

Future of leadership

APRIL 2009

PAPER 2

Developing NHS leadership: the role of the trust medical director

Key points

- The medical director role has changed considerably and current expectations of the role need to be clearer. New skills are needed to meet current challenges.
- A clearer career path in and out of the role is required, including shadowing and secondments in other organisations.
- Pay, job insecurity, loss of link to profession and pressures of the job can make chief executive roles seem unattractive to medical staff.
- If doctors are to be attracted to senior management roles, more effort should be made to communicate the positive aspects of the medical director role to junior doctors.
- Views vary on whether it is important for medical directors to retain some clinical work or 'do the job' full time.

Background

Over the last few years there has been a great deal of interest in developing clinical leadership. A substantial number of senior managers have a clinical background, but doctors are under represented. There is a need to bridge the gap between NHS managers and doctors. Strong evidence exists that organisations with engaged clinicians deliver higher quality care and are able to respond to change more effectively.

The NHS Next Stage Review continued this theme by stressing the leadership role of clinicians, particularly doctors. The NHS Institute for Innovation and Improvement has published research on engaging doctors in leadership and worked with the Academy of Medical Royal Colleges on a significant programme to define leadership competencies

and to integrate leadership into medical education. And the chief executive of the NHS in England, David Nicholson, has said that he would like to see a doctor on each chief executive shortlist. This reflects a concern that a large and able part of the workforce should be better represented among its leaders.

Key to this ambition is the role of the medical director and how doctors emerge and move on to chief executive and other key leadership roles. Although the role of medical director predates the 1983 Griffiths report on NHS management, and has been growing in significance over the last 25 years, a number of questions remain about it, specifically:

- What do medical directors actually do?
- How can the key elements be made more effective?

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“Being a medical director has become a full-time job. The role has changed dramatically in the last ten years and the work increased exponentially”

- What preparation is needed for the role?
- What should the career path look like and what is the route for exit or progression?
- How can more people be encouraged to take up the challenge?

To look in more depth at these questions, with NHS medical director, Sir Bruce Keogh, we ran two seminars and conducted in-depth interviews with current medical directors, deputy directors and clinical division medical directors. We were joined by primary care trust (PCT) medical directors, who brought some important insights, but it became clear that there is considerable diversity in the roles of PCT medical directors and that their different responsibilities and challenges make generalisation difficult. Some of the ideas in this paper are relevant to PCTs, but further work is needed to understand the specific challenges they face.

Clarity about the medical director role

It is hard to sell a role to potential applicants or get the best from it if there is insufficient clarity about what it entails. The role of medical director can be designed in different ways and its exact nature is not

always very clear. This may mean that chief executives and other board members are not certain about what they can expect from the medical director.

Our seminar participants thought there were a number of functions that should be contained in the role, regardless of how it is designed, including:

- leading the formation and implementation of clinical strategy
- taking a lead on clinical standards
- providing clinical advice to the board
- providing professional leadership and being a bridge between medical staff and the board
- providing translation, assessing the mood and, crucially, creating alignment between the organisation and doctors (this can be a particularly delicate task, especially where it is necessary to challenge medical colleagues)
- outward-facing work with the PCT, strategic health authority (SHA) and other external organisations.

A number of other important roles are sometimes delegated, but often seen as the medical director's responsibility:

- clinical governance
- acting as the Responsible Officer for revalidation
- quality and safety
- education
- medical staffing planning
- disciplinary issues concerning doctors.

We also heard that some medical directors get involved in Caldicott guardian roles, infection control and research and development.

One common feature was the involvement of the medical director in the immediate problems and crises connected to the day-to-day running of the organisation. While this is unavoidable, there may be too much of a tendency for staff to 'delegate upwards', making the role more stressful than necessary and detracting the medical director from more strategic issues.

The medical directors we spoke to thought that the role had changed considerably in a short space of time, reflecting the merger of trusts, increasing managerialism and the re-introduction of the internal market. They told us new skills are required to meet these challenges.

Structure and support

The size of the medical director role is significant and potentially too large for one individual, particularly in larger and multi-site trusts. The level of support provided is therefore crucial in determining effectiveness – everything from high-level managerial support from managers and associate medical directors to more basic back office and administrative support.

We heard of a range of models for the level below medical director, including associates and deputies. Examples of medical directors with both wide and narrow spans of control include:

- direct lines to divisional medical directors

- dotted lines, with divisional medical directors reporting to the director of operations or divisional general managers
- larger number of clinical directors reporting to the medical director or associate/deputy medical directors.

All of these models have advantages and disadvantages and there is no direct evidence about which works best. However, there seemed to be consensus against having a large number of clinical directors reporting directly to the medical director.

