

**TheKingsFund**>

Ideas that change  
health care

# Medical engagement

A journey not an event

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# 1 Introduction

Much has been written in recent years about the importance of clinical – and particularly medical – engagement in helping to create cultures within health organisations and systems that deliver sustained high-quality, safe and efficient services. [Francis \(2013\)](#), [Keogh \(2013\)](#) and [Berwick \(2013\)](#) have most recently espoused this importance when reviewing trusts with acknowledged failings. Other research studies have confirmed the relationship between medical engagement and clinical and organisational performance. However, little has been written to date that describes what good engagement looks and feels like in practice and how those organisations with good medical engagement create and sustain it.

This report builds on earlier work from The King's Fund including the National Institute for Health Research (NIHR) Service Delivery and Organisation Programme Report ([Dickinson et al 2013](#)), *Are we there yet? Models of medical leadership and their effectiveness: an exploratory study*, as well as recent annual leadership reports ([The King's Fund 2011, 2012, 2013](#); [West et al 2014](#)).

It also reinforces the conclusions of our recently published qualitative assessment of the impact to date of revalidation and the behaviour of doctors and the culture of organisations ([Nath et al 2014](#)). This revalidation report suggested that culture is changed 'when behaviour is so internalised that doctors are motivated to improve the quality of patient care – when no one is watching'.

The organisations we profile in this report share a common goal of achieving and exceeding their current levels of medical engagement so that it becomes core to the culture of the organisation. It specifically focuses on what lessons can be drawn from a study of four NHS foundation trusts with acknowledged high levels of medical engagement. Its aim is to help organisations think through how to create cultures in which doctors want to be much more engaged in the management, leadership and improvement of services and where boards and executives genuinely seek such a way of working.



This report should be read in conjunction with The King's Fund publication *Developing collective leadership for health care* (West et al 2014), jointly produced with The Center for Creative Leadership. In that report we stress that the most important determinant of an organisation's culture is current and future leadership and that collective leadership means everyone taking responsibility for the organisation as a whole. Staff engagement is critical to the development of a collective culture characterised by high levels of dialogue, debate and discussion to achieve shared understanding and commitment to improving the quality of care.

There is clear and growing evidence supporting the hypothesis that there is a direct relationship between medical engagement and clinical performance. The evidence of that association underpins our argument that medical engagement should not be an optional extra but rather an integral element of the culture of any health organisation and system. It should therefore be one of the highest priorities for NHS boards and leaders. It is not the purpose of this report however, to provide a detailed summary and critique of that evidence.

We recognise that our study is a snapshot of a particular time and our summaries are based on a small number of interviews. Not all staff in each trust would necessarily agree with all the perspectives offered but the following summaries and analysis provide useful examples of initiatives and approaches taken to secure greater medical engagement.

### **The study**

We identified four NHS trusts for study using data on medical engagement from the NHS staff survey and medical engagement scale, where available, and by consulting colleagues at The King's Fund and elsewhere who are knowledgeable about the performance of NHS organisations.

The four trusts are:

- Northumbria Healthcare NHS Foundation Trust
- Salford Royal NHS Foundation Trust
- Southern Health NHS Foundation Trust
- University College London Hospitals NHS Foundation Trust.



We adopted a semi-structured interview approach and held interviews with a range of senior executives including doctors in positional and non-positional leadership roles and some junior doctors. On average, we held 10 interviews at each trust. The following summaries have been compiled from the interviews and validated by the chief executives or their representative. Evidence from the interviews was reviewed and discussed by the authors and relevant colleagues within The King's Fund to identify similarities and differences between the four trusts and emerging themes.



## 2 Summaries

### Northumbria Healthcare NHS Foundation Trust

Northumbria Healthcare NHS Foundation Trust manages hospital, community health and adult social care services in Northumbria, and hospital and community services in North Tyneside. The trust has three general hospitals and six community hospitals. A new specialist emergency care hospital is being built that will be the first of its kind in the country. It has a budget in excess of £400 million, provides care to more than 500,000 people, and employs more than 9,000 staff, including about 250 consultants. The trust was created about 15 years ago from 3 previous organisations. It went through a difficult period before a clear strategy for clinical service provision was developed and this is still in the process of being fully implemented.

The trust was the *Health Service Journal's* Provider Trust of the Year in 2013 and has been widely recognised as one of the country's top-performing trusts for a number of years. CHKS, a leading UK independent provider of health care intelligence and quality improvement services, also named the trust as one of the best-performing hospitals for the sixth consecutive year.

#### Key points

Some of the key features of the trust include:

- stable leadership at all levels, with only 2 chief executive officers (CEOs) in 16 years
- devolved leadership to business units and directorates with a minimal executive team
- a strong corporate leadership culture focused on improvement, quality of care, safety and staff engagement
- a clear set of values against which senior staff, including all consultant medical staff, are selected and appraised



- strong duality or partnership-working and respect between medical leaders and managers at all levels
- sustained investment in leadership development including programmes for newly appointed consultants
- high levels of medical engagement and leadership
- a strong focus on training and education, including a talent management strategy
- high visibility of the CEO and other executives
- an interest in learning from other high-performing organisations nationally and internationally
- investment in creating a family culture through staff and family days, staff balls, occupational health and an informal conflict resolution service.

### Specific features

#### Culture

The trust has created a culture that puts patients at the heart of everything they do, with a strong focus on continually improving the care delivered and on patient satisfaction. As a consequence, levels of quality of care, safety and patient experience are among the highest in the country. Staff engagement is at the heart of the approach – that is, genuinely valuing the workforce and providing relevant education and development while maintaining good financial performance.

The trust did not set out to create a culture based around medical engagement as these comments indicate.

*It was not a carefully formulated plan – [it] grew out of chaos and merging of three organisations into one trust.*

Medical leader

*It is really hard to describe how it has happened and how it works but it is around shared values, quality, educational focus and a devolved and collective approach.*

Executive director



### Governance

The trust has implemented in an evolutionary way a service-line reporting structure and has created five business units: medicine and emergency care, surgery and elective care, clinical support services, community services, and child health. Each unit is headed by a business unit director who dedicates half their time to the role. All of the current business unit directors are doctors but it could be another clinical professional. The role is supported by a full-time deputy unit director who is generally non-clinical. Each business unit has a number of clinical units led by a part-time clinical head of service (clinical director) (one to two sessions to recognise the additional responsibility) and a full-time operational services manager. Along with the executive directors, the business unit directors and deputies are full members of the trust's executive team, which meets weekly. Each business unit gives a monthly report on key issues, for instance, delivery, safety, quality and financial challenges with the support of the corporate infrastructure. In addition to these trust-wide structures, each of the three general hospitals has a site clinical lead.

There is a very strong sense of the medical leaders and managers working together in partnership – a leadership duality where each respects the contribution of the other.

