most NHS managers, getting the job done is their primary concern – e.g. ensuring that patients receive the most appropriate clinical treatment, quickly and safely. However, there is huge pressure to achieve this within a set of tightly controlled national targets. In England, the Department of Health insists that referral to treatment time should be no more than 18 weeks, except in the case of suspected cancer, in which case the treatment must be much faster. NHS chief executives have a statutory duty to balance the books, so it is imperative that clinical services are delivered within tight financial budgets. This is only going to get harder as the UK economy goes into 'public sector recession'. Unfortunately, there is an acute danger that the targets take over and become the primary business of the organisation. So, a balance needs to be struck between the business side of the NHS and the clinical/professional side.

The vast majority of clinical care is delivered through clinical teams, comprising highly skilled clinical professionals who are required to use their training and experience to make informed judgements about the treatment and care to be delivered. There can be a conflict between desired clinical decisions, and required managerial ones – e.g. clinicians may not allowed to do what they think is right because of tight financial pressures on the organisation. Sitting at the interface between the business and professional components of the organisation is the clinical leader. In the diagram, above, we have depicted this as the clinical director (CD). In order to be effective in the new NHS world, CD's will need to have dual accountability:

- To the medical director/responsible officer for professional matters, including conduct and performance, for the delivery of revalidation;
- To the chief executive/director of operations for the delivery of a safe, effective and efficient clinical service, and for the improvement of the business.

Both accountabilities are as important as the other. Both need to have quality at their heart, because one cannot divorce service delivery and professional regulation from quality.

Fig 3: A Possible Triumvirate

We need to think about the leadership of clinical services in terms of a new partnership between clinicians (doctors, nurses, paramedics and other allied health professionals) and their general management and administrative colleagues. Fig 3, above, depicts a traditional triumvirate, which has in the past been based on a triangle where a doctor leader, general manager and another clinical leader (e.g. nursing) came together to provide a rounded approach to management and leadership. Our version depicts this relationship in terms of three overlapping circles, as

in a Venn diagram. It does not matter which of the three players takes the lead, or who holds the budget. What does matter is that they work together in partnership, putting quality centre stage, and that they allow each other to encroach onto each others' turf in an attempt to break down some of the traditional boundaries that have existed between professionals of all stripes, and have hindered the development of the service. Where all three circles overlap is where the quality and business improvement agendas sit. This partnership arrangement needs to be replicated at all management levels throughout the organisation, as is partly described in Fig 4, below.

Revalidation, as described above, is likely to be extended beyond the medical workforce, to encompass (over time) all clinical professionals and potentially even non-clinical staff. It would make sense, therefore to build good quality assurance and governance systems now that would serve for extended revalidation later.
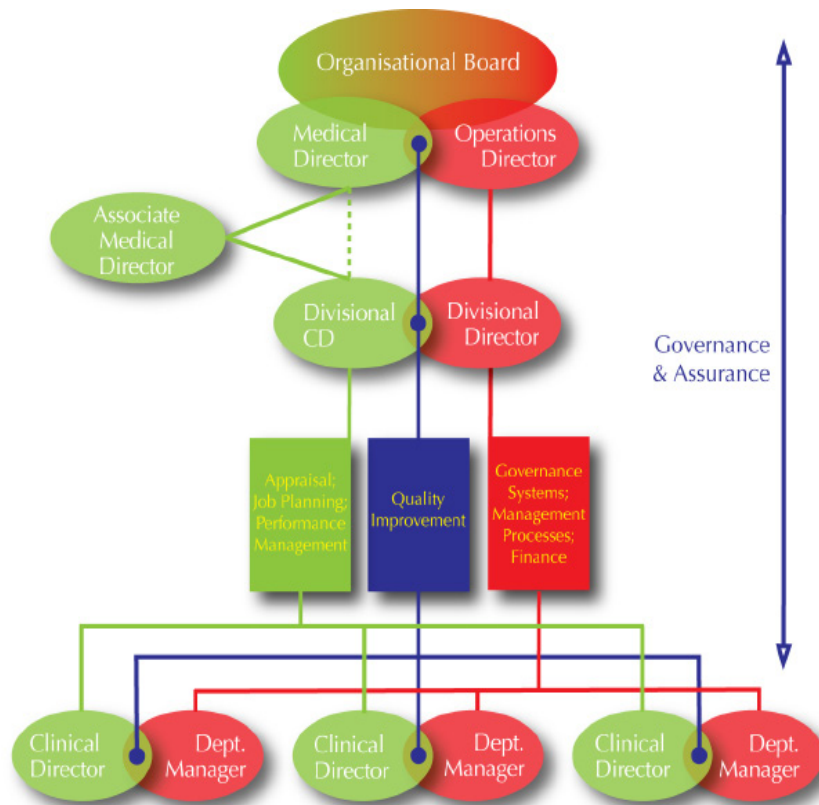