Our seminar participants concluded that culture and behaviour is probably more important than structure, and that the trend for organisations to cycle through different models suggests that decisions are based on people in roles, history and other local factors.

Administrative support and back up is a key issue for a number of the medical directors we spoke to. The number of meetings and areas in which they are involved often means it is difficult to follow up or implement decisions if they do not have administrative and managerial support. A number of them feel strongly that this aspect of their supporting infrastructure needs improvement.

Becoming a medical director

The route into the medical director role is generally through being a clinical director of a department or directorate. The motivation to do it often comes from a wish to make a significant difference to the

“At some point, I think, the size of the agenda for many medical directors will mean you have to think long and hard about whether you can continue”

organisation, particularly the quality of patient care. Importantly, the people we talked to believe that care for patients can be improved through changing the way that systems are designed, staff work and the organisation functions, as well as through excellent clinical work. Others were also interested in the opportunity to shape the strategic direction of their organisations.

However, preparing for the role is somewhat haphazard and should be more systematic. There is no definite career path. As one acute trust medical director put it: “You really

have to create these things for yourself, talk to people and manage your career for yourself”.

There is some value in formal courses to learn some of the basics of how the organisation works and core management skills. However, beyond this there is more value from courses which deal with real issues dealt with on the job rather than management theory.

Practical opportunities to learn are particularly valuable and a number of measures could be put in place that would help more doctors make the step up, such as:

- more mentorship, coaching and support
- project management roles, improvement roles and other specific tasks which provide a good introduction to some of the key skills

Being a medical director in the independent sector

A number of the themes outlined in this paper are similar for medical directors in independent sector organisations, for example the importance of putting in place systems to ensure that there is consistent and reliable delivery of standards. This needs to be supported with arrangements for clinical governance, training and education. Also, good understanding of the techniques of quality and efficiency improvement is required. As with the NHS role, dealing with issues of standards and behaviour is an important skill.

The medical directors we spoke to stressed the importance of their corporate role, namely their shared responsibility for strategy, finance and marketing and for bringing a clinical perspective to key decisions from procurement to strategy.

Learning the language of management and finance is a key challenge, but this is only the beginning of learning the role.

Independent sector medical directors see themselves as having opportunities to branch out into wider leadership roles.

- working in other organisations, even just on a secondment/shadowing basis – this can be particularly helpful for medical directors who emerge from within their own organisation, as a way of learning from others and of providing a reference point to compare the performance and functionality of their own organisation
- professionally facilitated learning sets and meeting colleagues to provide important learning opportunities.

Attracting more people into the role

Some significant obstacles are likely to be preventing more people from taking on the larger clinical management roles. The most obvious is the reward structure and the lack of access to clinical excellence awards, although the consultant contract provides some flexibility in dealing with this. Secondly, there is the requirement to give up significant amounts of clinical work. Others told us a significant leap of faith is necessary to make the step from a clinical director to a medical director (shadowing, coaching and support would help with this). Finally, our participants mentioned the lack of a clear career structure and, in particular, the need for a satisfactory exit or progression strategy.

Medical directors need to be involved in talent spotting. The people we spoke to said that some of those who will make the best clinical and medical directors are not necessarily those who put themselves forward.

Our medical directors were keen to encourage junior doctors to get more involved in medical management. They emphasised the importance of juniors being exposed to an accurate representation of the role, perhaps by shadowing, formal attachments and internships. A number were concerned that junior doctors only see the negative sides of the job, such as dealing with performance problems and conflicts, and have little exposure to the benefits. A clear message was that it is vital to show junior clinicians that medical management offers the opportunity to shape organisational strategy, improve the quality of patient care at a macro level and “influence things in a totally different way”.

The pros and cons of remaining in practice

Many of the medical directors we spoke to maintain some clinical practice. For some this is about maintaining credibility and providing a link to the realities of the clinical shop floor. But it is also seen as important as a way of providing a route back to full time practice from the medical director role.

While many feel strongly about maintaining a continuing clinical commitment, there was concern that managerial responsibilities make this increasingly difficult. Time constraints in particular were identified as a major barrier to effectiveness. A number of directors thought clinical commitments should be more clearly ring-fenced with protected time. One solution to this is job sharing between medical directors. While this raises obvious issues about consistency, continuity and handover, the job-sharing medical

“There is the real concern that if you aren’t seen on the shop floor you can lose the troops”

directors we talked to found that it had increased their effectiveness in the role and helped them retain their clinical practice. Job shares may also be an effective way of bringing in new medical leaders who could be put off by the need to give up significant parts of their practice.

