

Engaging Doctors:

What can we learn from trusts with high levels of medical engagement?

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Executive Summary



Medical engagement in the leadership and management of healthcare organisations is a key determinant of organisational success. This short paper shares the key findings from a study of seven trusts which achieved high Medical Engagement Scale¹ (MES) scores from an initial survey involving 30 trusts in England. This paper seeks to describe the actions and initiatives taken by these Trusts to achieve high levels of engagement and thereby to make this 'best practice' available to others. The research clearly indicates that medical engagement plays a crucial role in supporting organisational achievement and that leadership is essential in creating the appropriate culture for medical engagement to flourish.

Medical engagement:

"The active and positive contribution of doctors within their normal working roles to maintaining and enhancing the performance of the organisation which itself recognises this commitment in supporting and encouraging high quality care."

Spurgeon, Barwell and Mazelan, 2008, p214

Introduction

The need for medical engagement in the leadership of and involvement in the planning, design and delivery of NHS services is now widely recognised. A number of reports, including *High Quality Care for All: NHS Next Stage Review Final Report* (Department of Health, 2008), *The Coalition: Our programme for change* (Cabinet Office, 2010), and the *White Paper Equity and Excellence: Liberating the NHS* (Department of Health, 2010) all emphasise the importance of doctors being actively engaged in leadership and improvement of health services. Recent changes in the economic and political environments have made this requirement particularly acute.

The Medical Leadership Competency Framework (MLCF)², through its integration into medical education and training, will ensure that doctors acquire appropriate management and leadership skills at all key stages in their careers. This is central to enabling the motivational benefits of enhanced engagement to be effectively harnessed. In addition, leaders of healthcare organisations need to create and maintain the cultural

conditions which provide the opportunities and environment within which doctors will engage in management, leadership and quality improvement of health services. Indeed, this enhanced engagement can deliver significant benefits for the organisation and ultimately for patient safety and quality of care. (Spurgeon, Barwell and Mazelan, 2011, in press)

A large sample of trusts (N=30) participated in a study to establish norms for the MES and the seven trusts that scored highly on the MES were approached in order to explore how they created these levels of engagement and to develop individual case studies. From these case studies, we have identified a number of approaches that other organisations might use to enhance engagement in their own organisational context. We have also included seven examples of initiatives designed to engage doctors and other clinical staff in these organisations. It should be noted that leaders in these organisations had created the cultural conditions within which such initiatives were well received and embedded as part of 'business as usual'.

¹ The MES is designed to assess medical engagement in management and leadership in NHS organisations.

² The MLCF describes the leadership competences doctors need to become more actively involved in the planning, delivery and transformation of health services.(NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges, 2010).



Findings

The seven organisations interviewed had sought medical engagement in management and leadership for various reasons. Some through the strong conviction of a senior leader as the best way to run the organisation. Others found it was the most effective way of working to achieve organisational goals.

All organisations acknowledged that medical engagement was often challenging but highlighted the consistency of benefits attributed to high levels of engagement e.g. successful initiatives and innovation, staff satisfaction, staff retention, improved organisational performance and better patient outcomes.

Relationships between managers and doctors varied between organisations, some were historically good and others dysfunctional. In both cases, it was acknowledged that engagement takes time and disengagement has the potential to be sudden and precipitous.

All organisations faced challenges and difficulties from both internal and external forces e.g. service reconfiguration and economic climate. The potentially dynamic and shifting nature of engagement requires that there is an awareness of, and sensitivity to, current levels of engagement and their direction of travel. In this context, the MES is particularly useful. Monitoring levels of engagement requires active listening and discussion of issues and concerns. Understanding of various clinicians' propensity to engage is important so resources can be deployed effectively to generate engagement – 'the right individual, the right issue and the right time'.

Importantly, all organisations emphasised that engagement efforts should be proactive and persistent and should be extended to the entire medical workforce, not just those in designated leadership roles.

The key findings from the study are divided into the activities that helped to generate and maintain medical engagement and the principles for generating an organisational culture to transfer possibility into reality.

Generating and maintaining medical engagement

In the organisations interviewed, generating and maintaining medical engagement involved:

Leadership

Senior leaders supported and facilitated the engagement agenda at the highest level by setting expectations, leading by example, and being visible and available e.g. spending time 'on the shop floor' and having 'open door' policies. This helped to generate an environment that promotes and fosters relationships, particularly across professional and organisational boundaries.

Stability in top-level leadership also enabled a continuity of philosophy and the time to effect culture change. Furthermore, managerial stability demonstrated a personal commitment to and investment in the long-term success of an organisation.