*It has never felt like a culture of the managers as 'them and us' – it's more 'how can we get our heads together to sort this problem out'.*

Business unit director

*Clinicians are joined at the hip with their management colleagues. It is not about valuing one at the expense of the other; it's about partnership – and you'd struggle to differentiate in meetings who are the managers and who are the doctors.*

Executive director

*The link between the doctors and management is one that is important and vital for the organisation. I don't understand how the medical profession has made that [relationship] so difficult.*

Consultant

Each business unit holds regular operational board meetings involving their clinical heads of service and operational service managers. Similarly, each clinical head holds regular directorate meetings with clinicians and appropriate managers of that service.



Clinicians are very actively involved, not only through the operational structure described but also through other forums. For instance, these include a monthly half-day Clinical Policy Group (CPG), seen as ‘the soul and conscience of the trust’ and involving a wide range of clinical leaders and managers, as well as some general practitioners (GPs). Full-day meetings are also held for major issues such as development of the new specialist emergency care hospital.

*Most of the big decisions are essentially made at the CPG.*

Site clinical lead

Doctors are also involved in a range of other corporate and non-organisational leadership roles such as quality, safety and IT. The trust anticipates that about 35 per cent of the consultant medical staff have some form of leadership role within the trust, whether formal or informal.

*I think what does engage clinicians is the fact that there is support for innovative ideas and most clinicians have an opportunity to come up with solutions to the problems.*

Business unit director

Medical staff committees still exist on each site and are attended by the CEO. Clinicians’ attendance and involvement at departmental and directorate meetings appears to be much higher.

Values- and competency-based selection and appraisal

The trust has pioneered a values- and competency-based approach when appointing all senior managers, leaders and consultant medical staff. This has been adopted for all consultant appointments for the past 10 years and for senior managers for the past 8 years. Initiated after concerns about the performance of some consultants, the trust worked in close conjunction with a firm of occupational psychologists to develop a range of psychometric tests and simulations in line with the trust’s values.

These were developed with the help of clinical staff. Anybody involved in the selection of consultants is required to be trained in the process before being able to participate. The output from the selection process informs the start of a personal development plan (PDP) for the subsequent phases of a new consultant’s journey within the trust. Medical staff appear to value the selection process and there is



widespread acknowledgement that high-quality appointments have been made in recent years.

Around 25 per cent of the consultants have been appointed through this process and others who were appointed prior to its introduction are involved in the simulations. The trust actively seeks to identify those candidates with potential leadership abilities when appointing new consultants. Interestingly, nobody when asked said they wanted to revert to the previous selection method. The vast majority of consultants appointed over the past few years had previously undertaken part of their postgraduate training in the trust.

Appraisal for all staff (including doctors) is taken seriously and is seen as an important part of job-planning. This includes active personal development planning based on 360-degree staff feedback and from patient experience feedback. All appraisers are trained. By the time revalidation occurs, the responsible officer expects no surprises. Contribution to education and training and quality is also part of the appraisal process for all doctors.

#### Induction for new consultants

The trust has an orientation programme for all new consultants that incorporates an introductory leadership development programme including time with the chief executive. The PDP initiated through the selection process acts as the starting point for subsequent development and appraisal. Consultants also participate in the induction programme for all new staff.

#### Leadership development

The trust has a long history (more than 16 years) of sustained investment in leadership development. The CEO and executives are all committed to the importance of this as part of the vision for transforming health and social care and have continued to invest even during difficult fiscal periods. While a whole-trust approach is adopted, medical staff are particularly encouraged to take part in different programmes that relate to the trust's improvement and team-working strategies. These include:

- leadership programme for junior doctors (five days)
- new consultants leadership development programme (five days)



- consultant selection training
- Staff and Associate Specialist (SAS) doctors leadership development programme
- consultant appraisal skills and 360-degree feedback
- multidisciplinary and multi-agency senior leadership programme
- business unit development programmes.

In addition, as part of its commitment to talent management, the trust identifies consultants with the potential for future leadership roles to participate in the North East Leadership Academy and NHS Leadership Academy development programmes.

*I think the biggest thing for me is the investment that has gone into leadership development [linked] with succession planning.*

Business unit director

The trust has benefited from a long-term relationship with the external providers of the development programmes to the extent that external facilitators are in tune with the trust's culture, values and strategies.

#### Education and training

Education and training are key elements of the culture and core functions of the trust. They are performance-managed in the same way as for clinical work, including on quality of outcomes. The trust has invested in the appointment of educational leads at both trust and specialty levels. All have specific time dedicated to the roles with clear accountability for specific educational outcomes. The educational lead roles are valued as highly as the clinical leadership roles and appropriate sessions are allocated. A tariff has been developed to recognise the time required and is now an integral aspect of job planning. Clinicians and managers actively support the trust education board and specialty training boards. The director of education (a doctor) is a member of the trust executive. A number of the medical educationalists in the trust also hold appointments with the North East Local Education and Training Board.



Junior doctors are encouraged to undertake service improvement projects and are supported by the operational service managers. Foundation Year 1 and 2 doctors all participate in a professionalism programme which includes a range of management and leadership inputs, many of which are delivered by trust clinicians and leaders.

*Registrars say it feels like someone's trying to make our life reasonable here and looking out for us.*

Clinical head of service

*You've got no hope of doctors coming here [as consultants] if their postgraduate education and experience is terrible. We want the good ones to come back.*

Executive director

*I worked here as a registrar and I think I quite early on recognised the difference in terms of engagement between clinicians and managers in the trust compared to other trusts that I had worked within.*

Business unit director

*I came to the Trust because I wanted to come where I felt I could make a difference and as a trainee here it was blatantly apparent that this was an organisation where you could.*

Business unit director

#### Learning from others

The trust acknowledges that its culture and delivery of care model has been informed by looking at best practice nationally and internationally and by applying this learning to the Northumbrian context. This has included programmes and visits for staff at all levels to Kaiser Permanente, New York Presbyterian, Geisinger (United States), Jonkoping (Sweden), Australia, the Netherlands, Ireland and other NHS trusts. The trust regularly benchmarks itself against international comparators. Staff are encouraged to present at national and international conferences as well as internally.



## Salford Royal NHS Foundation Trust

Salford Royal NHS Foundation Trust is an integrated provider of hospital, community and primary care services, including the University Teaching Hospital for the City of Salford and specialist services to Greater Manchester and beyond. The trust has a budget in excess of £430 million, employs more than 6,500 staff and became a foundation trust in 2007. It has been recognised as having the highest consistent rating for service quality coupled with one of the highest sets of patient and staff satisfaction scores. It was also rated as the best place to work in the NHS, according to the annual NHS Staff Survey (2013). The trust was probably the first foundation trust to publish a Quality Improvement Strategy with the clear ambition of being the safest organisation in the NHS. This included the aim to save 1,000 lives during the first three years of the strategy. It takes medical engagement very seriously but as part of a wider culture that is genuinely focused on quality and safety improvement through valuing, empowering and listening to staff. Use of the Break Through Collaborative process has largely driven this.