Fig 4: Information Flows and bringing the business, professional regulation and quality agendas together

Fig 4, above, demonstrates how the Venn diagram shown in Fig.3 might translate into a directorate management structure. For simplicity, we have only shown the clinical director and general manager. The dia-

gram shows that there are business elements to running the organisation, and these are shown in red, with an information flow upwards to the board. Professional issues are shown in green. Clinical directors feed up to divisional clinical directors (where appropriate) using appraisal, job planning and other professional management tools. The Divisional CD feeds results upwards to the medical director, potentially through an associate or deputy medical director. At the core of this is quality, which is the business of all managers and sits at the core of all management relationships. Quality is shown in blue. As we have already described, all three components of this structure are intertwined and should be managed and improved together.

Quality of Information

There is an abundance of data available to senior managers, but a paucity of good quality and reliable information. Most of the data available is based on outputs from the Patient Administration System (PAS) and is presented as Hospital Episodic Statistics (HES) through the likes of Dr Foster Intelligence and CHKS (private, external companies providing data back to Trusts). Clinical Managers at all levels need good quality information on which to base their day-to-day management. From a medical director/responsible officer perspective, they need to have a simple dashboard showing how well individual doctors are doing in terms of revalidation:

- Appraisal outputs;
- Absence or presence of problems in relation to appraisal;
- Evidence of personal development plans (PDPs) for each completed appraisal, and that sufficient progress is being made in terms of personal development;
- Satisfactory progress being made towards revalidation for each doctor linked to the organisation.

Medical directors will also need to have confidence that systems and processes are working at clinical team level to assure them that any problems are being identified and dealt with, and that satisfactory progress is being made to raise the bar for quality.

The further down into the organisation one goes, the data needs to become more detailed. Clinical directors and their management colleagues need to have sufficient data on which to base day-to-day decisions.

It would make sense for Trusts to invest in an information management

tool that would allow responsible officers, at a glance, to gauge how well individuals are doing in terms of:

•   Appraisal;
•   Job Planning;
•   Multi-Source Feedback;
•   Progress towards revalidation.

Such a tool needs to link into existing IT platforms. It should provide, at responsible officer level, an overview of who has undertaken each activity and what were the results. It could be used by operational medical managers (as appropriate) to gauge how things are progressing for their team, and highlight emerging problems. Finally, it should be a resource for individual consultants, enabling them to use it to pull together their portfolios, and keep together all the material they will need for revalidation.

Unless Culture Changes, Nothing Changes

Many NHS organisations have put a lot of effort into changing structures and processes in the hope of driving sustainable improvements. To some healthcare leaders, the root cause of many organisational problems seems to lie in the organisation's structure, so they change it. Where, for example, directorates have existed, these may be replaced by divisions. Where divisions are the norm, they may be changed into directorates. Alternative structures have included care groups, geographically based units and patient pathway streams.

In reality, most problems that are associated with healthcare delivery stem from the way professionals relate with each other, and with the way clinical systems are designed. More often than not, problems occur when one clinical process 'hands off' the patient to another, or when a patient passes between different parts of the same organisation or even onto another – e.g. when care passes between a hospital, and a community-based provider to deliver home-based care post surgery.

The way things get done in any given institution is largely determined by its culture, and this varies from one organisation to another. Indeed, the more complex and organisation is, the more cultures that exist within it. Culture cannot and should not be ignored, because it is the main driver for how it delivers services. If any given organisation is shown to have certain problems – e.g. large waiting times, high numbers of healthcare acquired infection, etc. – then those problems will be the result of how people and processes interact with each other.

