Medical Engagement: an Underpinning Cultural Basis for Developing Clinically-Led Organisations

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Overview of Presentation

a) Background to growth of medical leadership

b) Concept of the leader, or leadership, and importance of differentiating the two notions

c) Purpose of medical leadership and hence recognition of effectiveness: From medical leadership to medical engagement

d) Creating cultures to support medical engagement and develop clinically led organisations

A) Background

"The quality of clinical leadership always underpins the difference between exceptional and adequate or pedestrian clinical services"

Sir Bruce Keogh [2011]

Almost a decade or more advocacy of increasing both the numbers and involvement of doctors in the management of organisations

Acceptance of this position has at least two conceptual implications -

a) how might the profesion best be prepared and equipped to undertake leadership roles

b) how might they be motivated to participate

Emerging Response

- **Establishment of the Enhancing Engagement in Medical Leadership Project – crucially with the endorsement of the Academy of Medical Royal Colleges**
- **Leadership much advocated but far less clarity about just what is meant by it, what type or style**
- **Individualised leadership tends to be presented in various lists of positive characteristics – how many, in what combination and how much of each?**
- **Kings Fund [2011] report suggested "a command and control, pace-setting leadership was the dominant style but was incapable of accommodating the complexities of more participative, supportive environment"**
- **A more recent report [2015] concluded**

a. leadership remains subject to fashion and is therefore fickle in its manifestation

b. content of training is often determined by the provider

c. growing consensus that a collective or distributed leadership model is required

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Key Outcome (1)

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Medical Leadership Competency Framework

www.institute.nhs.uk/mlcf

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Medical Leadership Competency Framework

Application of the MLCF will differ according to the career stage of the doctor and the type of role they fulfill. The following graphics demonstrate the emphasis that is likely to be given to the domains at each stage:

Undergraduate

Postgraduate

Continuing Practice

Key

- has limited opportunities to show competence in all elements of the domain
- has greater opportunities to show competence in all elements of the domain
- has frequent opportunities to show competence in all elements of the domain.

Outcome (2) - Engagement

If the medical Leadership Competency Framework (MLCF) addressed "what" of medical leadership training, the willingness or discretionary choice to become involved was not addressed

Hence – the medical engagement work

Competence may be thought of as "can do" – individuals are better equipped to undertake particular tasks

Engagement addresses the "will do" – the choice or motivational aspect

Medical Engagement Scale (MES) – the second outcome of the project to address this

Medical Engagement – What Do We Mean?

Widely used term and hence frequently used imprecisely

Engage for Success – a significant cross sectoral organisation say

"As a movement we have deliberately chosen not to champion any definition of engagement" (2016)

Despite this they report strong support and evidence from various sectors

- **retail (M&S) – top performing stores (sales & customer satisfaction) have higher engagement scores**
- **finance (RBS) – top 10% of engaged business units had twice level of business performance**

Macleod & Clarke (2011) conclude that

- **engagement is measurable**
- **the consistent correlational relationships across all contexts and individual case studies make for "a compelling case"**

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Definition of 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 recognisies rid contribution by supporting and encouraging high quality care"

Engage for Success has argued that no more than about a third of the workforce are highly engaged

The ratio is critical to the link to peformance

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Scales and Definitions

MES Scale		Scale Definition *[The scale is concerned with the extent to which…..]*
Index:	Medical Engagement	...doctors adopt a broad organisational perspective with respect to their clinical responsibilities and accountability
Meta Scale 1:	Working in an Open Culture	...doctors have opportunities to authentically discuss issues and problems at work with all staff groups in an open and honest way
Meta Scale 2:	Having Purpose and Direction	...Medical Staff share a sense of common purpose and agreed direction with others at work particularly with respect to planning, designing and delivering services
Meta Scale 3:	Feeling Valued and Empowered	...doctors feel that their contribution is properly appreciated and valued by the organisation and not taken for granted
Sub Scale 1: [O]	Climate for Positive Learning	...the working climate for doctors is supportive and in which problems are solved by sharing ideas and joint learning
Sub Scale 2: [I]	Good Interpersonal Relationships	...all staff are friendly towards doctors and are sympathetic to their workload and work priorities.
Sub Scale 3: [O]	Appraisal and Rewards Effectively Aligned	...doctors consider that their work is aligned to the wider organisational goals and mission
Sub Scale 4: [I]	Participation in Decision-Making and Change	...doctors consider that they are able to make a positive impact through decision-making about future developments
Sub Scale 5: [O]	Development Orientation	...doctors feel that they are encouraged to develop their skills and progress their career
Sub Scale 6: [I]	Work Satisfaction	...doctors feel satisfied with their working conditions and feel a real sense of attachment and reward from belonging to the organisation