### Key points

Some of the key features of the trust include:

- a very strong focus and investment on empowering all staff to identify and contribute to safety, quality and service improvements
- an overriding aim to be the safest organisation in the NHS
- strong influence of the Institute of Healthcare Improvement (IHI) methodologies in creating the Quality Improvement Strategy and focus
- the strategy is supported by a team of in-house experts in quality improvement
- a governance structure that reflects the improvement focus but with clear accountability
- highly devolved structure with doctors in key leadership positions with high levels of management support (there is no chief operating officer and executive directors are linked to each of the four operating divisions)



- rigorous assessment and development process for medical leaders introduced prior to dismantling the former divisional structure and beginning the governance model
- a strong culture of staff development including both uni- and multi-professional leadership development
- stable top leadership – the chief executive officer (CEO) has been in post for more than 12 years
- learning from other high-performing organisations nationally and internationally.

### Specific features

#### Culture

A key feature of the trust's emergent strategy around quality, safety and improvement was that initially, it was not a deliberate process. Instead it arose from a range of internal and external conversations and the realisation by the CEO and other senior leaders that they were too preoccupied with trying to satisfy those above them rather than engaging with the staff and focusing on safety and quality. It is also evident that participation by the CEO and other senior leaders in an IHI Executives Quality Academy in 2007 had a profound effect in helping to change the culture of the trust and helped it produce the vision to be the safest organisation in the NHS.

The trust has built a culture of safety through embedding its core values of:

- patient and customer focus
- continuous improvement
- respect
- accountability.



Involving staff – not just doctors – is another key feature of the culture at the trust. All staff are encouraged to think about how services might be delivered more effectively, based on the belief that they are in the best position to know what problems exist and how they might best be overcome. This includes considerable support from a central quality improvement team including extensive training in service improvement methodologies.

#### Governance

The structure has doctors in key leadership positions. The executive team is small with no director of operations. Each executive director has a link role to the four divisions in an oversight and supportive way. The divisions are led by a half-time clinical chair supported by a full-time divisional managing director (at the present time all former nurses) and a divisional nursing director.

*The medic is in the slightly superior role in terms of throwing the casting vote, but in practice, I don't think any of the divisions work in that way. I think it's fairly democratic – if some person voices a concern about anything it would carry equal weight irrespective of what their position is.*

Clinical chair

The chairs are accountable directly to the CEO. They are not members of the executive team but do attend and contribute to board meetings. In contrast with previous arrangements, it is expected that operational issues are dealt with at the divisional level.

*The position of chief operating officer was removed as too much operational decision-making power tends to be vested in such roles and we were keen to ensure that this responsibility lay with the divisions.*

Executive

*Previously medical leaders tended to be 'fair-weather'. When the going got tough they tended to see problems as the CEO's responsibility. Not now.*

Executive

Each division has a number of directorates (a total of 20) led by a clinical director (CD) supported by a service manager and an assistant director of nursing services, as appropriate. The CDs are accountable to the division's managing director. Consultants in each directorate are accountable to the CD.



In addition to the doctors in these leadership roles, many others lead particular projects. One CD is about to assume responsibility for Strategy, Innovation and Clinical Informatics across the trust.

Attendance at divisional meetings is apparently good. A medical staff committee (MSC) still exists but attendance is low.

*I think it [the MSC] is approaching being moribund, to be honest.*

Clinical director

Within the devolved structure there are bi-annual service review meetings and monthly assurance meetings.

Consultants appear to be proud of working in the trust and junior doctors commented on the difference between working at Salford and other hospitals. These comments perhaps best sum it up:

*I've seen some people [doctors] who were distinctly anti-organisation perhaps three or four years ago and they've really changed ... through various trust narratives eg, the Quality Improvement Programme.*

Clinical director

*I think the early medical engagement came as a consequence of the Quality Academy. We started to engage doctors using their language and I think that was a turning point for medical engagement in the organisation – to see an executive team not talking about cost reduction, cost improvement programmes but talking about quality improvement and efficiency.*

Executive

Values- and competency-based selection and appraisal

In appointing staff, including doctors, the trust seeks to appoint those who are committed to continuous quality improvement. The values are sent to candidates in advance and all consultants are selected against them. The selection process for consultants includes psychometric tests, role-playing and informal discussions.



*I've chaired interview panels when someone has been absolutely perfect on paper in terms of their clinical skills and we've not offered them a job because we didn't think their values were in keeping with the trust.*

Clinical chair

The executives rarely get involved in the selection of consultants. This is seen as the responsibility of the divisional chair.

The selection of chairs and clinical directors to lead the 4 divisions and 20 directorates in 2010/11 has been a key component of the new governance arrangements, which included a desire for accountability for clinical standards. A very thorough and transparent assessment, development and appointment process was adopted as part of the restructuring from the former medical leadership arrangements to the current ones.

In 2010, around 45 consultants expressed interest in being considered for a development programme. This included a three-day assessment process prior to being selected for the development programme.

A total of 20 consultants participated in a year-long management and leadership development programme before the formal appointment process for the new medical leadership positions.

*It wasn't just a management programme – it was actually getting the right people in the room to form that sort of network which I think has continued pretty well.*

Clinical director

Appraisal is taken seriously within the trust. In the annual staff survey (2013), the trust was voted the best in the NHS for appraisal. However, the executives recognise the need for even higher standards. A programme is about to start for all staff on how to get the best out of appraisal as well as sessions on how to have challenging and positive conversations.

The trust has drawn on the experience at the company GE to use objective-setting and appraisals to secure greater alignment among all the staff. This is based on the GE nine box values and behaviours grid.



*Implementation was really challenging when CDs in particular found their performance in the appraisal process was not as good as they thought and expected ... the shock of honest and direct feedback.*

Executive

This led to some consultants being very unhappy and prompted the resignation of a few medical leaders. However, some five years on, it appears to be much valued now and is used to inform the annual increments for staff (including doctors) and the Clinical Excellence Awards which are essentially based on contributions within the trust, taking into account any external roles. The clinical chairs take responsibility for this for all CDs and consultants. The CEO appraises the clinical chairs.

#### Leadership development

The trust has invested significantly – not only in quality improvement – but also in leadership development. The CEO was aware of the work at the Virginia Mason Institute in Seattle which influenced his approach to developing medical leadership through the ‘give and get’ compact. This also influenced the design of the medical leadership programme in 2010, before the appointment of the clinical chairs and clinical directors.

