Possibilities and pitfalls for clinical leadership in improving service quality, innovation and productivity

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1. Aims/Objectives:

The overall research question is:

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 are:

1) What general lessons about its nature and its practice can be educed from 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 governance, service redesign and improvement 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? What opportunities and challenges will GP Commissioning present for the exercise of clinical leadership?

2. Background:

In a fiscal context where budget constraints will require more from less, and a policy context which urges more effective clinical engagement, the overall aim of this project is to clarify the nature of, and conditions for, successful clinical leadership. The focus will be upon how successful clinical leaders develop and implement service quality improvements both within micro-systems and on a larger scale across traditional boundaries of primary and acute care.

3. Need:

There are areas of special challenge where leadership may be at a premium. An aging population and clusters of socio-economic problems mean that chronic long-term conditions alongside patterns of dysfunctional behaviours place enormous strains on NHS budgets. Clarifying the role of clinical leadership in meeting such challenges is an important issue and thus an objective of this research. This project focuses on the role of clinical leadership in two core challenge areas: sexual health and dementia.
4. Methods:

a. Setting

Two comparative health economies – one in London and one in North West England. Each comprising a number of PCTs, primary and secondary care providers, mental health trusts alongside local authorities and social care. Within each health economy the two service areas of dementia and sexual health are the focal points for the study of the leadership in service redesign.

b. Design

The research consists primarily of in depth cases studies at selected sites where there is a *prima facie* case that effective clinical leadership is operating. We are working with two main health economies – inner South London (comprising the boroughs of Lambeth and Southwark), and Salford in Greater Manchester. These both represent challenging inner-city health issues and they allow for comparisons and contrasts between a London context and a northern-city context. The collaborating institutions in these health economies include: Lambeth PCT, South London & Maudsley Mental Health FT; Kings College London NHS Foundation Trust, Guy’s & St Thomas’ NHS Foundation Trust; and Salford PCT, Salford Royal Hospital NHS Foundation Trust, Salford Council; and Greater Manchester Mental Health Trust.

Researching the two service areas of sexual health and dementia in these two different health economies results in four ‘cases’:

![Diagram showing Governance arrangements, Clinicians in Trust level leadership, Service Level Clinicians, and Dementia care and Sexual health working across boundaries for Inner South London Health Economy and Salford Health Economy.](attachment:image.png)


c. Data collection

Data collection is mainly through a programme of semi-structured interviews with clinicians and managers in each of the specified organisations. In addition, a series of practitioner workshops at the BMA is being used to evaluate, test out and enhance the interpretations from the initial data analysis.
d. Data analysis

The interviews are digitally recorded and transcribed. NVIVO software is being used to code and analyses the data.

5. Contribution of existing research:

The need for both cost effectiveness and improved service quality in the NHS is now paramount. How to secure them is a crucial question. While a wide range of component elements are relevant the Next Stage Review (Darzi 2008) especially emphasizes the role of clinical leaders as centrally important. This, in turn, reflects work by Michael Porter in the USA (2007) which also pointed to the crucial role of constructive engagement by clinical leaders. The 2009/10 Operating Framework similarly emphasizes service quality improvement and leadership.

Various SDO projects are addressing aspects of these - for example, the projects on the roles of clinician managers in PCT commissioning (Hyde SDO/241/2008) and the project on the different roles and structures for medical leadership in trust directorates and their impact on performance (Ham, SDO/236/2008). These, and other studies, are addressing structures and processes which can help engage clinicians in leading and managing major service improvements. Our proposal seeks to complement these studies by drawing on insights gained from the findings of our recently completed NIHR SDO project (Comparative Governance Arrangements and Comparative Performance Project 08/1618/129). This project found that in acute and primary care delivery settings, clinical leaders were often cautious about, and even critical of, top-down service redesign attempts (including those stemming from trust level service redesign teams and trust-sponsored management consultants). While these clinical leaders had accepted that a shift from simple improvements at the level of the individual clinician-patient-encounter, to wider, service-level innovations were necessary, they were nonetheless often sceptical about, and resistant to, centre-led interventions. They were comfortable with clinical microsystem improvements but cautious about institution-led interventions. In this context, the need is to home-in on those examples of effective clinical leadership and to distil the supporting conditions.