Views on the importance of clinical work for the medical director were not universally shared. Some medical directors were clear that there are other methods for staying in touch and that there is a danger in sending a signal that the medical director role is not important enough to do full time. Some also questioned whether retaining clinical practice really provides credibility. They argued that a small amount of practice may not actually be that credible and that credibility comes from effectiveness in the medical director role and clinical reputation before taking up the role.

Exit and progression

David Nicholson and the NHS Next Stage Review have both expressed a desire to see more doctors become chief executives. The UK is unusual in having so few doctors in chief executive roles. The USA and much of western Europe certainly have more doctors in these roles, but it is very far from being an actual requirement of the role. While being a doctor can bring important insights, so can being a nurse or an accountant. The real issue is that, if doctors are effectively excluded from

“There is not a strong tradition of medical directors moving between organisations”

chief executive positions, a major pool of talent is locked away from the system and we need all the talent that is available.

Our seminar participants supported the idea of more medical chief executives in principle but were not very enthusiastic about taking on the role themselves. The issues they raised included:

- pay and pensions
- exit strategy – what do you do once you leave the chief executive role?
- the overlap between medical director and chief executive role, namely that becoming a chief executive means “giving up being a doctor” – clinical work has to cease, requiring self-identity to be redefined
- duration of tenure – the role is seen as having too many risks in relation to the rewards
- many chief executives are under very significant pressures and the job therefore appears unattractive.

Our medical directors observed that many medical chief executives start their career as chief executive in the hospital in which they are already a medical director. They felt that medical directors would have a disadvantage in applying for chief executive roles in other trusts as they generally lack the experience of a wide range of managerial work in different organisations that other candidates might have.

If moving from the role of medical director to chief executive is not very appealing, the question of where to go next is also uncertain, given that there is not a strong tradition of medical directors moving between organisations. The fear that a return to practice will be difficult may also be an obstacle to some doctors taking up the role and a more formal approach to planning exit or clinical re-entry is required. This could include incorporating retraining or necessary top-up training as part of the contract, and opportunities to move to project and improvement work within the local organisation or elsewhere.

Leaders need followers

As we noted in our first paper in this series, *Reforming leadership development ... again*, more emphasis is needed on followership. Significant effort has been expended to create a critical mass of hospital consultants who can act as clinical directors and, in this role, provide an element of leadership for their peers. There has been some success in this; there is now competition in some places for these roles which are increasingly seen as attractive to younger consultants. However, much less attention has been paid to the conditions that need to be met if their peers are going to embrace this leadership role and practise effective followership. For example, while some attention has been given to the structures, systems and technology that need to be in place for the clinical director to communicate effectively with their peers, a number of other issues have not been addressed.

- Are the challenges of leadership (and followership) the same in, say, geriatrics as they are in orthopaedics?
- Are the leadership (and followership) challenges the same or very similar in large and small directorates?
- If the chief executive of the organisation has a particular approach to and style of leadership (and fostering followership), what implications might this have for leadership at directorate level?

Change in the education and training syllabus will help this but a much more systematic approach is required.

Conclusions

Some measures to address the issues we raise in this paper are already underway, such as the proposal to incorporate management into medical education. But other practical proposals could be implemented relatively quickly, such as:

- clarifying expectations of medical directors
- ensuring they have appropriate support
- helping them with their own personal development plans
- providing opportunities for job shares for clinical and medical directors
- providing management and leadership experience for clinicians by offering opportunities to get involved in improvement work and other projects (these would also benefit doctors in training)



- providing more mentoring, peer support/networking and opportunities to learn about how other organisations work
- medical leaders doing more to communicate the positive contribution they can make to juniors
- focusing on mechanisms for allowing re-entry and retraining (doing this at national level would make more sense).

The barriers created by the current reward structures need to be removed, along with the perception of an unfavourable risk/reward ratio in entering the top leadership positions, such as chief executive or medical director. There is also an interesting question about how reasonable it is for clinicians going into these positions to expect there to be the safety net of return to clinical practice within the same organisation. We heard that this is a common aspiration, but the safety net is not available in the same way to other executives and the question was raised about whether this will remove some of the incentives to perform.

We are keen to see the medical director of the NHS and the new National Leadership Council work to address the barriers and create an environment in which the role of clinical director and medical director can flourish.

Questions

This paper is designed to stimulate discussion and we look forward to hearing from members and others with their views on the following:

- This document is about medical directors in acute and mental health trusts but what are the key differences in the role for PCT medical directors? What is required to help this role develop?
- What can be done nationally to improve career progression, exit and re-entry for medical and clinical directors?
- What other policy changes would help overcome the barriers to getting more doctors taking up leadership and management positions?
- How could more opportunities be created for clinicians to experience management and leadership roles?
- How do we raise the esteem of management among clinicians?

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