ACADEMY OF MEDICAL ROYAL COLLEGES

NHS Institute for Innovation and Improvement

Engaging Doctors

Can doctors influence organisational performance?

Enhancing Engagement in Medical Leadership

Patricia Hamilton
Peter Spurgeon
John Clark
Julie Dent
Kirsten Armit

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning /	Finance
Clinical	Social Care / Partnership Working

Document Purpose	For Information		
ROCR Ref:		**Gateway Ref:**	10133
Title	Engaging Doctors: Can doctors influence organisational performance?		
Author	NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges		
Publication Date	14 Jul 2008		
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of PH, PCT PEC Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Postgraduate Medical Education and Training Board, General Medical Council, British Medical Association, NHS Confederation, NHS Employers, Medical Royal Colleges, Medical Schools Council, Conference of Postgraduate Medical Education Deans		
Circulation List			
Description	Shares findings from research into a link between medical engagement and organisational performance, including a literature review, interviews with chief executives and medical directors, and development of a Medical Engagement Scale. Activities were undertaken in support of the Enhancing Engagement in Medical Leadership project.		
Cross Ref	N/A		
Superseded Docs	N/A		
Action Required	N/A		
Timing	N/A		
Contact Details	John Clark NHS Institute for Innovation and Improvement Level 9, Victoria House, Southampton Row London WC1B 4AD 02072 710306 medicalleadership@institute.nhs.uk www.institute.nhs.uk/medicalleadership		
For Recipient's Use			

ISBN 978-1-906535-67-4

Executive Summary

"The essence of clinical leadership is to motivate, to inspire, to promote the values of the NHS, to empower and to create a consistent focus on the needs of the patients being served. Leadership is necessary not just to maintain high standards of care but to transform services to achieve even higher levels of excellence."

(Department of Health, 2007)

The Enhancing Engagement in Medical Leadership project aims to create a culture of greater medical engagement in management and leadership. Activities undertaken by the project team indicate that engaging doctors at all levels is an important factor in improving organisational performance and patient services.

The project team has developed the Medical Leadership Competency Framework, designed to ensure all medical students and doctors acquire competence in management and leadership and understand that this is integral to their role. The Framework will be integrated into the curriculum at the undergraduate and postgraduate stages of a doctor's training and career and throughout their continuing practice in the NHS. The team has also developed a Medical Engagement Scale designed to help organisations evaluate levels of medical engagement and develop strategies to improve it.

Engaging Doctors: Can doctors influence organisational performance? outlines how the medical engagement scale can measure and improve medical influence and the impact of good medical engagement on organisational performance. This document explains how the Medical Leadership Competency Framework will embed clinical engagement into the culture of the NHS. It shares findings from a literature review, outcomes of interviews with chief executives and medical directors and provides real examples of good practice in medical engagement.

Background

The Enhancing Engagement in Medical Leadership project is a UK-wide initiative undertaken jointly by the Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement. It aims to encourage doctors to become more actively involved in the planning, delivery and transformation of services and to help the NHS create a culture where doctors are much more engaged in the health system in which they work.

During the project we have sought to work with and keep informed the main medical professional, regulatory and education bodies and health service organisations across the UK.

Further information and publications about each element of the project is available at: www.institute.nhs.uk/medicalleadership.

Introduction

Enhancing medical engagement is a priority throughout the NHS. Medical engagement is not only about the appointment of a small group of leaders to roles such as medical or clinical director. It is recognition that leadership is a social function and not just defined by hierarchical reporting lines. Enhanced medical engagement should work towards a model of diffused leadership, where influence is exercised across relationships, systems and cultures. It should apply to all rather than a few.

If doctors are engaged in management and leadership then organisational performance will improve and if there is good organisational performance there is likely to be high levels of medical engagement.

Exploring this hypothesis has underpinned the Enhancing Engagement in Medical Leadership project. In the search for evidence, a literature review was undertaken, to see what evidence, if any, already existed. This was followed by interviews with chief executives and medical directors in high and low performing trusts (as defined by the Healthcare Commission 2006) and in a sub-sample of these trusts, an assessment of their levels of engagement through a specially designed Medical Engagement Scale.

What does the literature say?

"Clinical engagement and managerial engagement with clinicians is key to success and often falls short at every level."

(NHS Confederation, 2007)

Engaging Doctors in Leadership: A review of the literature (Ham and Dickinson, 2007), looked at existing research on the impact of medical engagement and the experience of the NHS in involving doctors in leadership. It found more evidence of the negative impact of lack of medical engagement than its positive counterpart. The improvements in healthcare provision will not be achieved without the positive involvement and engagement of all clinicians.