Part of the wider background is that our previous study also established for the first time that good governance at trust level was positively associated with effective use of resources and could be shown to be so. That is, from a national survey of all trust board members, we found robust statistical evidence that where non-executive directors and executive directors worked together effectively as members of unitary boards, providing appropriate strategic direction, oversight and challenge, these efforts resulted in better resource use and sound financial management. However, the impact of good governance on service quality was less easy to demonstrate. The supporting qualitative research using case studies did suggest that good governance could also apply to service quality and a positive patient experience. But, the engagement of clinicians at service level in leading well defined service improvement programmes with clinical teams was crucial and it required both bottom-up, autonomously derived innovations and also, for some purposes, constructive engagement with ‘external’ (including trust-initiated) interventions. Thus, clinical engagement in service improvements has a dual problematic. One part requires local innovation. Another part requires a positive relationship with institution-wide initiatives.

The emergence of this idea can in part be traced to analyses made by academics and policy-oriented consultants concerning how health systems in other parts of the world have tackled issues of performance and quality improvement. Two major themes can be identified in this literature – first, the importance of a close relationship between clinical career structures and leadership responsibilities and second, the grounding of leadership and improvement activity in a codified body of quality improvement techniques, which has become known in North American health services as “improvement science”. Within this stream of work, Mountford and Webb (2009) draw on research conducted by McKinsey Consultants into what makes leading health care providers in the USA able
to meet the quality and productivity demands placed on them by insurers and service users. They
argue that both Kaiser Permanente and the Veterans Administration have achieved superior clinical
and financial performance because doctors and managers work together to design services, evaluate
their performance and resolve issues. Clinicians have become centrally involved both in considering
how resources are best used and in judging trade-offs between different approaches to providing a
service on grounds of costs as well as benefits. Kaiser Permanente and the Veterans Administration
see themselves as making an explicit break with the established cultural separation between the
spheres of clinicians and administrators, whereby clinicians advocate better care and administrators
try and restrict the cost. Mountford and Webb argue that in these settings there is now joint
decision-making which has been achieved partly through building-in service leadership and
improvement competencies. – including understanding costs - into the career development of all
doctors, and partly through providing career structures which make it easy for doctors to move into
and out of formal leadership positions where, working alongside non-clinical managers, they have
greater responsibility for overseeing service performance. Lord Darzi’s attempt to shift and expand
the professional identities of NHS clinicians to a triumvirate of “practitioner, partner and leader” can
be seen as clearly related to the “healer, leader and partner” model adopted by the Medical Director
of Kaiser Permanent Colorado in designing leadership development programme for his medical
workforce.

Similar factors have been identified by Ham (2008, 2003) who cites international evidence that
performance improvement programmes have not delivered unless there has been significant
participation by doctors in their leadership. Like Mountford and Webb, Ham (2008) places strong
emphasis on the way that service leadership and quality improvement competencies are built into the
normal career structure for clinicians in the highest performing US providers, and the way that
moving into and out of medical leadership positions has become accepted as part of what a senior
clinician should expect to do.

The profound influence of these ideas on recent thinking in the NHS can also be found in Clark,
Spurgeon, & Hamilton (2008). They argue that management and leadership competencies need to
be recognised and developed at all stages of medical identity and competency formation. They draw
upon Darzi’s analysis that the time for clinical autonomy from managerial matters is past and that
nowadays doctors and other clinicians need to be at the forefront of transforming services to meet
patient needs more fully. They also use the findings of two reports on the changing nature of
medical professionalism - a King’s Fund and Royal College of Physicians report (Dewar, Levenson,
& Shepherd, 2008) and an earlier Royal College of Physicians report (Royal College of Physicians,
2005). Both reports argue that organisational skills of leadership and “followership” need to become
part of the medical training and medical professionalism, and even that managerial skills could
become incorporated into fitness to practice requirements. Clark et al make the case for the medical
leadership competency framework developed in collaboration between the joint Academy of Royal
Medical Colleges and the NHS Institute for Innovation and Improvement.