Simply changing structures and processes will have little or no impact on overall quality because nothing has been done to change culture. To make sustainable and lasting change, it is therefore imperative that culture be addressed. The NHS talks about clinical 'engagement', but this is nowhere near good enough. Effective change will require clinical leaders to affect hearts and minds. Clinical leadership development, therefore, needs to take cognisance of every aspect of the way people relate to each other, what they prioritise as important, and how they relate to the wider organisation.

It is for this reason that we believe in the importance of driving change at clinical team level rather than just at whole-organisation level. Effective organisational development, where the whole organisation is subject to massive improvement and change can only be effective when individuals work differently. Whole organisation improvement is at its best when there are lots of sustained small changes happening in clinical teams. Each team works hard to improve the way they work – and this happens small and often, rather than big and rare. Lots of small and often changes, together, makes for more effective whole-system redesign. However, as we will describe below, each small change actually significantly alters the state of the organisation. This means that clinical leaders need to stop and re-think their strategies on a more regular basis than they currently do. Longer-term strategies become increasingly inaccurate in this approach, as long-term planning is based on a starting point that rapidly becomes extinct.

Change Changes the Organisation

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Any form of change, no matter how large or small, has the effect of changing the overall state of the organisation. To many, this may sound self-evident. However, we often fail to recognise it. We set about making improvements to the organisation, by putting in place hugely complex and multi-faceted strategies that run over a period of years.
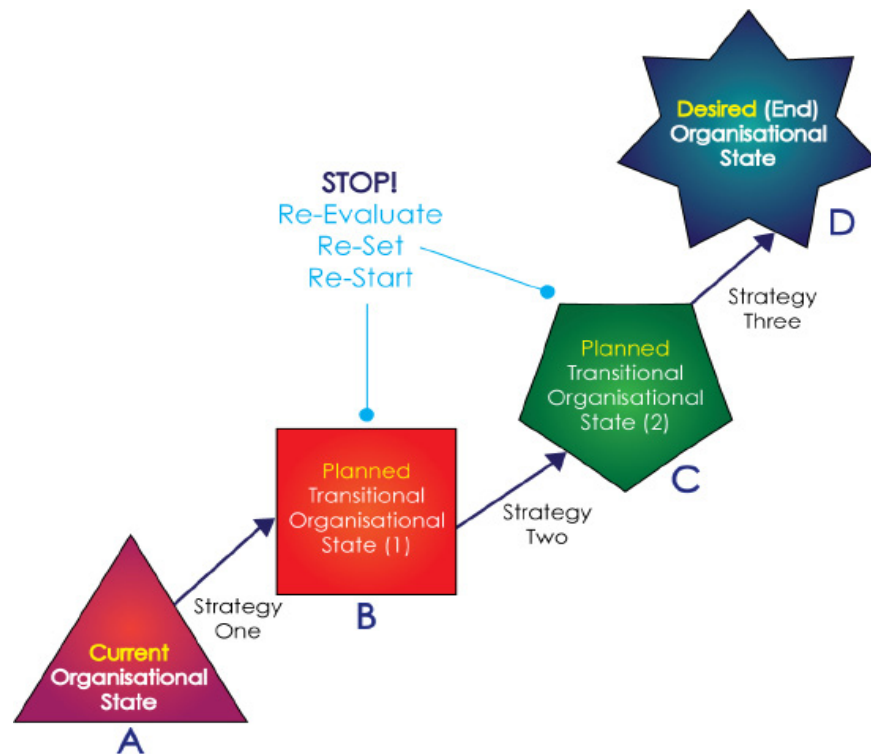
Fig 5: Organisations Constantly Change

The assumption that we make is that the factors that affect the organisation at the start of the process will still be there throughout the life of the strategy. The fact is that factors change over time. In Fig 5, above, an organisation plans to change from its current state (A) to a planned new state (D). Its leaders sit down with key people inside the organisation and put in place a series of strategies that they hope will take them forward. Strategy 1, in year one, will result in altering the organisation to State (B). Strategy 2, in the second year, will change the organisation into State (C). Finally, Strategy 3, in year three will result in the organisation changing to State (D). How likely is it that the strategy will result in the achievement of (D) as desired?