All new consultants undertake a three-day orientation to the trust and are offered mentoring and coaching. They are also encouraged to participate in the new consultants leadership programme that is offered annually. There are also multidisciplinary leadership development programmes in which doctors are encouraged to participate. There is a strong focus on service improvement and human factors in all the development programmes.

Junior doctors are encouraged to participate in quality improvement projects as well as contributing to quality assurance and clinical governance meetings. There is also strong support from the North West Local Education and Training Board. The trust is currently seeking to extend the engagement of all junior doctors in service improvement projects. To facilitate this, the trust has worked in partnership with junior doctors to set up ‘TICKLE’ (Trainees improving care through leadership and education). The core emphasis of this group is to educate, build capability and facilitate the practice of non-consultant grade doctors in quality improvement and health care management and leadership.



## Southern Health NHS Foundation Trust

Southern Health NHS Foundation Trust provides community health, mental health and learning disability services across a large part of southern England. The trust has more than 200 sites including community hospitals, health centres, inpatient units and social care services. It employs more than 9,000 staff. The trust is relatively new, formed in 2011. It brought together a number of services for the first time and created the opportunity for a major service redesign. The trust would not suggest that it has an embedded culture of medical engagement at this early stage and indeed has recently been challenged by the Care Quality Commission over one of its services. Nonetheless, it is an organisation that is clear about the importance of medical engagement. It has a clear strategy to enhance engagement not just of doctors but all staff, and is making good strides towards this aim.

The trust has won a number of awards since its inception including *The Guardian* Award for Leadership Development in 2013.

### Key points

Some of the key features of the trust include:

- board and executive team commitment to a set of values that underpin the behaviours expected of all staff
- clearly stated and increasingly embedded values around high-quality, safe services which improve the health, well-being and independence of the people served by the trust
- a strong culture of staff and leadership development including an award-winning programme for senior leaders and programmes for new consultants
- a clear set of values and competences against which senior staff including consultants are selected and appraised
- the development of a staff compact outlining expected organisational and staff behaviours



- an explicit strategy of enhancing medical engagement and leadership – the trust has used the Medical Engagement Scale on two occasions
- strong Wessex Local Education and Training Board delivery of leadership programmes for junior doctors linked to service improvement opportunities within the trust
- increasingly devolved leadership to directorates and service units led by a clinical leader, each with managerial support.

### Specific features

#### Culture

When forming the new trust, Southern Health was very clear that a new culture should be embraced based around quality of care, levels of safety, patient experience and efficiency. In so doing they created a set of values and behaviours expected of all staff. These have been informed by Virgin Atlantic's focus on customers. It is not therefore a culture where medical engagement is central but one where it is an important component of an overall organisational culture that seeks to engage all staff. It is very clear that the chief executive officer (CEO), chief medical officer and one or two other senior medical leaders have been very influential in recognising the importance of creating a more medically engaged workforce and that they are the champions and drivers for change.

*The CEO has developed a culture that is about supporting and developing our workforce and has put a huge amount of investment in time and money into leadership development, and we have an appraisal system that's based on the values of the organisation.*

Medical leader

*The CEO describes herself as the Director of Organisational Development.*

Medical leader

The trust has used the Medical Engagement Scale (MES) as an important mechanism for assessing the extent of medical engagement. It was also used for stimulating discussions with the medical staff about how to create a culture where they feel more valued and to identify where more work needs to be done for doctors to feel more valued.



*The first time the MES was used there was a barrage of criticism but what ultimately emerged was a really rich resource of information about how people [doctors] felt about the things that were making them unhappy in their working lives.*

Medical leader

It is clear that the use of MES has been a key feature in how the trust has developed a range of initiatives to respond to the issues raised. However, it is worth noting that the senior executives were somewhat surprised by the higher level of engagement shown in the survey, particularly by consultants, than they would have anticipated.

*We knew the evidence about how good engagement resulted in better quality of care for patients and so we felt we could not just sit back and do nothing.*

Medical leader

### Governance

The organisational structure has doctors very much at the centre of the governance arrangements. Each of the six clinical directors (of both clinical services and geographical areas) is accountable to the director of operations and is supported by a directorate manager. The clinical directors (CDs) devote between 5–10 sessions to the role. A total of about twenty-five clinical service directors are responsible for sub-units within each directorate. They are accountable to a clinical director and are supported by managers. Each clinical service director receives one to two sessions for the additional leadership responsibility.

Doctors undertake many other leadership roles within the trust including workforce, education, informatics, revalidation and safeguarding. In total, about 25 per cent of the consultants are involved in leadership roles.

An important fairly recent initiative has been to revamp the Medical Advisory Committee (MAC) with the aim of using it to discuss and secure the best medical practice. The MAC includes all doctors with positional leadership roles and others, and it meets monthly.

*The energy and enthusiasm in that room is just worlds away from where it was.*

Medical leader



### Values- and competency-based selection and appraisal

In conjunction with a firm of occupational psychologists, the trust has developed and implemented a values- and competency-based assessment process. This has been adopted for all senior managerial and leadership positions, including consultant medical staff. It sets out a standard that is sustained through the appraisal process.

*We have found it enormously valuable to be able not just to look at somebody's technical expertise but also to observe them interacting with other people and to be able to evaluate them according [to] those other characteristics alongside.*

Medical leader

The trust is committed to enhancing its appraisal processes as part of a stronger focus on identifying talent across the organisation and providing targeted development to individuals and teams.

It is seeking to introduce a staff compact outlining what is expected of staff and the organisation, influenced by the Virginia Mason Institute. It is still at an embryonic stage and the trust is keen to implement it in an evolutionary way.

The trust has also introduced a managing concerns and recognising excellence group to monitor quality issues.

*We are going to call it something different because it sounds a bit negative but there is something really important for us about how we more effectively pick up where there are concerns about medical practice and what we do with that, how we support individuals but also how we use the information to help us understand whether there might be other quality issues in the organisation.*

Medical leader

### Induction for new consultants

The trust has an orientation programme for all new consultants and all of them participate in a week-long leadership development programme during their first year. They are also offered coaching and/or mentoring and are encouraged to take on a leadership role within the trust.



### Leadership development

The trust has invested significantly in leadership development. A range of programmes is offered at all levels based around nurturing the culture. Many are led by external facilitators who have been involved with the trust in developing the values and are therefore consistent contributors and messengers. A key element of the leadership development strategy is the Going Viral programme which won *The Guardian* Award for Leadership Development (2013). The aims of this programme are to:

- bring about a sustainable cultural shift through leadership development
- accelerate the delivery of the three strategic goals
  - enhanced service-user experience
  - improved clinical and social outcomes for service-users
  - reduced costs
- equip leaders to deal with future as well as current challenges
- build connections both across the trust and outwards to key stakeholders.