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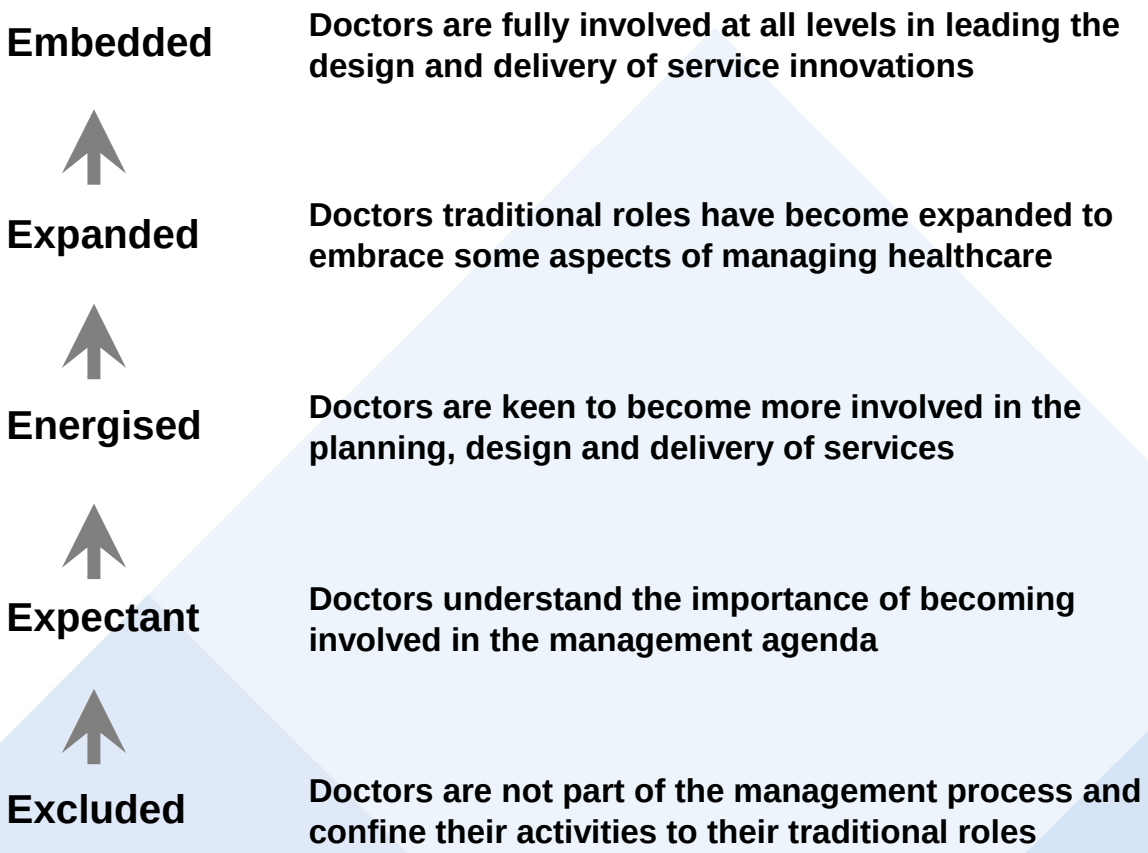
The Levels of Medical Engagement



Current Position

- Database has expanded considerably since original 30 Trusts
- Now over 100 U.K. trusts & Health Boards – so over 12,500 individual doctors
- Analysis possible across specialties, staff grades, roles in organisation, organisational types
- Smaller but growing international database – Australia, New Zealand, Malta, Denmark, Norway, Italy, Canada, U.S.A (3-4000)
- Largely a secondary care database but strong growing interest in U.K. primary care as General Practice provider confederations develop