There is a compelling synergy – and considerable cross-referencing - between these writings on the
benefits of integration between clinical and managerial roles in service improvement and a body of
literature on the application of quality improvement techniques in healthcare. Just as quality
improvement techniques are widely seen as the substance of clinical leadership, so quality
improvement is seen as dependent on clinicians leading in the use of a battery of techniques (Crump,
2008). Thus, Batalden & Davidoff (2007) articulate on behalf of clinicians in North America
associated with the Institute of Healthcare Improvement a position that service improvement
requires the routine application by clinicians of several areas of knowledge in addition to
generalisable scientific evidence as to efficacy of medical or surgical procedures. These additional
areas include: understanding contexts (the habits, practices and traditions of the care teams currently
working); measuring and analysing service performance in a meaningful way, taking account of
different perspectives and the need to reveal whether expected changes are actually taking place over
time; using statistical process control techniques to measure and understand the causes of variation
in performance; and understanding systems of power and incentives which need to be worked with to bring about change. They argue further that these areas of competence are all central to the continuing professional development of clinicians, and that leadership involves acquiring these competencies and fostering their development in junior clinicians.

A number of other North American researchers have emphasised the key roles of engaging clinicians as individuals and as multidisciplinary teams in applying quality improvement techniques (Reinertsen et al 2007). Service improvement requires multiple levels and kinds of leadership involving clinicians at board level, at the level of formal service leadership, but also at the level of direct service provision, with different clinical occupations taking authority to provide collaborative leadership over different aspects of service performance (Nelson et al 2002).

Recent work in the UK echoes some of these points, but also suggests a need for further research in the NHS context into the relationship between clinical leadership and service improvement. Clinical leaders have been found to work within a collegiate model although they also need to recognise the realities of working within trusts where formal authority lies increasingly with a management hierarchy (Dickinson and Ham 2008). Edmonstone (2008) identifies clinical leaders simply as clinicians who retain a significant degree of direct clinical practice with patients but at the same time take on a significant role in leadership functions such as developing service strategy, making decisions on the allocation of resources, and influencing the work of clinical colleagues. He holds that such clinical leaders generally work through influence and persuasion within a collegiate model although they recognise the realities of working within healthcare organisations where formal authority lies with a management hierarchy. He argues that in most health contexts, different health care professions each provide their own forms of leadership, so that clinical leadership is best thought of as distributed within service teams. While this is a useful conceptual basis for understanding the nature of clinical leadership, there are however very few rich studies of the nature and conditions of the exercise of this kind of leadership in bringing about service improvement in practice. The UK literature has tended to focus on describing clinical leadership development programmes (eg Edmonstone 2008) whereas much work in the American healthcare literature is essentially normative rather than research-based. Overall, the precise nature of clinical leadership roles in bringing about service improvement remains relatively unexplored.

Of course the leadership phenomenon is itself problematical (Storey 2009). There are numerous perspectives on its nature. One important point highly relevant to this project is the distinction between leadership understood as individual practice (often translated as the charismatic or heroic leader), ‘distributed leadership’ understood as leadership behaviour at multiple points in an organisation and not confined to persons occupying positions of formal authority, and ‘organisational leadership’ as a more complex array of attributes (Tate 2009). This last conceptualisation highlights the system-wide and thus attends to organisational development elements such as identifying obstacles to the practice of leadership. In consequence of these multiple interpretations, our project will attend to clinical leadership as a process and will be as much concerned with the organisational conditions enabling or blocking the practice of leadership as it is with leadership as individual performance.