Example 1: Patient safety walkabouts

Each week a team, comprising of at least one senior clinician and manager, visit a different clinical area. The walkabouts aim to provide frontline staff with an opportunity to discuss issues relating to patient safety, as well as wider concerns, with senior leaders and managers. The exercise serves a number of purposes related to engagement – it allows leaders to engage, listen to concerns and identify issues, to be visible, and to demonstrate to all staff that their efforts are valued. It also helps to provide an emphasis on a particular issue, in this instance patient safety.



Example 2: Season's greetings

Each Christmas and Easter a senior manager visits each team within the trust, across all the sites, delivering seasonal gifts. The exercise is time consuming rather than expensive, but provides a useful opportunity to understand staff within the organisation and the challenges they face. It demonstrates that their work is valued, not only by the gifts given but also (and perhaps more importantly) through the time invested in the exercise by senior staff. In trusts where this is done a direct, but short-lived, beneficial effect has been noted in terms of engagement with management initiatives.

A future-focused and outward-looking culture

Organisations demonstrated an aspirational and competitive culture by actively encouraging and engaging in current and future best practice to improve upon their performance and develop. They were also keen to make a wider contribution to the NHS through the publication and promotion of local work and involvement of doctors in regional and national schemes. This was also beneficial to medical engagement by developing individual leadership ability, acquisition of learning and knowledge and increased organisational loyalty through the facilitation of personal interests. Such organisational approaches to engagement demonstrate how doctors are increasingly required to engage in the wider environment beyond their clinical area. It reflects the new definitions of medical professionalism as articulated in *Doctors in Society: medical professionalism in a changing world*. (Royal College of Physicians, 2005)

Attention to selection and appointment of the right doctors to leadership and management

Selection and appointment of the right doctors to leadership and management roles was achieved through:

- selection based on ability and open competition (rather than seniority or informal succession planning)
- incorporating leadership aptitude and potential into recruitment
- selecting individuals with the right attitudes i.e. willingness to collaborate, ability to take a wider perspective and interest in team rather than individual success
- senior input (chief executive or medical director) into all consultant appointments
- ensuring adequate support was available to doctors taking on leadership roles who need to retain 'clinical credibility'
- a willingness not to appoint anyone rather than select an unsuitable candidate
- ensuring there was a choice of candidates available. This involved active management of top-level leadership through talent spotting and succession planning and providing support, development, and opportunity for individuals to equip themselves with the necessary skills to take on leadership roles.



Providing support, development and leadership opportunities

A number of methods for developing both individual and collective leadership ability were cited, including:

- Developing individual and collective leadership ability of the medical community by investing in leadership development courses and providing ongoing leadership training. Mentoring and coaching schemes also helped to promote understanding of the way in which the organisation works and maximising individual effectiveness.
- Increasing the number of leadership development opportunities available both in terms of the organisational structure and official roles available and projects and initiatives which doctors could take a lead role in to increase breadth and depth of leadership capacity. This also involved recognising the need for doctors to avail themselves of external leadership opportunities through courses or involvement in regional, national or specialty college-based projects. Another option was to build leadership roles and activities into job plans.
- Developing ability and reputation in medical teaching and training. At an individual level this developed leadership skills and ability as a teacher and trainer, skills which were easily transferable to an organisational management or leadership setting. At an organisational level, the cultural impact of these activities resulted in attracting the right type of individuals to positions, enhanced constructive and collaborative working across departments and organisations (which medical educators need to do).
- Ensuring development of specific individuals identified through talent spotting and succession planning to enhance the individual's skills and effectiveness and therefore their ability to fulfil current or prepare for future roles. This required an understanding of their respective needs in consideration of the context of the wider organisation requirements and ability to provide support, development, and opportunity for individuals to equip themselves with the necessary skills to take on leadership roles.

"It is relationships between people which hold organisations together...the formal and informal parts of our lives do fit together; to deny that is folly, but to use it brings lots of advantages."

Interviewee

Example 3: The power of appraisal

One organisation has recognised and harnessed appraisal as a tool to drive development and engagement. Starting with the requirement for all doctors to undertake a yearly appraisal the process has been developed through the training of a team of able and effective appraisers. Doctors are given access to an array of data relating to their practice, including data from Dr Foster, complaints data and teaching and training feedback and are expected to refer to this in the material prepared for the appraisal and their personal development plans (PDPs). PDPs are required to be realistic (unachieved objectives cannot be unquestioningly reset year on year) and comprehensive (each objective must be accompanied by a description of how success will be measured and achieved).