At the start of the process, the team will have made out a list of all the things they would like to change about State (A) and they set about changing them. When they started to move towards (C) having reached the first way-point (B), they would probably have continued to work

on the list they made at (A). The problem is that the organisation has now changed. There are different factors that influence organisational state (B) that could not have been planned for at the outset – they only emerged later. The same will be true of State (C) when they reach it and plan to move towards (D).
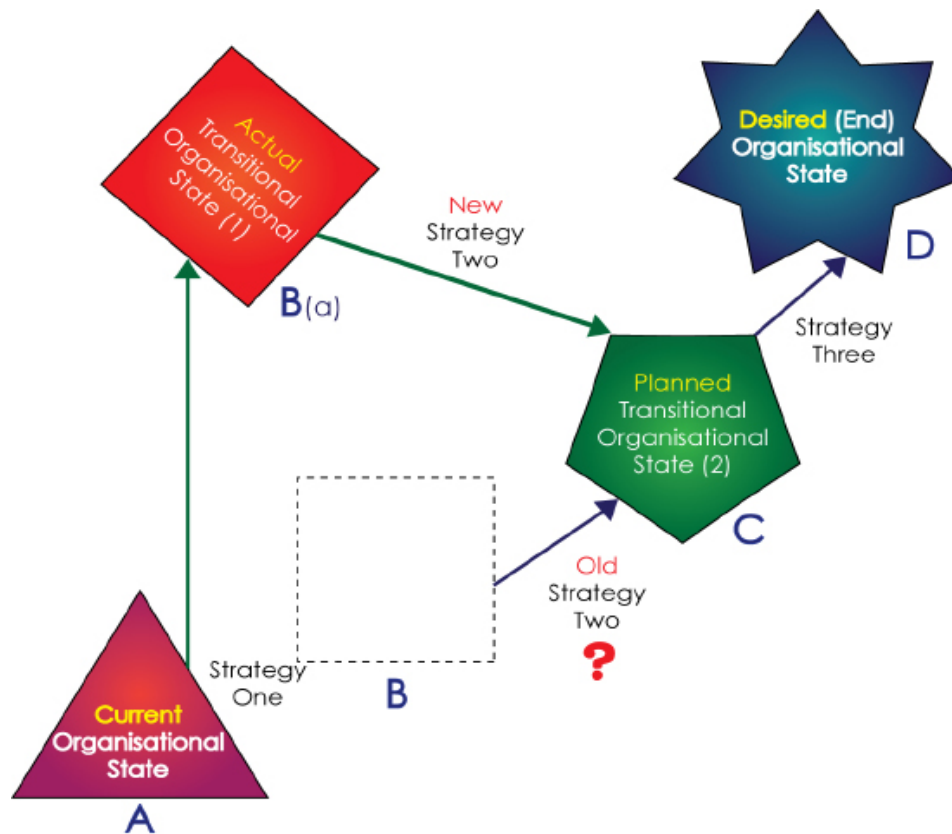

Fig 5a

What if Strategy 1 actually resulted in the organisation looking like (B(a)) as depicted in Fig 5a, above? We were expecting it to become a red square, where it actually became a red diamond shape, and in a completely different position. Our planned next move, Strategy 2, was originally designed to take us to the third stage of the project (C). Strategy 2 was designed, based on us starting out as a red box in the original location. What we actually need is a new strategy, shown as Strategy 2a, that takes account of the actual new state of the organisation.

The same problems will be replicated when we eventually arrive at (C), which we expect to be a yellow five pointed star, but could look like a purple triangle. Clinical leaders need to have the skills to spot the changes to their organisation, and what this means to the overall direction of travel. They will need to be able to adapt to the new environ-

ment, and develop new strategies as they move forward.

Conclusion and the Way Forward

What we have been describing is a new way to think about clinical leadership, within the context of a highly complex and challenging national agenda (revalidation), and set against the most difficult financial pressures ever faced by the NHS. The challenge for us is to emerge from this set of circumstances and create an improved healthcare system, fit to be passed to future generations. The key to such an idea is the empowerment of a cadre of highly motivated, inspired, and skilled healthcare leaders, able to think and work differently. Traditional, silo, thinking is vastly outmoded and old fashioned. Similarly, we need to embrace new ways of thinking. We cannot rely on national solutions to local problems. The only way to bring the NHS out of the shackles that have bound it for so long, and create a new and vibrant health care community is to work together to build highly effective clinical teams that constantly improve what they do, within the context of a newly framed vision at organisational level. Einstein said; "New ideas need new shapes". We cannot build a better NHS unless we change the 'shape' of its thinking.