The findings from our recently-completed project suggest that realising value from clinical leadership requires resolution of challenges at three levels: first, leadership of a localised and circumscribed microsystem; second, institutional engagement with initiatives from the managerial and policy hierarchy; third, leadership which transcends microsystem boundaries and which drives and enables service improvement across the primary and secondary divide. This third mode includes, for example, leadership from an acute setting which extends across into primary care - and vice versa. We found trusts where one part of the challenge was met, others where one or two of the challenges were met and some rare instances where all three were met. Our follow-on research proposal is to crystallise the learning from these rare instance sites and then to test out these ‘rules’ with a wider learning community of clinical leaders.
6. Plan of Investigation:

The four case studies will be used to investigate the nature of clinical leadership and contextual conditions in specific areas of clinical practice where there are improvement initiatives which involve rethinking boundaries between clinical microsystems. The case study framework operates across three levels: Governance level, Leadership level and Operational level. Within PCTs this means attending respectively to the Board, the Medical and Nursing Director roles, and the GPs and community clinicians. Within acute trusts it means attending to the interface between the Board, the Medical Director(s), Clinical Business Directors and practising clinicians.

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<th>Months</th>
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| 1      | Project start up | • Visit case study sites and confirm list of people to be interviewed and documents to be studied, including data on service performance  
• Convene meeting of Advisory Panel to begin planning of Network Workshops and dissemination routes |
| 1-7    | Case study research | • Complete schedule of 12 to 16 interviews in 4 cases studies, collect and analyse relevant documents, produce initial analytic report for each case on key features of cross-boundary clinical leadership and organisational and governance arrangements that have helped and hindered service improvement. Share draft report for discussion with each case study site |
| 7- 8   | Interim report | • Complete cross-case analysis of key features of cross-boundary clinical leadership and conditions that help and hinder its effectiveness in improving services in dementia and sexual health |
| 9      | Two network Workshops | • Convene network workshop for primary and acute clinicians and managers involved in (a) sexual health and (b) dementia. Each will discuss working hypotheses concerning nature of effective clinical leadership and supporting organisational and governance arrangements for achieving service improvement, and set directions for achieving further service improvement |
| 9 -11  | Draft case-study based guidance | • Produce guidance for clinicians and managers on achieving cross-boundary working for service improvement, based on rich case study analyses of experiences in sexual health and dementia, drawing out key issues to be resolved and effective approaches for doing do. |
| 11-12  | Refine outputs | • Discuss draft guidance with Advisory Group  
• Refine guidance based on their advice  
• Present guidance in NHS forums concerned with service improvement  
• Write summaries of lessons learned for medical and nursing journals in order to disseminate the guidance  
• Produce final project report |

7. Project Management:

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The project is managed by a steering group chaired by Cath McDermott. Dr McDermott is medically qualified with a background in community gynaecology. She is an editor with BMJ Learning, responsible for developing CPD for doctors, including in the areas of leadership, management, patient safety and service improvement. Other members include:

Dr Mark Kinirons, Consultant in Geriatric and General Medicine at Guy’s and St Thomas’ who has been active in the new integrated care pathways for patients with dementia and related problems.

Dr. Susan Mann, Consultant in Sexual Health at Kings College Hospital, also Research Associate at the Margaret Pyke Centre, University College London.

Dr Gillian Moss, Consultant Psychiatrist, Greater Manchester West mental Health Trust

Dr Benjamin Goorney, Consultant in Sexual Health, Salford Royal NHS Foundation Trust.

Nicholas Hicks is qualified as a medical doctor; he is Chief Executive Director of Public Health for Milton Keynes Primary Care Trust. Has expertise in leading the development of the commissioning strategy. He has experience many levels of the NHS, has researched and published widely and was a Harkness Fellow.

### 8. Service users/public involvement:

The project is involving patient user groups based on the advice of the project steering group.

### 9. References:


Dickinson, H and Ham, C (2008) *Engaging doctors in leadership: review of the Literature*, NHS Institute for Innovation and Improvement, Academy of Medical Royal Colleges


This protocol refers to independent research commissioned by the National Institute for Health Research (NIHR). Any views and opinions expressed therein are those of the authors and do not necessarily reflect those of the NHS, the NIHR, the SDO programme or the Department of Health.