Why medical leadership matters and how it can be developed

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Chief Executive
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What I want to cover

› Some theory

› Examples from around the world

› Medical leadership in the NHS today

› What now needs to be done
Improving the performance of health services: the role of clinical leadership

Chris Ham

Reform of health-care systems in the past decade has been driven by ideas such as public/private partnerships, managed competition, managed care, and integrated care. These abstractions bet part the grand nature of ambitions harboured by reformers. Faced with funding pressures on the one hand, and failures of service delivery on the other, policymakers have entertained radical solutions in the hope they will lead to improvements in health-system performance. In practice, reform has generally fallen short of both rhetoric and expectations, leading to reappraisal of the strategies pursued and a search for new policies.

The failure of radical solutions stems in part from their limited effect on clinical practice. Improvement of the performance of health care depends first and foremost on making a difference to the experience of patients and service users, which in turn hinges on changing the day-to-day decisions of doctors, nurses, and other staff. Reforms based on ideas like managed competition and integrated care might have some effect on clinical decisions, but in professional organisations like hospitals and primary-care practices, many effects on decision-making exist. In these organisations, policies initiated by health-care reformers have to compete for attention with established ways of working and other imperatives, which may result in a gap between policy intent on the one hand and delivery on the other.

A key feature of professional organisations, as Henry Mintzberg noted over 20 years ago, is that professionals have a large degree of control. As a result, the ability of managers, politicians, and others to influence decision-making is more constrained and contingent than in other organisations. Thus, ways have to be found of generating change bottom-up, not just top-down, especially by engaging professionals in the reform process. This includes recognition of the importance of collegial mechanisms in professional organisations and the role that leaders from professional backgrounds themselves can have in bringing about change. Mintzberg’s insights into the nature of professional organisations have been reinforced by studies of the effect of quality-improvement initiatives in health-care organisations in several countries, and we now draw on findings of these studies to explore the challenges entailed in improvement of performance.

Engagement of clinicians

Accepting that influences on clinical practice are many and varied, no one approach to improvement of performance is likely to be sufficient. Rather, several interventions are needed, including educational initiatives, use of opinion leaders, peer-review mechanisms, and financial and other incentives. In many of these interventions, clinicians need the time and space to review established practices, and to introduce new and more effective ways of delivering services.

Of particular importance is the need to understand what motivates professionals in their daily work. As research in the UK has shown, the desire to help people by offering a high standard of service in a timely and courteous manner remains the main motivation of clinicians, notwithstanding well published examples of failures of clinical performance. Strategies that appeal to this motivation—such as the provision of opportunities for professional education and development—are more likely to attract commitment than are those with the view that professionals need tighter control to deliver services in an effective way. The limitations of initiatives that direct professionals to change what they do has been underlined in studies of the effect of organisational reform.

A good example is a study of the effect of re-engineering of an English hospital. Workers on this study showed that changes in working arrangements initiated by managers had a variable and limited effect. Hospital doctors and their clinical colleagues were unwilling to make changes unless they could see benefits for their own practice and for patients. As a result, many anticipated gains were not realised, and the centrally directed approach to achievement of change that characterised this initiative at the outset gave way to an approach that was adapted to the needs and preferences of individual clinical services and staff working in these services.

This approach was more effective in bringing about change because professionals felt they were leading the process instead of having change imposed upon them. As the study concluded:

“Significant change in clinical domains cannot be achieved without the cooperation and support of clinicians... Clinical support is associated with process redesign that resonates with clinical agendas related to patient care, services development and professional development. ‘To a large degree interested doctors in re-engineering involve persuasion that is often informal, one consultant at a time, and interactively every time... clinical commitment to change, ownership of change and support for change constantly need to be checked, reinforced and worked upon.’”

Researchers on other UK studies have reported similar findings, and have underlined the fragility of changes that are introduced without effective engagement of clinical teams. These studies echo work in Canada that has highlighted the need to show that clinicians will benefit from changes designed to improve the experience of patients. The more general lesson here is that hospitals and other health-care organisations have an inverted power structure, in which people at the bottom generally have greater influence over decision-making on a day-to-day basis.