Example 4: Multidisciplinary leadership development

Leadership development for doctors is undertaken simultaneously and as part of the same programme as that for managers. At one organisation the programme takes place over 2 years; consultants and managers go away for three days, twice per year to learn about leadership development, team dynamics and quality improvement (QI) techniques. The relationship between managers and consultants is cemented by undertaking QI project work together. Senior executives listen to presentations of all projects and praise the work. A number of projects have delivered significant improvements.

Example 5: A team-based approach

One of the trusts within this study has focussed intently on adopting a team-based approach within the organisation. The strength of this lies in the fact that teams are inclusive and multidisciplinary, incorporating both managers and clinicians. The organisational development team works hard with teams to support their working as a group, in addition to the individuals within them. Teams that are identified as having difficulties, either by internal or external sources, are targeted with 'special measures.' These measures form the basis of a developmental approach aimed at facilitating teams and individuals to acquire the skills required to solve their own problems.

Effective communication

Communication is key to developing relationships and building trust. Organisations interviewed emphasised the following:

- Creating a unifying language or narrative, recognising that use of respective professional language by managers and clinicians could be divisive. The unifying language or narrative was set in the context of organisational vision and issues of patient safety and quality of care e.g. using 'safer care' rather than 'clinical governance'.
- Communicating widely and effectively, promoting a spread and understanding of messages using a plurality of methods and persistence. Many stressed the importance of face-to-face communication especially from senior leaders on both a one-to-many and one-to-one basis.
- Facilitation and engagement of individuals in open, honest and frank discussion on a routine basis. There was an emphasis on listening and responding, closing the feedback loop to confirm what actions had or hadn't been taken and why. This effectively broke down barriers and guarded against a natural tendency to work in 'silos'.
- Communication was also important to understanding and facilitating individual abilities, interests and current capacity. For example, one medical director sought to harness and encourage individual enthusiasm, 'farming out' issues picked up through horizon scanning to those able and willing to take a lead in assessing and addressing them. Taking an interest in the issues, problems and difficulties, whether or not they could be addressed was a key part of communication.



Principles for generating an organisational culture to transfer possibility into reality

The following are some principles for generating an organisational culture which facilitates the transformation of possibility into reality.

Promotion of understanding, trust and respect between doctors and managers

An important part of this was enabling both managers and doctors to realise that they were on the same side and shared a common goal: to build a successful organisation delivering high quality healthcare to patients.

Achieving this involved openness and transparency to generate trust. Challenging and deconstructing prejudices, suspicions and stereotypes of the respective professional groups was also key. These need to be replaced with acknowledgment and acceptance of professional differences such as motivations, timescales and drivers. For example, targets highlight different professional attitudes to an organisational requirement. Promoting a constructive attitude i.e. doctors recognising that managers need to deliver on targets as part of their jobs and helping them do so, and in return managers sought to support doctors with service improvement or development initiatives delivers results and increases professional satisfaction. Other examples included – ‘medicine for manager’s’ programmes where doctors present clinical developments and issues to managerial colleagues, and management slots incorporated into medical grand round timetables.

Example 6: Organisational speed dating

As part of a drive to identify potential efficiency savings one trust organised an evening ‘speed-dating’ event. Individuals from all the different professions (clinical and non-clinical), at all different levels and across the entire organisation were brought together to participate in discussion aimed at generating potential efficiency gains. The event allowed staff to own part of the problem and be integral in its solution, unlocking their knowledge and potential. It also helped to bring together individuals who would not usually come into contact and allow them to develop and strengthen professional relationships.

Example 7: Specialty board forums

At one institution the medical director acts to chair a number of various ‘specialty board forums.’ These are multidisciplinary meetings based around clinical services that bring together doctors, nurses, managers, service users and carers. The meetings are used to present data and identify problems and potential solutions. It is expected that when a problem is identified in a meeting, a team of individuals will also be chosen to help solve it. The process brings together a wide variety of individuals from key groups, helps to improve communication, break down barriers and promote collective ownership of problems and their solutions.



Setting expectations, enforcing professional behaviour and firm decision-making

Structures and policies can help set organisational expectations and describe developmental or punitive measures that may be instituted in the event that expectations are not met. This needs to be balanced by inducements and incentives to demonstrate that engagement is not only expected but is valued.

Setting expectations in relation to both good and unacceptable professional and behavioural practice by both clinicians and non-clinicians was highlighted by the top-performing organisations. Actions to clamp down on destructive and disengaging behaviours and to safeguard patients were welcomed by those within organisations where they occurred. This official moderation of poor behaviour decreased frequency, emulation and cultural acceptability of such behaviour. Developmental methods of addressing poor performance were preferred however no organisation shied away from disciplinary or statutory proceedings where the developmental approach was unsuccessful or rejected. These and other difficult decisions were 'made early, made together and stuck to' to avoid potential for unresolved issues to fester and generate ill will and discontent leading to disengagement.

