A current perspective on a moving target: clinical leadership in postgraduate medical education

Clinical leadership is now part of the curriculum for all doctors in training. This article describes one deanery's approach to the development of clinical leadership.

This article examines how the concept of clinical leadership has risen to prominence. It looks at how we might train good clinical leaders and how we ensure that leadership in all specialties and at all levels is effective in improving patient care and safety. It begins with a brief historical overview of leadership in the NHS, and then moves to examine current developments, with a focus on the approach taken by the Kent, Surrey and Sussex Deanery to facilitating leadership development in postgraduate medical education.

Background

In the years following the inception of the NHS, central government saw its role as one of planning and allocating resources. It took little responsibility for the quality of health care. There was an assumption that individual health-care professionals would manage the care of patients, exercising clinical freedom to achieve the best outcomes for them. Doctors saw themselves as accountable to their peers and their professional bodies alone.

In the 1980s, the anticipated reduction in spending on health as a result of a healthier nation had not materialized and costs were rising steeply, outstripping funding by an ever-increasing margin. Central government's approach to this problem was to propose policies to increase the efficiency of the NHS as a business. In the Griffiths report, managers were introduced into the system in order to look for cost improvements and to provide leadership and motivation to staff (Department of Health and Social Security, 1983). Griffiths identified that the NHS had no process for continuous evaluation of its performance against criteria and no way of assessing whether it met the needs of patients effectively. Griffiths also highlighted the need for clinicians to accept the management responsibility that accompanies clinical freedom.

In the 1990s ongoing attempts to engage clinicians in managing care led to the establishment of clinical directorates and training opportunities such as 'Clinicians into Management'. There was discussion that management activities might not necessarily be the best use of a clinician's time and there was debate about tension between management and the provision of clinical care (Fitzgerald and Sturt, 1992). Subsequent research has demonstrated a wide variation in the success of the directorates in managing budgets and maximizing clinical effectiveness (McKee et al, 1999) and dissatisfaction expressed by clinical directors (Davies et al, 2003).

The Bristol inquiry (Department of Health, 2001) into the management of care of children receiving complex heart surgery, together with Harold Shipman and the retention of organs at Alder Hey children's hospital (Department of Health, 1999), sensationally brought the public's attention to the failure of the profession to monitor its own performance effectively. The Bristol report specified the need for accountability and leadership and highlighted the failure of clinicians to take responsibility for the quality of patient care.

In 2000, the *NHS Plan* was published (Department of Health, 2000). This sought to ensure services were subject to continuous improvement in order to justify the unprecedented investment in health services. Both the Bristol inquiry and the *NHS Plan* became drivers for the development of clinical leadership at the beginning of the new millennium.

The British Association of Medical Managers was established in 1991 to look at ways to professionalize management for doctors, and to help those in leadership positions gain appropriate skills. This organization drew up leadership competencies in 2003, and by 2005 these were underpinning their 'Fit to Lead' programme for senior and emerging medical managers (British Association of Medical Managers, 2004).

Further developments include the Royal College of Physicians publishing *Doctors in society: medical professionalism in a changing world* (Royal College of Physicians, 2005), in which they recommended that leadership and managerial skills should be strengthened as key competencies of professional practice. In 2008, the Academy of Medical Royal Colleges, and the NHS Institute for Innovation and Improvement (2008) produced the Medical Leadership Competency Framework which provided a framework from undergraduate to the early years post-certificate of completion of training. Underpinning this framework was a growing academic body of knowledge linking good patient outcomes with high levels of clinical engagement (Dickinson and Ham, 2008). The Postgraduate Medical Education and Training Board accepted that the medical leadership competences should be included in the curricula of all postgraduate specialties and the first curricula with leadership included were published in 2009.