Approximately 50 per cent of the consultant medical staff has participated in this programme.

Clinical service directors are also participating in a uni-professional development programme, in conjunction with peers in a neighbouring trust. This programme includes some general practitioners (GPs). It is highly valued and is helping clinical service directors better understand their role.

*I came into the role and felt immediately like a houseman, that sense of not really having any understanding of what was expected of me.*

Clinical service director

A number of medical leaders have participated in national leadership programmes including The King's Fund and Ashridge. This inspired one to develop the internal leadership development programmes for new consultants.



The trust has given particular emphasis to an annual medical staff conference that is also attended by executives and other senior managers. However, the majority of participants (around 100) are senior doctors (consultants, Staff and Associate Specialist (SAS) doctors, GPs and a few senior registrars). This has provided the opportunity to reinforce the importance of medical engagement in resolving some of the more difficult issues across the trust. It has also created opportunities for greater networking and appears to have led to a better working relationship between managers and clinicians, including some 'buddying' between senior managers and doctors.

Local and Education and Training Board leadership programmes have supported and encouraged SAS doctors in being trained to undertake appraisal and other leadership roles.

*We hardly use the word 'consultant' anymore – we are all referred to as 'senior doctors'.*

Senior doctor

Future strategies include developing the leadership of integrated teams to co-create services with patients, including providing support and development to those that are central to driving system change and integration.

#### Education and training

Education and training is a key element of the culture. There are approximately 20 doctors with formal educational roles. The trust is part of the Wessex Local Education and Training Board, which has a reputation for its leadership development programmes and its support for junior doctors, including some clinical improvement fellowships. The trust encourages junior doctors to participate in these programmes and time is allocated to pursue special interests.



## University College London Hospitals NHS Foundation Trust

University College London Hospitals NHS Foundation Trust (UCLH) is situated in the heart of London. It is one of the most complex NHS trusts serving a large and diverse population. In July 2004 it became one of the first hospitals to achieve foundation trust status. UCLH provides academically led acute and specialist services, and serves a local population including the London boroughs of Camden, Islington, Barnet, Enfield, Haringey and Westminster. It also provides services to patients throughout the United Kingdom and abroad. UCLH balances the provision of highly rated specialist services alongside provision of acute services to its more local population.

Its mission is to deliver top-quality patient care, excellent education and world-class research. In 2012/13 its turnover was around £840 million and it had contracts with more than 70 commissioning bodies. Its staff saw 870,000 outpatients, attended to 120,000 Accident and Emergency (A&E) admissions and admitted 150,000 patients. UCLH is made up of the following hospitals: University College Hospital, National Hospital for Neurology and Neurosurgery (NHNN), Eastman Dental Hospital (EDH), Royal National Throat Nose and Ear Hospital (RNTNEH), Heart Hospital (HH), and Royal London Hospital for Integrated Medicine.

UCLH is one of the United Kingdom's five government-funded comprehensive biomedical research centres. It is a founding member of UCL Partners (UCLP) that brings together a number of the UK's world-renowned medical research centres and hospitals. UCLP was officially designated as one of the first academic health science centres in the country in 2009. It has a close relationship with UCL Medical School and has strong links to London South Bank and City Universities.

Doctors in formal leadership roles at UCLH have greater responsibility and accountability than doctors in comparable roles at other organisations and this is widely recognised at UCLH.



## Key points

These are some of the key features of this trust.

- Leadership at the most senior level is consistent and stable. The current chief executive officer (CEO) has been with UCLH for 14 years and under his leadership, UCLH was one of the first NHS trusts to achieve foundation status in 2004. It opened the largest private finance initiative (PFI) in the 2004/5 financial year.
- Leadership is devolved through four medical directors (MDs). Three of the MDs are chief operating officers (COOs)/CEOs of their own boards. Each MD manages a number of divisional clinical directors (DCDs) who run individual service lines within each board.
- The 8,000-strong workforce is split into 3 health boards. UCLH is characterised by visible and structurally strong medical leadership, supported by a number of clinical and managerial roles.
- The structure of nursing at UCLH is ‘flatter’, with enhanced roles for ward sisters and matrons who are accountable to the clinical directors of the service lines in which they work. The chief nurse has a key role in overseeing quality, safety and performance.
- In 2012, more than 1,000 members of staff and patients were involved in developing UCLH’s new values. These guide everything UCLH does, how it makes decisions, and how staff behave with patients and with each other. The values are ‘safety’, ‘kindness’, ‘teamwork’ and ‘improving’.
- These values partly form the basis against which senior staff, including all consultant medical staff, are recruited, selected and appraised.
- There is a track record of achieving the best outcomes by external measures such as Dr Foster.
- UCLH was awarded the *Health Service Journal* Award for Board Leadership in 2013.
- There is a strong commitment and/or interest in developing a high-performing workforce through investment in learning and development.



## Specific features

### Culture

The devolved medical leadership model has some unique features. Three of the four MDs are COO or CEO of their own board. They each manage a number of divisional clinical directors (DCDs) who run individual service lines (there are 16 DCDs distributed within 3 boards). The DCDs have a number of clinical leads (CLs) and lead consultants (LCs), of whom there are about 80 in total, with responsibility and accountability to a DCD. UCLH employs 700 consultants. About 12 per cent of UCLH's medical workforce has involvement in the day-to-day management and leadership of the organisation. The fourth MD is the corporate MD and oversees quality, safety and is also the responsible officer for UCLH. There are also three non-executive directors on the board with medical backgrounds.

*So we have nearly 8,000 staff here. It's impossible for me to engage with all 8,000 of them, but it is possible for the 3 MDs and 16 clinical directors to engage with them in a much more effective way than I could ever do. So really the vast majority of our staff engagement is through the management structure led by the medical/clinical directors.*

CEO

*Medical leadership is highly valued at UCLH and that's reflected in the unusual position of us having four medical directors on the board of directors. We also have three non-executive directors who are doctors as well, so we have a very strong medical presence on the board. Medical leaders are expected to take responsibility and to be the key decision-makers, strategy thinkers for their clinical services.*

Executive director

There is a high degree of formality and prominence given to medical leadership at UCLH. The MDs have defined roles and responsibilities as executive and board directors. The DCDs undertake a formal appointments process. DCDs will (with slight variation between the boards) spend between three and five sessions a week formally in that role. Some DCDs spend far more time than that. DCDs receive a responsibility allowance. The DCD role is enshrined in a formal appointment, a formal contract and payment, and a defined term of office.



Clinical leads who are responsible for a sub-specialty, reporting to DCDs, also have their role recognised in a job plan with one session per week devoted to this. There is a degree of competition to take up the post. The duration of this, in keeping with the DCD role, is three years.