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About the Authors

Stuart Haines

Stuart Haines is a co-founder of Haines Business Systems Ltd (HBS), a multi-sector organisation, working in business and IT consultancy, business development, health leadership and retail. It's a wide-ranging business portfolio and reflects Stuart's breadth of experience and interest.

Stuart is well experienced in working in clinical leadership. For more than twelve years, he was part of the British Association of Medical Managers (BAMM), serving that organisation in the roles of General Manager, Director of Strategy, Deputy Chief Executive and latterly as an independent associate. Stuart was key in the development of the Fit to Lead programme, and in writing the underpinning medical management standards. He has designed and delivered many successful medical leadership development programmes throughout the NHS in both the primary and secondary care sectors.

Stuart built a good reputation throughout the senior medical community. He was invited to contribute to numerous national conferences and events on the subjects of medical management and clinical leadership. He was part of the Academy of Medical Royal Colleges Re-Certification Project Board, helping to shape the professional standards underpinning Revalidation and has delivered dozens of workshops on Revalidation throughout the NHS. He has a wealth of knowledge and experience around revalidation, appraisal and clinical governance, and a deep knowledge of NHS processes necessary to deliver effective regulation. His passion, though, is healthcare quality. He believes strongly that quality and business management go hand in hand, and that the key to success is through effective clinical leadership.

Stuart created the innovative Business and Knowledge Gym, mainly to support and develop small and medium sized businesses. He believes that the lessons learned in healthcare leadership are relevant to small businesses, and vice versa.

Dr Bob MacKenzie

Bob has been Principal Consultant and owner of Bob MacKenzie Associates for the past eight years, and is Professor of Management Learning with the International Management Centres Association. This is a global Business School, with its headquarters in New Zealand. From 2004 - 2010, Bob was also an Associate

Consultant with The British Association of Medical Managers (BAMM), when he coached, tutored and mentored many senior medical and clinical leaders. Bob has run a variety of management and leadership development programmes in Trusts around the country. He has conducted major evaluation projects, e.g. during a four-year stint as Lecturer in Research and Evaluation at the University of Botswana, Lesotho and Swaziland UBLS). He was also Lead Consultant commissioned to design and conduct a major Impact Evaluation of the United Nations High Commissioner for Refugees Senior Managers' and Middle Managers' Learning Programmes.

Bob is conversant with the cultures of diverse public and voluntary sector organizations, such as local government, Social Services Departments, the Ministry of Defence, the Civil Service, FE and Higher Education Institutions, the emergency services, as national Training Manager for the National Association of Citizens Advice Bureau, and as a former member of the Arts Council Training Advisory Committee. He draws upon this varied background in the public, private and voluntary sectors to straddle and connect the worlds of daily business practice and applied management and leadership theory, facilitating thoughtful and effective leadership.

Bob's goal is to support outstanding performance in the workplace. His default style is to model and encourage applied problem-solving and action, grounded in the strategic use of innovative projects and other initiatives. Through thoughtful and informed questioning, writing and conversations, he encourages managers and leaders to take due account of the wider environment, working with individuals or groups of various sizes, especially at middle and senior levels in organisations.

Bob is Action Learning Set Advisor on IMCA Business School's Senior Executive Action Learning (SEAL) doctoral programme, and a Director and Council Member of the Association for Management Education and Development (AMED). He is also Convener of the AMED Writers' Group, and a Mentor on the Leaders UK fast track development programme, which is run by the National School of Government. Bob has lived and worked in several different countries and diverse cultures in Africa, India, North America and Western Europe. Here, he has collaborated with senior national and local government politicians and officials, international development agencies, charities, educators, doctors, medical managers, nurses, and members of other professions and commercial organisations.

Bob has written numerous articles, chapters, bespoke learning materials and reports, and edited several books for the benefit of reflective practitioners.

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