MES / Performance Links

U.K – Correlations between TDA (NHS Trust Development Authority) Categories of Concern (April 2013 - Jan 2014)[1] and MES Engagement Bands[2]

		Within 2 yr time period (n = 10)	
		b	*sig*
INDEX	Index of Medical Engagement	0.88	***
MET1	Working in a Collaborative Culture	0.86	**
MET2	Having Purpose & Direction	0.72	*
MET3	Being Valued & Empowered	0.80	**
SUB1	Climate for Positive Learning	0.80	**
SUB2	Good Interpersonal Relationships	0.65	*
SUB3	Appraisal and Rewards Effectively Aligned	0.84	**
SUB4	Participation in Decision-Making & Change	0.68	*
SUB5	Development Orientation	0.64	*
SUB6	Work Satisfaction	0.78	**

Level of significance

* p < 0.05
** p < 0.01
*** p < 0.001
ns not significant

1. TDA Escalation Scores

5. Formal action required
4. Material issue
3. Concern requiring investigation
2. Emerging concerns
1. No identified concerns

2. MES Engagement Bands

Lowest Relative Engagement (Bottom $^1/_5$th Trusts)
Low Relative Engagement (Next $^1/_5$th Trusts)
Medium Relative Engagement (Middle $^1/_5$th Trusts)
High Relative Engagement (Next $^1/_5$th Trusts)
Highest Relative Engagement (Top $^1/_5$th Trusts)

U.K – Correlations between all Risks identified in Acute Trusts by CQC (2014) and Average MES Scale Scores

Index of Medical Engagement	-0.50
Meta Scale 1 Working in a Collaborative Culture	-0.50
Meta Scale 2 Having Purpose & Direction	-0.44
Meta Scale 3 Being Valued & Empowered	-0.52
Sub Scale 1 Climate for Positive Learning	-0.43
Sub Scale 2 Good Interpersonal Relationships	-0.56
Sub Scale 3 Appraisal and Rewards Effectively Aligned	-0.42
Sub Scale 4 Participation in Decision-Making & Change	-0.44
Sub Scale 5 Development Orientation	-0.52
Sub Scale 6 Work Satisfaction	-0.49

Further Types of MES / Performance Links

a) Similar positive correlations in Australia between MES & waiting time targets

b) In Canada a controlled study demonstrated that those participating in medical leadership development programmes had higher consequent levels of medical engagement

c) N. East U.K., higher levels of medical engagement predicted willingness to change clinical practice

d) In Denmark study of 1500 GPs found links between MES and quality of primary care provision. (Director of research, Univ. Southern Denmark – *"never seen any metric that explains so much variation in General Practice"*

Clinically Led Organisations

- A stated aspiration by many, if not all U.K. Trusts – but much less frequently achieved in practice
- Grimes & Swetteham (2012) – based in Canada conducted world wide review of engagement in health organisations. Concluded "A world class high performing health system can be realised only when physicians are engaged"
- Several U.K. based reports (Francis Report. Sir Bruce Keogh, NHS Med. Dir. & Don Berwick, I.H.I.) have all expressed a view of medical engagement in helping to create cultures that sustain high quality, safe & efficient services
- Ham (2014) contends that *"transforming the NHS depends much less on bold strokes by politicians than on engaging clinical staff"*

Conclusion

a) Advocacy of medical leadership is helpful but not enough

b) Virtually all healthcare organisations have medical leaders but organisational performance is very variable –so it is effective medical leadership that matters

c) Leadership overall has been shown to operate on organisational performance via culture

d) This culture (frequently & vaguely advocated) can be described as medical engagement

e) Thus effective medical leaders must be equipped to create the critical underlying culture of medical engagement

Ref: Spurgeon, P., Long, P., Clark, J. & Daly, F. (2015) Do we need medical leadership or medical engagement? Leadership in Health Services, vol. 28, No. 3, p. 173-184