There is a formality to the appointments process during which responsibilities are set with a view to using them to gauge appraisals. DCDs are appraised using the standard format as for any other executive director or senior non-medical member of staff.

#### Governance

Each board operates clinical governance procedures and processes that fit with the overall internal regulatory processes. A non-executive director sits on the internal clinical governance committees and there is a high priority assigned to incident reporting and quality control processes, including capturing and using data provided on patient experience.

The chief nurse oversees quality, safety and performance. Nurses report to a divisional nurse who in turn reports to the DCD of their board. The director of quality and safety has been employed at UCLH for the past 12 years and works with each of the 3 boards and the trust's corporate medical director to support its commitment to quality, safety, clinical governance, human factors and risk management.

All clinical staff receive training and development in human factors at UCLH's purpose-built facility.

#### Values- and competency-based selection and appraisal

As with most executive searches, the recruitment and selection of a consultant post at UCLH begins with advertising and short-listing before moving to a more formal selection process. This can include the following parameters. However these can vary, depending on which of the three boards the appointment is being conducted for. Each MD has tailored a process for appointments to their board.

- Prospective consultants must give a presentation on a set subject to a multidisciplinary team. This can be on some area of improvement or it may seek to establish the degree to which the candidate can take a strategic view, depending on departmental need.



- They are also required to demonstrate fitness to lead an activity for some time, for instance, leading a clinical governance meeting, responding to a complaint, responding to a serious incident, or dealing with a difficult family member.
- Since 2013, the recruitment and selection of consultants includes a values-based element with designed psychometrics and an interview including values-based questions alongside competency checks.

This process was evolved to try to recruit ‘more rounded consultants’ rather than competency processes where those who were typically selected succeeded purely on their technical or academic skills. UCLH is now also recruiting with their values of safety, kindness, teamwork and improvement in mind. The addition of values-based questioning also ensures some degree of consistency between consultant and other staff appointments.

*The results of the psychometric testing are fed back to the divisional clinical director and the HR business partner, who is helping us with the interview. They then feed that back to the interview panel. The interview panel is chaired by a NED – a non-executive director. I sit on all business consultant panels if I possibly can. I think that’s crucial – these are significant investments and we need to get the right people.*

Medical director

#### Induction for new consultants

As with all appointments at UCLH, induction forms part of the formalised process. Consultants attend a corporate induction alongside all new appointments to reinforce that they are part of the team.

*The trust induction includes our vision and values, the structure of the organisation, how it works, their role within it, so making sure they understand their place in the organisation, within the structure and wider issues around patient safety and quality of care as well as how we manage quality and safety issues in the organisation.*

Executive director



Local face-to-face induction and/or orientation interviews are arranged for newly appointed consultants depending on the board to which they are being appointed. UCLH is keen to take a more 'consistent and robust' approach to all consultant appointments with regards to orientation.

Medical directors have indicated that they expect DCDs to track the progress and oversee newly appointed consultants as part of their leadership roles.

From 2013, all newly appointed consultants are meant to have formal job-planning sessions which are tied into their appraisals within the first 30 days of appointment. There is also an intention to have a review of objectives and job-planning 'a couple of times per year'.

#### Leadership development

There is an overriding philosophy espoused by the CEO, clinical and non-clinical senior executives and non-executive directors including the chair at UCLH that leadership development for medical and all staff groups is critical.

The leadership development of consultants once appointed varies between boards. However, there is a strong desire expressed by the medical directors to do more to create a stronger rapport between consultants and UCLH such that 'doctors see our issues as their issues and we see their needs and issues as ours', according to one non-executive director.

There was strong agreement that UCLH must do more to 'put in place the leadership development programmes that are needed to make sure that we continue to be successful in future,' one medical leader said.

UCLH set up its own staff college to help build internal leadership competency within its medical workforce. It is also keen to grow its own talent pipeline.

*For UCLH there is genuinely an issue of kind of making sure they've got the next tranche of medical directors coming up.*

Medical director



The philosophy shared by all those interviewed is summed up thus.

*...all consultants are leaders. Whether they know it or not, whether they like it or not – consultants are leaders within the multidisciplinary teams. They'll be setting the culture, the standards and the pace of work for a massive range of people who look to them to do that.*

Executive director

The strong commitment towards doing more in this area was expressed by one executive.

*My personal view in terms of leadership and the future is that we're going to have to rely far more on clinicians. They're an extremely intelligent section of the population generally in society and in the trust, and we don't make enough use of their potential managerial talents and I think a huge amount has to be done in the future to engage clinicians more in leadership development – all the way back to medical school.*

Executive director

### Education and training

One successful component of education and training that UCLH is currently engaged in is the executive shadowing programme. This involves about 8 per cent of junior doctors. One MD leads the programme on behalf of the organisation, and it has created a cohort of junior doctors who now have time with the chair and CEO. UCLH has 537 training posts; the number of new doctors employed each year varies as some posts are filled by two doctors and some doctors move to new posts within the trust.

The executive shadowing programme is trust-wide and available to all specialties. It was originally established with one-off funding from the London Deanery, for which UCLH competed. The programme is also open to clinical scientists because they were identified as a group with fewer routes of development as perhaps other professional groups. Each cohort has a mixture of specialties and a mixture of seniorities. So, a given programme will include trainees who are about to become consultants and trainees who are in core medical training. Participants learn to work together and there is a feedback event at the end where they present their learning and projects. This programme has led to promoting understanding, respect and empathy between clinical, scientific and managerial perspectives and boosts the creation of a more interdependent culture.



The only criticism of this programme is that there is the need for more of it.

*Again, I would say that's fantastic but that only represents about 7 or 8 per cent of our junior workforce at any one time. So, it's a brilliant initiative but I would love to quadruple it.*

Executive director

UCLH's clinical education programme has a reputation as one of the best in the world. Attaining a place at this prestigious teaching hospital means that UCLH attracts the best doctors in training.

Learning from others

UCLH executives have fostered a culture of learning that encourages looking outside UCLH and abroad. The medical directors have taken part in international study tours that included learning from the best health care institutions, including those in the United States.

There is evidence of speciality leads informally and formally benchmarking their services against speciality services in the United Kingdom and abroad, always asking 'what more, what next?', according to one clinical director.

Influenced recently by the work of the Virginia Mason Institute, a number of medical leaders, executives and non-executives feel that the time is right to build on their current level of medical engagement by evolving 'a consultant compact'. This would:

*...put a substantial effort behind enhancing medical engagement, creating a compact with our consultant body about the 'gives and gets' of being in our organisation, and empowering them with the tools, the expectations and the training allowing them to both escalate the quality of outcomes for patients but also enable us to be a much more efficient organisation with the resources we have available.*

Medical director



This compact would also allow UCLH to build a culture and/or capacity in quality improvement through involving more consultants formally in the process. This may also lead to greater engagement in other existing structures, eg, consultants' committees.