Why doctors? A fundamental question was whether doctors have a differential impact from other staff groups in health organisations. The research suggests doctors have the most influence when it comes to implementing operational changes that can lead to improved performance. Failures in care were often blamed on inadequate medical leadership, poor communication, disempowerment of staff and patients, and a disconnection between doctors and managers. Without doctors, attempts at radical large-scale change were doomed to fail.

Engaging Doctors in Leadership: What we can learn from international experience and research evidence? (Ham and Dickinson, 2008) confirms the persistence of healthcare organisations as professional bureaucracies. Frontline staff have a large measure of control by virtue of their training and specialist knowledge and through professional networks and collegial processes, rather than involvement in the organisation's bureaucracy. The development of clinical directorates has been only partially successful and doctors who occupy hybrid roles such as clinical and medical directors face the challenge of bridging these two disparate cultures.

Published research into the impact of clinical directors highlights the difficulties of introducing new ways of working into the NHS, the strength of traditional relationships, and the orientation towards stability rather than change. The evidence also suggests that medical management has often been under resourced and the incentives for doctors to become involved in management and leadership have been weak.

The literature and international reviews revealed limited empirical evidence about the positive impact of enhanced medical engagement on organisational performance but did demonstrate that the lack of engagement presents significant problems in the organisational pursuit for change and improvement. The next phase of the project sought to examine how the link between organisational performance and levels of medical engagement might be facilitated.

Exploring organisational performance and engagement

"Leadership is ineffective if doctors are not in agreement around a vision for the organisation, and physicians' expectations of their practice life are incompatible with what change requires of them."

(Silversin and Kornacki, 2000)

To explore the relationship between medical engagement and organisational performance, semi-structured interviews were conducted with chief executives and medical directors drawn from 15 high performing and seven low performing NHS trusts as reported by the Healthcare Commission in 2006.

All high performing trusts were in the excellent or good Healthcare Commission category and had been there for a number of years. Low performing trusts all had significant long-term performance issues and many had longstanding structural and service changes.

The findings

The findings from the interviews suggest that there may be a link between good medical engagement and performance. High performing trusts consistently identified higher levels of engagement, while the poorly performing trusts reported significantly lower levels of engagement.

When asked what percentage of doctors they felt were engaged, the high performing organisations reported an average 44 per cent and the poorer performers 17 per cent. Similarly when rating achieved level of engagement from 1 to 5, the high performers averaged a rating of 4 and the low performers 2.5.

There was a tendency for most organisations to refer specifically to the top 20 or so medical leaders represented in formal positions. This underlines the need to reinforce the message that engagement means attaining a strengthened contribution from all, rather than a potentially isolated few.

However, there was wholesale willingness to improve medical engagement amongst both the high and low performing trusts. All chief executives wanted to get to know their doctors better and a few had strategies in place to address this. No single or simple approach was identified but clues emerged as to how engagement might be promoted.

What can a chief executive do?

Chief executives interviewed described a number of activities which were helpful in promoting medical engagement:

- **Seek and arrange informal opportunities for face-to-face meeting with medical staff**
  Exploit all opportunities for informal listening such as having lunch with different groups in the canteen, pre-arranged walkabouts to see innovations and improvements and issuing invitations for coffee or dinner.

- **Have fixed formal meetings with clinicians outside the medical staff committee structure**
  These sessions need to be planned with a formal agenda including a continuous focus on quality and safety and involving the whole senior management team. The structure should be a dialogue, not a one way session.

- **Participate in all consultant appointments through informal meetings and sitting on panels**
  This includes taking part in all consultant appointments. This may involve: informal meetings, participation in panels and in the best cases developing more extended, perhaps competency based, assessment frameworks that go beyond clinical skills. There may be parallel opportunities here for GP appointments to PCT roles.

- **Meet all newly appointed consultants/principals as part of their induction programme**
  Clearly signal interest in doctors by seeing all doctors as part of an induction programme in their first week and again for one-to-one meetings two to three months after appointment when they have had an opportunity to form views about the service. Use these meetings to listen to doctors' ideas for the service and to set out organisational expectations.