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Mintzberg

- Health care organisations are professional bureaucracies, not machine bureaucracies
- They are disconnected hierarchies or organised anarchies
- They are also inverted organisations: power rests at the bottom as much as at the top
Batalden

- Health care organisations comprise a collection of clinical microsystems
- Change has to impact on microsystems to make a difference
- Organisations need leaders at all levels – distributed and shared
- Clinical leaders are critical in health care organisations
“Significant change in clinical domains cannot be achieved without the cooperation and support of clinicians ... Clinical support is associated with process redesign that resonates with clinical agendas related to patient care, services development and professional development ... To a large degree interesting doctors in re-engineering involves persuasion that is often informal, one consultant at a time, and interactive over time ... Clinical commitment to change, ownership of change and support for change constantly need to be checked, reinforced and worked upon”
High performing organisations in other countries

- Kaiser Permanente, Mayo Clinic, Intermountain Healthcare
- Long term investment in medical leadership
- Medical leaders from the top to the bottom
- Followership is also a critical ingredient
- Medical leaders are bilingual
Doctors must lead efforts to reduce waste and variation in practice

US healthcare organisations show that leadership by doctors is essential in tackling the pressure of further financial cuts and to halt the decline in performance if the NHS model is to survive, says the King's Fund chief, Chris Ham

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The King's Fund's latest survey of NHS performance in England points a picture of a service struggling to cope with increasing demands at a time of unprecedented resource constraints.¹ The pressures on the NHS are greatest at the front doors of hospitals, with waiting times in emergency departments the longest they have been in a decade. The prime minister's pledge in 2007 to maintain the commitment to treat 95% of patients within four hours in emergency departments was broken in the first quarter of 2013, a clear and worrying signal of what lies ahead.

With public spending under renewed scrutiny as the chancellor concludes the spending review for 2013-14, there is little prospect that more money can be found to deal with these pressures. Instead, with press reports suggesting that some of the supposedly ring-fenced NHS budget may be taken to support localised social care services, health service leaders will have to make their efforts to squeeze more out of existing budgets. The challenges they face is how to do so when about two thirds of these budgets go on staff, and when recruiting and retaining sufficient nurses and other front line staff are critical to the delivery of high quality care.

This challenge will not be met by simply slicing budgets and cutting management costs and back office functions. Instead, the focus should be on the myriad decisions taken every day by doctors, nurses, and other clinicians on how to treat patients. These decisions—for example, on which drugs to prescribe, what tests to order, and whether to admit patients to hospital—determine how most of the resources of the NHS are used. Reducing wide and unwarranted variations in decisions between general practices and hospitals could help cut waste and release resources to deal with the increasing demands on the service.²

The autonomy of doctors helps explain why variations in medical practice persist, and why politicians and managers cannot reduce them without the full and enthusiastic involvement of medical staff. Putting general practitioners in charge of commissioning care for patients is an attempt to do this, but it is too early to assess how effective clinical commissioning groups will be. Equally important is to engage doctors providing care in hospitals and other services to see greater stewardship of scarce public resources as a key part of their role. Recently published research shows that the NHS still has a long way to go in supporting doctors to take responsibility for budgets and services, just at the time when this has never been more vital.³

The importance of doctors leading the quest for improvements in the NHS was brought home to me on a recent visit to several high performing healthcare organisations in the United States. Without exception, these organisations are led by experienced doctors who combine credibility with their peers with a deep understanding of what needs to be done to deliver high quality care within available resources. Medical leaders in Kaiser Permanente in California, for example, explained that in their experience improvements are best achieved by doctors being committed to high quality care rather than having to comply with externally imposed targets and standards. It is this culture of commitment and not compliance that is fundamental to the high standards of care delivered in Kaiser Permanente, as seen in independent national rankings of health plans.⁴

Intermountain Healthcare in Utah goes further, to argue that in some cases high quality care costs less. This is because of the ways involved in care do not receive the right treatment first time and have to remain in hospital longer than necessary or in some cases to be readmitted for errors to be corrected. A core strategy in this organisation, widely admired and studied for the excellence of its care, is to standardise how care is delivered by medical leaders working with their colleagues to agree on best practice guidelines, thereby reducing variations in care. Intermountain Healthcare enables its staff to make improvements by a long term investment in training in quality improvement techniques.

The same applies to the Virginia Mason Medical Centre in Seattle, which for many years has led the adoption of Toyota’s Lean production system in healthcare. Like the other organisations visited, Virginia Mason understands the key role of doctors in leading change and their intrinsic motivation to provide the best possible care. It supports them and their colleagues to do so by honing their skills in reviewing how services can be improved by reducing delays and eliminating activities that are not worth doing.