Clarity of roles and responsibilities and empowerment

Clarity on the respective roles and responsibilities of 'medical' and 'management' staff and the ways in which they were expected to work together is vital. Most organisations had adopted a duality (doctor and manager) or triumvirate (doctor, nurse and manager) model where those individuals led departments together with joint accountability but separate portfolios. Several organisations made clinicians accountable for quality of care and managers for financial management. There was a clear expectation that this method of working should be replicated at all levels throughout the organisation from the medical director and chief executive to individual consultants and their service managers. This made medical engagement both the ideal and usual way of working in these organisations. Furthermore, this ensured engagement was meaningful as it empowered doctors to shape and develop the organisation and its strategy and determine how resources are allocated.



Conclusion

Medical engagement is clearly important for organisational performance and there is a need to build a culture of engagement in the health service. The organisations that scored highly on the MES readily acknowledge the benefits derived from the engagement of doctors. None claimed to have a perfect solution, and there was acute awareness of the work still to be done and the challenges that lay ahead. However the examples observed in trusts with the highest levels of engagement provide an indication of what is required to build a culture of engagement.

Reform and improved performance in health systems is in itself dependent upon fully engaged doctors and that in order for this to happen the organisational culture, shaped and influenced by its leadership, must be appropriately supportive and constructive (Armit and Roberts, 2009). The acquisition of leadership competence by doctors themselves will form an important element in creating this enhanced engagement.

The diagram on the following page illustrates some of the key issues to consider to build and maintain medical engagement.

It is hoped the research published here will be helpful to healthcare organisations in the UK and internationally to develop a culture that provides the opportunities and environment to engage doctors at all levels. Each organisation will need to make such initiatives meaningful in their own circumstances but the crucial role of engagement in supporting organisational achievement suggests the rewards are clear and long-term.

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Enhancing Engagement in Medical Leadership



Enhancing Engagement in Medical Leadership is a UK-wide project led by the Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement. The purpose of the project is to promote medical leadership and help create organisational cultures where doctors seek to be more engaged in management and leadership of health services and non-medical leaders genuinely seek their involvement to improve services for patients across the UK. Some of the key project materials include:

Medical Engagement Scale

The Medical Engagement Scale (MES) offers NHS trusts a greater insight to the level of engagement of doctors in their organisation and ways in which this engagement might be improved.

The MES is designed to assess medical engagement in management and leadership in NHS organisations. It has been designed to differentiate between the individual's personal desire to be engaged and the organisation's encouragement of involvement.

Interested trusts should contact Applied Research Ltd. - research@perform.gotadsl.co.uk or 0121 434 3511.

Medical Leadership Competency Framework (3rd edition)

The Medical Leadership Competency Framework (MLCF) describes the leadership competences doctors need in order to become more actively involved in the planning, delivery and transformation of health services.

The MLCF applies to all medical students and doctors throughout their training and career. The MLCF is being used in NHS organisations to inform the design of development programmes, appraisal and recruitment and it can assist with doctors with personal development planning and career progression.

Guidance for Undergraduate Medical Education – Integrating the MLCF

Following the review of the General Medical Council's (GMC) *Tomorrow's Doctors* (2009), which includes the MLCF leadership competences, the project team worked with several medical schools to develop a guidance document to help all medical schools integrate the competences into their curriculum.

Medical Leadership Curriculum

Following the former PMETB's scrutiny of the Medical Leadership Curriculum (MLC) (based on the MLCF), the project team has worked with all Medical Royal Colleges and Faculties to integrate the MLC into their specialty curricula.

LeAD

Online e-learning materials developed in conjunction with the Department of Health's e-Learning for Healthcare project for postgraduate trainees and clinical tutors to facilitate their leadership competence development. More information on how to access LeAD can be found at www.e-lfh.org.uk/projects/lead.

Medical Chief Executives in the NHS – Facilitators and Barriers to Their Career Progress

This report summarises findings from interviews with 22 medical chief executives in England. It identifies the factors that influenced them to assume Chief Executive roles and also what changes may be required to encourage more doctors to seek Chief Executive positions.



Engaging Doctors – Can doctors influence organisational performance?

A report that shares findings from research into a link between organisational performance and medical engagement. The report provides real examples of good practice in medical engagement, as well as a set of behaviours and approaches emerging from the research that should lead to a more positive and effective way of engaging doctors in management and leadership.

Engaging Doctors – What can we learn from international experience and research evidence?

A systematic and research based overview of the evolution of medical leadership and the reasons why a concerted focus on the training and support for doctors who are taking on leadership roles is needed.

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ISBN: 978-1-907805-02-8

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