UCLH recognises the necessity to equip its medical leaders to face up to the future challenges in health.

*I think there's a kind of a particular engagement challenge over the next couple of years and it's not unique to doctors here. I think probably it's at least as big for other clinical professionals. It's engaging people on how challenging their financial pressures are going to be, how innovative we're going to have to be with our solutions.*

Medical director



## 3 What can we learn from these four trusts?

While each of the trusts studied is at a different phase of cultural change – with Southern Health in particular at an early stage as a new organisation – all offer some powerful messages.

### Time

It is evident that cultural change takes time and needs to evolve in a sustainable way. It is in effect a journey that over time will reap rewards but it requires doctors to be motivated to assume greater engagement and leadership, and for general managers to work in partnership with, and to support, clinical colleagues. For general managers who for the past few decades have perhaps been centre-stage, it requires a leap of faith to support different roles and perhaps even changed status in order to bring about the cultural changes desired. But the rewards for patient care should be worthwhile compensations.

None of the trusts would suggest that it has been a smooth journey nor would they contend that the change process is completed. Each of the trusts experienced different barriers to elements of the cultural change process. For example, as changes were made in organisational structures and appointment processes for medical leaders, some clinicians felt undervalued. But each of the trusts would argue that the short-term (and even medium-term) pain of change is well worth the sustained improvements in patient care.

Confirming previous studies of high-performing health organisations, a key feature of the four trusts has been stable top leadership. Three of the trusts have had their current chief executive in post for more than 10 years. This stability alone is not going to secure greater medical engagement but a cultural change programme does require sustained commitment from executives and clinicians. Constant changing of top-level leaders is unlikely to create the foundation for such programmes.



It is also evident that, with one exception, the trusts had not spent time specifically developing a medical engagement and leadership strategy but had seen this as an integral element of wider organisational cultural change. However, each trust has a chief executive and medical directors or a chief medical officer who are totally committed to medical engagement and leadership, viewing them as important and integral elements of the wider change programme. Practising the values and beliefs consistently is central to embedding these strategies and to ensuring they are not just paid lip service.

### **Culture**

Medical engagement is not going to occur unless it is part of an overall organisational sustained commitment from the board to the ward around quality, safety, service improvement and engagement. Doctors need to be convinced of the organisation's genuine commitment to this and their pivotal role within such a strategy. It is evident that all four trusts have clear strategies based on quality but perhaps the real distinction is how such strategies dominate operational life. For the leaders, these strategies are not seen as individual projects but are the way the organisation works.

It is also evident that in all four trusts, there was a very healthy respect between most managers and clinicians, that is, working in partnership to deliver high-quality care more efficiently. While individuals – generally doctors – are held accountable within the governance arrangements, it is clear that the paramount concern is for there to be mutual respect between the medical and other leaders at all levels, and an ability to support each other. It is not about whether medical leadership or general management should be dominant; it is about being clear on vision, values and aims and working together with colleagues to achieve common goals. The drive for delivering higher quality patient care and engaging doctors in discussion about quality and service improvement is core to these organisations' success in engaging doctors.



## Governance

In the earlier Service Delivery and Organisation study ([Dickinson et al 2013](#)), we commented that some 30 years after the Griffiths Report set out a vision of doctors taking control of budgets and services, much still remained to be done to realise this vision. We felt that it was hard to escape the conclusion that medical leadership was a minority interest on the margins of the NHS. In the four trusts studied here, this is not the case. All have embraced a strong medical leadership structure with doctors in key leadership roles at divisional and departmental levels, supported by managers. However, despite making great progress, none would claim to have a completely embedded medical engagement culture.

The structures within each of the trusts differ. One trust is very clear that a director of operations is unnecessary where there is a fully devolved governance arrangement holding the divisional level accountable for all business targets and standards. All the trusts practise a genuinely devolved style of leadership with pared-back executive teams and functional departments supporting these key business units. The trusts differ about who clinical professionals are accountable to within each division but all demonstrate a clearly devolved and accountable structure and performance management arrangement.

There is variability between the four trusts with regard to whether the associate medical/divisional directors are part of the executive team. Structure, and who sits on what level of executive team, appears to be less relevant than the culture and leadership style of the organisation. All four trusts have very clear accountability frameworks, regular performance review mechanisms and supportive learning cultures.

In one trust, each of the divisions is linked to an executive director who provides coaching and advisory support but who is not seen in any superior role. It is a good example of how the divisions and executive team can work together for the greater benefit of patients and staff. A common feature of all four trusts is a corporate leadership culture focused on improvement, quality of care, safety and staff engagement.



In addition to doctors in key leadership positions at divisional and department/service levels, all four trusts encourage other doctors to lead projects. While difficult to assess accurately the exact number of doctors fulfilling positional or non-positional leadership roles within each of the trusts, it would appear that between 15 and 40 per cent of senior doctors in each trust have some form of leadership role. All four trusts have created forums, including consultants and GPs, to discuss how services can be improved locally and to take responsibility for implementation rather than just reacting to external or executive demands.

### **Selection of consultants and medical leaders**

Each of the trusts puts considerable effort and resources into the selection of their senior staff including consultants. One trust in particular has put great effort for the past 10 years into a 2-day values- and competency-based selection process for all consultants and for the past 8 years for all senior management and leadership positions, including medical leadership roles. Variants of this intensive but highly innovative approach are also used within the other trusts and indeed a number of other trusts in the NHS are beginning to adopt similar versions. Each of the four trusts consider the investment in this approach to appointing consultants – who may well be working in the trust for 30 or more years – as a key element of their organisational culture.

Each trust adopts the stance that being a clinical expert is not sufficient. They seek out doctors with values aligned with those of the trust and who wish to offer more to running it, particularly around education and leadership. A couple of the trusts use the outputs from the assessment centre to inform the appointee's initial personal development plan and then link this to their annual appraisal. The link between the selection and the subsequent support and encouragement given to participate in development activities and leadership of extra-clinical interests strongly reinforces the message that engagement is not just about selection but is an integral element of life thereafter as a consultant within the trust.

Another key feature is the way in which medical leaders are appointed. Considerable time goes into clarifying expectations, determining the key leadership competences and values, and appointing against such frameworks. Each trust appears to provide the necessary management and development support to their medical leaders. In most cases, dedicated time is allocated for the leadership role, particularly for those in



medical director or associate medical/divisional director roles. It is therefore recognised that appropriate time has to be allocated to the role and not undertaken around a full clinical work plan. This is seen as a key element of the job-planning process.

### **A consultant's journey**

Each of the trusts select consultants who not only have the appropriate clinical expertise and experience but also have the values and desire to contribute more to the trust. Hence, each of them pays particular attention to the early months and years of newly appointed consultants. Orientation and leadership development programmes are features of all four trusts. Every effort is made to ensure that the values and expectations expressed pre- and immediately post-selection are translated into personal development plans and programmes. Mentoring and coaching is offered.