Convinced by this body of evidence, Lord Darzi in his next stage review (Department of Health, 2008) supported the teaching of leadership to all doctors and proposed developing those showing talent in this area with leadership fellowships. Furthermore, to provide national oversight, the National Leadership Council

Dr Lindsay Hadley *is Clinical Head and* **Dr Clare Penlington** *is Academic Head of the School of Clinical Leadership and* **Professor David Black** *is Dean Director, Kent, Surrey and Sussex Deanery, London SE1 2DD*

Correspondence to: Dr L Hadley

was formed in 2009 to coordinate the drive for improved clinical leadership throughout the NHS in all disciplines (Department of Health, 2009).

Currently, the concept of clinical leadership and its importance to good health care is again in the public domain. The mid Staffordshire Trust's poor emergency care was investigated (Health Care Commission, 2009). Alan Johnston, the health secretary, said that their problems with health care were the result of a 'lamentable lack of clinical leadership'. This case has been widely covered in the media, and the chairperson of the patient group at mid Staffordshire asked why, if clinical leadership was to blame, were clinical leaders not facing disciplinary action?

Implications

So what is clinical leadership and what does it mean for improving patient care? The Darzi review emphasizes that clinical leadership will increase effectiveness in the NHS by driving change, increasing innovation, and facilitating continuous improvement in the quality of care delivered. In short, clinical leaders demonstrate behaviour that motivates others and catalyses change for the good of patients. Evidence shows that those hospitals where clinicians are engaged in strategic planning and decision making perform better than those where clinicians play no part in the strategic processes of the hospital (Bowns and McNulty, 1999). It is also the case that significant change in clinical domains cannot be achieved without the cooperation and support of clinicians (Goldstein and Ward, 2004).

Clinical leadership in the NHS is not only about being able to motivate others; it is about being engaged with the improvement of patient care from within the organization itself. Thus, it is not enough for doctors to merely be aware that they have a responsibility to make the organization in which they work one that is committed to improving patient care, they also have to actively shape their practice in accordance with this principle.

Because the NHS is a huge and complex organization with many clinical microsystems, leadership is needed not just at the top but at all levels (Denis et al, 1999). Moreover, research on leadership initiatives in the NHS shows that we need to move away from a model in which we view the good leaders as the hero figure, leading from the front, towards a model which encapsulates the notion that in some contexts a good leader is a good follower (Walmsley and Miller, 2008).

There are a variety of reasons that doctors have not tended to take up formal and informal leadership roles in the NHS. First, there has been little recognition of leadership and management as a specialty within the NHS. Indeed, the skills involved in leading and managing have not been valued by other clinicians; rather these activities have been viewed as a distraction from the real job of doctoring. Second, few clinicians have been willing to undertake major training in leadership or management and have often found it difficult to span both the leadership-management and clinical roles, with the result that they may be unsuccessful in bringing about organizational improvements in either role (Fitzgerald et al, 2006). Third, the way that some leadership roles are time-bound and take doctors out of their clinical roles has tended to make them less attractive. The main deterrent here is the worry that the result of taking on a leadership role will inevitably take one out of the clinical setting to a greater or lesser extent, and that this distance from the clinical role will result in an attrition of one's identity as a doctor (in the doctor's own eyes, and those of clinical colleagues), making the transition back into a traditional clinical role a difficult one.

The Kent, Surrey and Sussex approach

In the authors' view effective clinical leadership is at the heart of effective clinical practice at every level in the NHS. It should be incorporated into the training for all doctors because it underpins good medical practice and safer patient care. As it becomes increasingly embedded within clinical practice, the current perceived tension between the leadership (management) role and the clinical role will diminish allowing doctors to achieve a balance that is appropriate to their patients' needs and their own skills at each stage in their career. A good doctor should always have leadership skills and good clinical leaders will use those skills for patient benefit.

So how do we improve clinical leadership? First, we need to value clinicians who lead for their leadership and management of change as much as clinicians who excel in their clinical field. It is only by valuing these clinicians that we can attract the very best talent to take on top leadership roles and also encourage others to aspire to effective leadership at all levels. Second, we need to encourage all doctors to develop the relevant leadership skills that will enable them to achieve excellence in clinical practice.