- **Spend a significant amount of time involving doctors in all aspects of running the business**
  Treat doctors as partners and move towards structures where doctors lead whole areas of the business with support from general managers and specialists such as human resources and finance. Chief executives from the high performing trusts understand that only 20 per cent of doctors want to be involved in strategic planning, but expect all doctors to be engaged in improving services for patients.

  Doctors in high performing organisations are system builders who encourage and facilitate change, recognising that the underlying values of the NHS must be visible and articulated. Individual and team performance is a focus of regular report and discussion, not something dealt with elsewhere.

- **Devote resources to organisational development through talent management**
  Ensure adequate resources and access to programmes that develop leaders. The highest performers actively pursue talent management, succession planning and understand that organisational development is essential to effective organisations.

Appendix 1 provides some good practice medical engagement examples the project team has learnt about throughout the project.

Medical Engagement Scale

"Typically these expectations are not written down and formalised, but they do shape physician behaviour and in turn the organisation's culture."

(Silversin and Kornacki, 2000)

The Medical Engagement Scale is designed to assess medical engagement in management and leadership in NHS organisations. The scale differentiates between the individual's personal desire to be engaged and the organisation's encouragement of involvement.

The measure contains two types of engagement scale:

- **Organisational opportunity scales** which reflect the cultural conditions that facilitate doctors to become more actively involved in leadership and management activities
- **Individual capacity scales** reflecting perceptions of enhanced personal empowerment, confidence to tackle new challenges and heightened self-efficacy.

It also includes a framework of organisational strategies to enhance medical engagement and performance at work.

The scale has been tested in four trusts where reliability of the scales was found to be good and the levels of engagement assessed in the trusts were precisely in accord with the predicted level from external information.

The pilot data, from this small sample of trusts, revealed three actions by chief executives and executive team members that were statistically associated with higher levels of engagement:

- The participation of the chief executive and/or other executives in doctors' induction programmes
- Regular formal meetings between doctors and the chief executive and/or other executives to discuss quality, safety and performance
- Regular informal opportunities to meet with chief executive and/or other executives to discuss quality, safety and performance.

There are two types of scales, depending on the depth of coverage required. Both versions provide an overall index of medical engagement together with scores on sub scales (feeling valued and empowered, having purpose and direction, working in open cultures) and have face validity and construct validity. This is being strengthened through further data collection to establish an empirical link to performance, as well as developing norms across the NHS. A modified measure for use in Primary Care is also being developed.

(Barwell, Mazelan and Spurgeon, 2008)

Medical Leadership Competency Framework

"The doctor's frequent role as head of the healthcare team and commander of considerable resource requires that greater attention is paid to management and leadership skills regardless of specialism. An acknowledgement of the leadership role of medicine is increasingly evident."

(MMC Inquiry, 2008)

A major output from the project is the Medical Leadership Competency Framework which describes the leadership competences doctors need to become more actively involved in the planning, delivery and transformation of health services as a normal part of their role as doctors in 21st century healthcare.

The Framework will apply to all medical students and doctors. It will have a long-term impact on the culture of medical engagement and influence the next generation of doctors to view engagement and leadership as part of their working lives.

The concept of shared leadership forms the basis for the Framework i.e. leadership occurs at every level and is not the sole responsibility of individuals at the top of their organisation. Shared leadership implies a shared sense of responsibility for the success of the organisation and its services.

The Framework is set around five domains: personal qualities; working with others; managing services; improving services; and setting direction. The areas highlight the skills doctors need to be competent, with emphasis on engagement and involvement as an integral part of clinical practice. The Framework runs through undergraduate and postgraduate levels as well as into the first period of post certificate work. The Framework has been tested in a variety of medical education and service communities in the UK to ensure that the competences are relevant to doctors at the different stages in their training and careers.

Development of the Framework has been informed by a review of literature and key publications, comparative analysis of leadership competency frameworks, analysis of medical curricula, consultation with members of the medical and wider NHS community and input from the project steering group, reference and focus groups. The Framework is available on www.institute.nhs.uk/mlcf.

Conclusion

No single activity is the answer. Enhanced engagement is a cultural issue for organisations and needs constant support and reinforcement. Successful medical engagement is seen as crucial to future NHS improvements and is emphasised in Lord Darzi's *High Quality Care For All: NHS Next Stage Review Final Report* (2008).

NHS organisations need the tools to not only measure their performance, but also to improve it. The methods need to be at the core of an organisation's culture, but have a very personal interface. Every doctor needs to know they can make a difference.

Successful organisations focus on building and maintaining relationships, rather than processes and procedures. Chief executive leadership style is key; one-to-one meetings and informal chats over lunch in the canteen can be more effective than any number of human resource initiatives.

