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Possibilities and Pitfalls for Clinical Leadership in Improving Service Quality, Innovation and Productivity

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interviewees are those of the interviewees and not necessarily those of the NHS, the NIHR or the Department of Health.

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Executive Summary

Background

The idea that something called 'clinical leadership' is the favoured 'answer' to many of the huge challenges facing the NHS has been advanced with increasing intensity. *Inter alia,* Lord Darzi in the Next Stage Review emphasised the importance of clinical leadership; the Health and Social Care Act (2012) puts clinicians to the fore; and the Royal Colleges have accepted the need for Medical Leadership Competences to be defined and developed.

Despite such emphasis and expectation, the reality of clinical leadership attempts to redesign services across the extant boundaries of the NHS and which reveal how the many barriers can be overcome, has not so far been studied.

Aims

The overall research question was:

What can be learned from the experience of enacting the Darzi model of clinical leadership in practice? What are the main enabling and constraining conditions for its effective realization and performance?

Subsidiary research questions that feed-in to this main research question were:

1) What general lessons about its nature and its practice can be educed from a series of examples of effective clinical leadership in introducing more integrated models of care? What variations are required when enacting the model in very different service areas?

2) What are the enablers and the blockers of effective clinical leadership?

3) How do effective clinical leaders both initiate and lead service improvements while also engaging constructively with top-down service redesign and improvements initiatives?

4) How do service-level clinical leaders in acute and primary care develop and implement service quality improvements through achieving greater integration between primary and acute care? How do they go about mobilising other clinicians while also engaging with commissioners and managers?

Methods

The nature, scope and potential for clinical leadership were explored by focusing on its practice in four 'cases'. The cases were cross-boundary service redesign attempts in two service areas: dementia and sexual health. These were studied in two different health economies: one in a part of London and one in a part of Greater Manchester. Hence, the two service areas in two geographies gave rise to 4 distinct cases. Each case contained multiple organisations including GPs and primary care trusts, acute hospital trusts, mental health trusts, local authorities and independent sector providers.

We interviewed a total of 74 informants across the 4 cases including hospital consultants, junior doctors, nurses, other clinicians, managers and commissioners. The interviews were supplemented with a series of observations of meetings and service contexts.

Feedback events were held with informants and additionally there were inter-disciplinary workshops where managers and clinicians were able to respond to our findings and to offer additional insights about their generalisability beyond the case sites. Insights from these events are included in this report.

Results

The main findings of the study were:

1. The obstacles to the exercise of the clinical leadership of cross-boundary service redesign within the context of the NHS are many.

2. Despite the extent and severity of the obstacles, we found some significant examples of clinical leadership of service redesign which were all the more impressive because of the challenges that had to be surmounted.

3. In general, clinical leadership was found to occur at multiple interlocking levels and the role of clinicians in shaping national policy should not be underestimated. Many of the important changes required national endorsement – and often funding – in order to put traction behind good ideas.

4. Successful clinical leadership requires the enactment of skilful practice across a number of constellations including collaborative working with a host of actors including managers, IT staff, project managers, estates and many others.

5. Clinical leaders were capable of being open to new ideas and new knowledge while also having the political wisdom to seek new reworked boundaries around which professional identity could be redefined and reformed.

6. Implementation leadership was important; it is the essential minimum for change.

7. Informal, lateral, leadership can mobilise and bring along clinical colleagues and conversely formal project planning on its own can be relatively ineffective but the most effective service redesigns were achieved when both of these processes worked in tandem.

Conclusions

Different types of clinical leadership were found. We identified four main types: the relatively passive; those who utilised effective interpersonal and planning skills to achieve localised and rather incremental service improvements; those who brought passion and vision to bear and rushed ahead but who lacked followers and therefore became exposed; and high-impact leaders who brought both an appropriate scale of ambition and a set of micro-political capabilities to bear so as to achieve significant cross-boundary service redesign.

A focus on patient and service user needs and wants is underscored. Likewise, the need to attend at an early stage to the identification of the public health case for service redesign proposals is reinforced. This entails a concomitant awareness and capability in calculating the resource implications and the trade-offs. This in turn means forging positive collaborative relationship with a range of critical actors.

Making the case for redesigning services across established boundaries is linked to establishing a fresh and compelling focus on patient and service user needs. Local clinical leadership of this nature stems in part from the intrinsic interest of many clinicians - doctors, nurses and allied health professionals - in understanding the wider system of care experienced by their patients. The motivation to improve interfaces and bring together the forms of care people need often finds expression in informal initiatives to link with other parts of the health service and with social care. This emergent activity form of cross-boundary improvement is an important resource for more formal and structured service redesign projects. It is often frustrated by the compartmentalised nature of NHS organisations, but continues to thrive nonetheless.

Network organisations linking clinicians and managers in similar clinical areas across a locality or region have a vital role in fostering this kind of clinical vision, and help develop a sense of belonging and commitment to a community engaged in improving a wider system of care. There is a case for extending their scope, bringing in social care and third sector organisations that have a role in the overall system of care for a particular condition.

National strategies for clinical areas can provide an important form of legitimisation for service redesign projects. Indeed, challenges emanating

from the national level which have been well forged with high quality clinical input appear to provide a vital top-down mechanism for shaking up established thinking at local and regional level as to how services should be configured, providing clinicians who have been thinking about how to improve the structure of the services with an opportunity to make their case and take it forward. Local clinical leadership is not an alternative to top-down national strategies; rather the two can productively feed off one another.