1. King’s Fund 2013
2. King’s Fund 2013
3. King’s Fund 2013
4. King’s Fund 2013
Culture

- KP achieves improvement through a ‘culture of commitment and not compliance’
- Medical leaders work in partnership with experienced managers and other clinical leaders
- Top level leaders foster this culture and invest in leadership and skills development
- Improvement occurs mainly ‘from within’
Critical mass

▶ Medical leadership is more than a minority interest
▶ Medical leaders commit serious time to their leadership roles
▶ There is no sense of doctors ‘going over to the dark side’
▶ Leadership roles are valued, sought after and properly remunerated
A caution

▷ Professional bureaucracies can be conservative and reluctant to change
▷ Left to their own devices, they may be unresponsive and lack capacity to innovate
▷ Organisational leaders have to set stretching improvement goals
▷ These goals must resonate with clinical agendas
Are We There Yet? Models of Medical Leadership and their effectiveness: An Exploratory Study

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The results

- Our research reveals variations in structures and processes between NHS Trusts in England.
- These variations reflect in part lack of prescription by successive governments, and the decisions of local leaders on what is appropriate.
- There are also variations within Trusts, including in the perceived effectiveness of medical leadership arrangements.
- Much hinges on the quality of medical leaders themselves and their relationship with general managers in the dualities we identified.
Results (2)

- The personal credibility of medical leaders and their ability to lead skilled and autonomous colleagues is perceived to be critical.

- Trust leaders are investing in leadership development and introducing greater formality and professionalism into the process of identifying medical leaders.

- This may have contributed to the ‘engagement gap’ we identified between medical leaders and followers because medical leaders may be associated with trust management.
Results (3)

- Progress has been made in the development of medical leadership since previous studies in the 1990s.
- The journey that began with the Griffiths report has continued but our evidence shows that there has been no *fundamental* change in established relationships and dynamics between doctors, managers and nurses.
- Much greater priority has been attached to general management than medical leadership.
Medical leaders continue to occupy hybrid roles in the precarious middle ground between managers and medics.

The perception that doctors who go into leadership roles have ‘gone over to the dark side’ has been slow to change.

There are also many obstacles to doctors taking on leadership roles relating to pressures of work and time, the perceived status of these roles, and the absence of a well defined career structure.
Why does this matter?

- Health care systems worldwide face growing financial and performance challenges.
- The insights of Mintzberg and Batalden remind us that change cannot be mandated by politicians and managers.
- The experience of high performing health care organisations demonstrates what needs to be done.
- We now need to act on the evidence and do so urgently if we are to make progress.
Improving NHS productivity
More with the same not more of the same

Executive summary

Funding prospects for the NHS

- Last year, The King’s Fund, with the Institute for Fiscal Studies (IFS), examined the implications of the economic crisis for the funding prospects for the NHS. We compared likely funding with the original funding estimates produced by Sir Derek Wanless in his 2002 report in order to quantify the difference between required and actual funding.
- Using this framework, £126 billion would be required in 2013/14 to meet Wanless’s aspirations for the ‘solid progress’ scenario. While exact spending commitments from 2011/12 onwards will be published in the autumn spending review, the government has pledged a real-terms rise in total NHS funding each year for the rest of this Parliament.
- We concluded that, with no productivity improvement and no real rise in spending, the funding shortfall could still be around £21 billion by 2013/14. The inescapable conclusion from The King’s Fund/IFS analysis was that closing the gap would inevitably involve major improvements in NHS productivity, with year-on-year gains of up to 6 per cent for six years.

The scale and composition of the productivity gap

- In this paper, we have ‘decomposed’ the gap between required and actual funding to understand whether the assumptions about the drivers of increased expenditure still hold – whether they have already been met, or are still appropriate, given the state of public finances. Our analysis reveals the key decisions facing health care leaders at national and local levels over the next two to three years as they try to contain and manage demand and cost pressures.
Figure 6  Action required at all levels of the system

- **Clinical microsystems**
  - Engaging clinical teams
    - Supporting and enabling them to improve quality and productivity

- **Providers**
  - Improving operational efficiency
    - Tackling variations
    - Ensuring workforce productivity

- **Commissioners**
  - Doing things right and doing the right things
    - Priority setting and managing demand
    - Enabling greater integration

- **Regional**
  - Setting tone for local health economies
    - Controlling finances and performance
    - Supporting quality and productivity gains

- **National**
  - Defining the rules of the game
    - Reviewing quality standards and targets
    - Constraining pay settlements
    - Setting tariff and incentives
    - Determining capital investment levels
Medical engagement
A journey not an event

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Implications

› A step change is needed to realise the potential of medical leadership

› This requires a concerted effort to remove obstacles and to provide training, development and support

› The time commitment of medical leaders needs to increase substantially, and the proportion of doctors in leadership roles also needs to increase

› Supporting doctors to be developed alongside managers, nurses and others should be a priority
Implications (2)

- A range of factors need attention: developing career structures; valuing medical leadership roles; nurturing a culture that supports medical leadership and followership; and creating an expectation that medical leaders are needed at all levels.
- We need to learn from the experience of organisations in other countries where medical leadership is well developed.
- If these findings are not acted on there is a risk that our medical leaders are being set up to fail.