It is clear that engagement is not a one-way process. It is not about asking doctors to be more engaged and shrugging shoulders when they choose not to. Each organisation must develop reciprocal competences to enable it to create and respond to opportunities, regardless of where it is in the cycle of organisational growth and change.

From the interviews with 15 NHS trusts, there was a clear tendency for most organisations to refer specifically to the top 20 or so medical leaders represented in formal positions when discussing leadership. This underlines the need to educate managers - and doctors themselves, that engagement is a process of strengthened contribution from all, rather than a potentially isolated few.

But there is a strong belief in the value of improving medical engagement. Chief executives want to get to know their doctors better. Further development of the Medical Engagement Scale will include strategies and proposals to help organisations promote and enhance engagement.

Nationally, we need to ensure that a renewed commitment to the education and development of doctors as leaders is linked to appropriate incentives and career progression, with recognition and reward for those taking on leadership roles.

Finally there is an opportunity for the UK to become an exemplar in medical leadership and its development. International research has shown that few countries had made more progress than the UK. Through this project, the Institute for Innovation and Improvement and the Academy of Medical Royal Colleges has the potential to position the UK at the leading edge of international practice.

Further information about the project is available on www.institute.nhs.uk/medicalleadership.

References

Barwell, F., Mazelan, P. and Spurgeon, P. (2008) *Enhancing Medical Engagement in Leadership Project Report: Developing the Medical Engagement Scale*, Applied Research Ltd: UK.

Department of Health (2008) *High Quality Care For All: NHS Next Stage Review Final Report,* TSO: London.

Department of Health (2007) *Our NHS, Our Future: NHS Next Stage Review Interim Report*, COI: London.

Ham, C. and Dickinson, H. (2007) *Engaging Doctors in Leadership: A review of the literature*, NHS Institute for Innovation and Improvement: Coventry.

Ham, C. and Dickinson, H. (2008) *Engaging Doctors in Leadership: What we can learn from international experience and research evidence?* NHS Institute for Innovation and Improvement: Coventry.

Healthcare Commission, 2005/2006. Annual Health Check [online]. Available from: http://annualhealthcheckratings.healthcarecommission.org.uk/annualhealthcheckratings.cfm [cited: 2007]

Najim, O., Clough, D., Cousins, D., Johnston, M., Sunderland, H., Tan, K. and Ahmed-Little, Y. (2007) *Junior doctors involved in management of rotas*, British Medical Journal Careers, 17 November 2007: 179-180.

Silversin, J. and Kornacki, M.J. (2000) *Leading Physicians Through Change*, American College of Physician Executives: Florida.

NHS Confederation (2007) *The challenges of leadership in the NHS*, NHS Confederation: London.

MMC Inquiry (2008) *Aspiring to Excellence: Final Report of the Independent Enquiry into Modernising Medical Careers*. Aldridge Press: London.

Appendix 1
Examples of good practice

Good practice examples

Throughout this project, the team has spoken to many doctors at all levels across the UK. Many shared their own experiences of becoming involved in management and leadership activities and roles. Below are a few examples of medical engagement and leadership and recommendations by doctors for senior leaders. Other examples are available on the project website www.institute.nhs.uk/medicalleadership.

Example 1

On the first day of joining the healthcare organisation, Foundation Year (FY) 1 doctors met, as a group, with the trust medical director. At that meeting, the medical director asked the FY1 doctors to record every time they saw a service issue that resulted in patients receiving sub-optimal care. A few weeks later, when the FY1 doctors met again with the medical director, they were asked what issues they had recorded and what they had done to correct or improve the service issue for patients. This simple action by the medical director emphasised that it was the responsibility of all doctors to improve services for patients and empowered junior doctors to be involved.

Example 2

When David was a Specialist Registrar (SpR), the chief executive of the organisation in which he worked regularly met with SpRs informally and used them as a temperature check for how the organisation was performing.

The chief executive also involved SpRs as part of the consultant group following a public enquiry into patient care. SpRs were invited to many meetings where sensitive and difficult issues about the organisation were discussed.

By doing this, the chief executive demonstrated good leadership and a keen interest in the doctors and the service. This was unlike any previous experience David had of a medical manager or board member. Such a positive example encouraged David to become involved in medical management and leadership.

Example 3

As a junior doctor, Nikita became interested in service improvement. Her desire to improve the service and system in which she worked led her to seek a dual role as service modernisation lead and trust specialist.