Each of the trusts has well-developed appraisal and revalidation processes and takes talent management seriously. Through appraisal and other development activities, consultants and other senior doctors with the potential to assume greater leadership responsibilities are identified and offered further leadership development in-house, regionally, nationally and internationally, as appropriate. Most of the recently appointed medical leaders in each of the trusts had already been exposed to different levels of leadership development – a far cry from the days when any development offered to medical leaders was generally remedial!

### **Leadership development**

All four trusts invest significantly in management and leadership development at all levels. They view building internal capacity to develop leadership capability and quality improvement as business-critical activities. There is a mix of uni- and multidisciplinary programmes available for doctors essentially from day one and every encouragement given for participation. Each of the trusts takes a slightly different approach to the value of uni- and multidisciplinary programmes. However, common to all is the importance attached to ensuring that all consultants and other senior doctors have an appropriate set of management and leadership competences. These foundation programmes provide a platform for those with the potential to move into positional leadership roles to then participate in more advanced local and national programmes.



## Education and training

The focus on leadership development is part of a wider commitment to education and training generally within each of the trusts. One has a director of education who sits on the executive team. Educational leads are valued as much as other operational leaders with specific sessions allocated to the role and incorporated into the job-planning and appraisal process.

Education and training is seen as an integral element of each of the trust's cultures and not separate from clinical and other non-clinical activities.

This philosophy is particularly translated into practice in those trusts that include leadership development programmes for Foundation Year 1 and 2 doctors and registrars. Others not only deliver in-house programmes but also encourage junior doctors to participate in Local Education and Training Board programmes and, on occasion, national and international leadership programmes. A number include opportunities for junior doctors to undertake service improvement projects supported by the trust's quality improvement team.

## Learning from others

Each of the trusts takes a very positive attitude towards learning from other high-performing organisations. Those trusts that have had a long-term and sustained approach to their current culture have been strongly influenced by a range of bodies including Inter Mountain, Institute for Healthcare Improvement, Geisinger, New York Presbyterian, Jonkoping, GE, Virgin Atlantic and the Virginia Mason Institute. This has included study programmes for staff at all levels, both overseas and internally. These are firmly incorporated and integrated into each trust's wider quality improvement strategy and are not seen as isolated visits.



## 4 Medical engagement checklist

Our study suggests that, while medical engagement should lead to enhanced clinical and organisational outcomes, the real benefits for patients and staff occur when it is part of a much wider organisational cultural process.

The following checklists might help organisations and individuals with medical leadership roles assess the extent to which medical engagement is being actively sought and developed.

### For organisations

- Is there an organisational culture strategy that includes medical engagement as an explicit component? If so, how often is this strategy reviewed?
- To what extent are the board and the executive team (including non-executive directors) fully committed to medical engagement? What activities do you use to evidence that this engagement translates into the way the organisation functions?
- How is medical engagement promoted and brought to life by the chief executive, chair, medical director(s) and director of nursing? To what extent do these individuals communicate with the medical workforce?
- Do the governance arrangements and organisational structure reflect a culture that seeks high levels of medical engagement? How many doctors within the organisation hold formal quality improvement/clinical governance roles?
- What is your organisation's goal for engaging its medical workforce? How does your formal structure reflect this?



- What talent management/succession process do you have in place as an organisation and how does this meet the need to develop your medical leadership pipeline?
- Are junior doctors offered leadership development opportunities, particularly around quality, safety and service improvement? How are doctors empowered to innovate and lead quality improvement initiatives?

### For medical leaders

- What activities are in place to attract, recruit, induct and develop medical leaders/consultants? How often are these reviewed?
- To what extent do these processes connect and reflect aims, values and goals at an organisational and divisional level?
- To what extent are doctors involved in strategic planning and prioritising the organisation's decisions? How are doctors involved in the planning and accountability of the services they contribute to?
- How are you developing your organisational capacity and capability for developing and supporting leadership and quality improvement methods?
- How much engagement can you evidence and demonstrate of job-planning, appraisal and revalidation? How do you assure yourself that these processes are fit for purpose?
- What proportion of time are doctors in formal leadership roles accorded specifically for this role and how is their contribution to managing and leading their services and quality improvement projects recorded, measured and valued?
- What processes are in place to ensure that consultants, other senior doctors (eg, staff and associate specialty doctors) and medical leadership appointments are made through a competitive and competency-based process that reflects the organisation's values?



## 5 Conclusion

This report has specifically focused on the importance of medical engagement as part of the cultural change needed within the NHS. The case studies highlight what can be achieved if there is a sustained and collective vision and will to create the organisational culture where all staff, particularly doctors, are motivated to share in delivering the highest quality care.

This report should be read in conjunction with the Fund's annual leadership reports – particularly the most recent, published in conjunction with The Center for Creative Leadership, *Developing collective leadership for health care* (West et al 2014) – and *Reforming the NHS from within* (Ham 2014) which stresses that transforming the NHS depends much less on bold strokes and big gestures by politicians than on engaging doctors, nurses, other staff and patients in improving services.

Medical engagement makes a critical contribution to achieving innovation and improvement for patients. It requires doctors, executives and all who contribute to patient care to work together to create organisational cultures that meet this challenge. It requires investment in a sustained programme of cultural change based on clear and explicit values. It needs to be supported by investment not only in service and quality improvement, engagement, leadership development, education and training and appraisal but also by governance arrangements that facilitate and promote the desired culture. The current generation of newly appointed doctors need to see that any investment in leading and managing innovation and quality improvement as an attractive, rewarding and valued proposition. It is too important to be left to chance.



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Much has been written in recent years about the importance of good medical engagement in creating cultures that deliver high-quality, safe and efficient care. But what is good medical engagement? In those organisations where it exists, how has good medical engagement been created and sustained?

*Medical engagement: a journey not an event* seeks to answer those questions by looking at what can be learned from four NHS trusts with acknowledged high levels of medical engagement. The King's Fund conducted interviews with executives, senior and junior doctors in those trusts and through those interviews explored their cultures.

Common features include:

- long-term stable leadership
- total commitment by senior executives and doctors to medical engagement and leadership
- a strong medical leadership structure with doctors in leadership roles at divisional and departmental levels
- well-developed appraisal and revalidation processes, and well-resourced and values-based appointment procedures
- commitment to education and training, and to learning from other high-performing organisations.

Creating cultural change has not been a one-off event for these trusts - it has been an evolutionary journey for organisations and consultants.

The report's final section highlights common themes from these case studies and includes a checklist to allow organisations and individuals to assess how far medical engagement is being sought and developed.

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