The School of Clinical Leadership

In the Kent, Surrey and Sussex Deanery, a School of Clinical Leadership has been set up to address these issues in postgraduate medical and dental education. The school is structured with a clinical head of school and a full time educationalist as the academic head. In recognition of the diffuse nature of leadership (cutting across all specialties) the school works across all parts of the deanery, primary care, secondary care and dentists and the clinical head works in partnership with the other clinical heads of school and trust directors of medical education. Currently, the work of the Kent, Surrey and Sussex School of Clinical Leadership falls into two main strands, each of which is described below.

Leadership Fellows

Like some other deaneries, we have appointed clinical leadership fellows. Unique to the Kent, Surrey and Sussex Leadership Fellowship programme (a full-time 1-year out of programme activity) is the way a work placement is partnered with an MSc Management (Leadership for Clinicians). In this programme, the leadership fellows work alongside a very senior manager who acts as a facilitator for their leadership training within the workplace. They also complete MSc modules, the assignments for which are all workplace-based projects. In this way, the Kent, Surrey and Sussex Leadership Fellowship programme combines practical patient safety and quality improvement projects in the workplace with the achievement of an academic Masters qualification (Playdon and Shaw, 2009).

In drawing up a curriculum for this unique Leadership Fellowship programme, the focus has been on developing a structure that could be rolled out as a 3-year part-time course in the future, thereby providing trainees who show interest and aptitude in leadership with an opportunity to develop key leadership skills and knowledge, alongside and as a part of their clinical training. In the future, it is expected that trusts would find it an advantage to sponsor talented individuals to work alongside senior managers on projects of local importance while gaining this qualification.

Champions Network

Second, attention has been focused on the best way to support the provision of leadership training to all trainees in the Kent, Surrey and Sussex region. A network of leadership champions has been established, comprising a senior clinician and manager from each trust. A central purpose in forming this community of leadership champions is to not only facilitate good practice, but to raise the profile and understanding of the leadership development programmes in postgraduate medical and dental training. The champions work together as a learning set across a number of development days in which they will be developing strategies to implement cross-curricular teaching within their particular trusts using the established networks of local specialty faculty groups in the Kent, Surrey and Sussex region.

Part of the task of implementing cross-curriculum leadership teaching is to think about how leadership competencies will be assessed. A crucial aspect of the work of the Kent, Surrey and Sussex community of leadership champions is thus to consider how current workplace-based assessments might be modified to assess the leadership competencies. This approach ensures that leadership development is thought of as integral to clinical development, as opposed to an 'added extra' or 'bolt on' part of the curriculum to be taught in a series of lectures. As we move ahead with this strand of work we will be providing clinical and educational supervisors with training – both in how to provide opportunities for trainees to develop leadership skills and knowledge, and how to assess trainees against leadership competencies.

Conclusions

Implementing improvements in patient care by leading and taking responsibility for implementing constructive change is the professional responsibility of every doctor. There is now a strong and growing evidence base linking good patient outcomes with clinical engagement and leadership. In response to this agenda the Kent, Surrey and Sussex Deanery has set up a School of Leadership to facilitate the education, recruitment and retention of excellent and effective clinical leaders. **BJHM**

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KEY POINTS

- There have been a number of initiatives to engage doctors in leadership and management.
- Past and present examples of poor patient care are often blamed on failures of clinical leadership.
- Clinical leadership is now part of the curriculum for all doctors in training.
- Kent, Surrey and Sussex Deanery has set up a School of Leadership.
- The school includes clinical leadership fellows undertaking a new workplace-based Masters in clinical leadership who have the support of senior managers.
- There is also a cross-curricular approach to the teaching and learning of leadership using both clinical and managerial champions and the established educational network.