Nikita was encouraged to establish this role by a number of senior leaders in her who helped her develop a business case for the new role which was approved by the trust board.

Nikita now devotes half her time as a trust specialist in general internal medicine and the remaining half on service improvement projects such as redesigning emergency access and medical pathways.

In her service improvement role, Nikita has found that she has an advantage of having worked in most clinical departments and therefore has a good understanding of the procedures and issues faced by each department.

Example 4

An SHA and two deaneries took a unique and innovative approach to achieving compliance with the European Working Time Directive (EWTD). Six junior doctor advisors led by a junior doctor manager were recruited for a team that is responsible for ensuring full directive compliance is achieved for all junior doctors in training by August 2008. Junior doctors in the team drew upon their knowledge and experience to provide expert, impartial advice while providing a performance management role to ensure all Trusts comply with the EWTD. They are influencing changes to working practices and rota planning.

The position provides these junior doctors with a wealth of managerial experience and helps them develop skills such as negotiation, communication, presentation, budgeting and line management. These doctors have developed a greater understanding of management roles and pressures and gained experience that will be useful throughout their careers.

(Najim, Clough, Cousins, Johnston, Sunderland, Tan, and Ahmed-Little, 2007)

Example 5

A paediatric dentist specialising in paediatric maxillofacial surgery noticed a high cancellation and delay rate in transplant operations for children. The delays occurred due to problems with getting children's teeth checked before the transplant.

There was no system in place, with the children just fitted into already crowded clinics. The delays caused not only great distress to the children and families but also great problems with the rest of the team dealing with these very sick children.

The dentist was able to update the care pathway, working with the transplant coordinator to ensure there was designated clinic time for children in her routine work, ensuring timely examination.

She also worked with the general dental practitioners in primary care for appropriate checks to be done in a community setting; ensuring problems would be seen as part of the routine outpatient work.

No clinic felt overstretched by extra work, the coordinators knew when the children were going to be seen and the families were able to experience a seamless and trouble free pathway prior to the transplant.

Example 6

A GP chose to work in an inner city practice because of their interest in diabetes. Within a few months he noticed an ongoing delay in initiating insulin for patients who had type 2 diabetes. Upon investigation, he found these delays were caused by a very long wait to see the dietician, before a longer wait to be seen in the classes run by the diabetes specialist nurses.

He worked with the practice manager and made a business case for the practice to employ a dietician for a session a week, and found a training course for himself, one of the other doctors, a practice nurse and a district nurse to attend, enabling them to initiate insulin in house.

Further work with the PCT attracted a locally enhanced service payment, which offset the extra time spent with the patients. The dietician was also able to see patients with other health issues, and more patients were seen and treated in the community. The PCT used this scheme to design a care pathway for other practices to do the same thing.

Further examples

If you have examples of good practice in enhancing medical engagement we would be pleased to hear about them and if appropriate include them on our project website. Please email us at medicalleadership@institute.nhs.uk.

Recommendations

The following are some recommendations made by doctors (particularly at postgraduate level) for NHS senior leaders:

- Empower junior doctors
- Demonstrate good leadership practice
- Ensure development opportunities are available
- Ensure the system encourages and supports doctors
- Protect and enable doctors to take on leadership roles
- Ensure the system does not suppress doctors interest
- Remove barriers to dual clinical and managerial roles
- Ensure doctors gain a wider perspective of the system in which they work
- Recognise the importance of role models and mentoring
- Establish communities of quality and service improvers where doctors are involved
- 'Make the right thing easy to do' (Kaiser model)
- Remove barriers in career paths and disincentives
- Ensure job descriptions allow for flexibility
- Create a culture where leadership roles are aspired to
- Build flexibility into the training systems
- Ensure doctors are involved in decisions about the service
- Help break down barriers between professions.

However, all the doctors we spoke to recognise that individuals also needed to have the drive and right skills to seek out these opportunities.

You can also visit our website at www.institute.nhs.uk/medicalleadership
If you require further copies of this document please quote NHSIDRORG

Contact: Prolog Phase 3,
Bureau Services,
Sherwood Business Park,
Annesley,
Nottingham NG15 0YU
Tel: 0870 066 2071
Email: institute@prolog.uk.com

NHS Institute for Innovation and Improvement
Coventry House
University of Warwick Campus
Coventry CV4 7AL
Tel: 0800 555 550

ISBN 978-1-906535-67-4