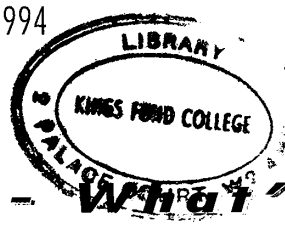
STRATEGIC AGENDA FOR MEDICAL DIRECTORS

Discussion paper 1

November 1994

KINGS FUND COLLEGE



STATE OF FLUX
Creating Capacity for Change

Medical Director - What's that?

Reflections from Ray Flux and Judith Riley on discussions with Medical Directors who are seeking a strategic agenda.

The Reforms

The 1989 Reform proposals for the NHS contained relatively few commands and a relatively high number of options compared with previous re-organisations or changes in the public sector. One of the commands was the introduction, in legally recognisable organisations at Purchaser and Provider level, of Board structures. These had a common "shape"comprising a Chairman, five Non-executive Directors who live or work in the local community, and five Executive Directors. Virtually every Provider Trust Board has to have a senior doctor on its Board as an Executive Director (para.4c of Part II of the NHS Trusts (Membership and Procedures) Regulations 1990).

The Role

The role of this senior doctor is to advise the Board on medical matters and to lead the doctors within the organisation. It is a different and much more active role than that of the previous medical representative or advisor.

The person appointed is nearly always a senior consultant of the Trust; only a few Trusts have used an open advertisement to make their appointment, but this practice may become more common.

Trusts also have to have a registered nurse or midwife among their Executive Directors and together, the Medical and Nursing Directors provide clinical leadership.

[illegible] nversion to Trust arrangements for [illegible]e is completed within the next year or so, over 400 Medical Directors will occupy this statutory role. Many are asking, What should I be doing? What constitutes a valued contribution and one which, looking back, I can be satisfied with, or even, proud of? How is the role changing and how am I changing? What will the Medical Directors need to be doing in future?...**What distinctive strategic contribution might I make as Medical Director?**

This document reflects something of the feelings and ideas of groups of Medical Directors who have discussed these issues with the authors in workshops over recent months. The debate will continue and develop in a series of events scheduled for 1995. In sharing our work with colleagues nationally, we are not intending to prescribe roles or contributions, but rather to offer some possibilities and to affirm that Medical Directors have a key role to play as a body in the development of healthcare in this country.

To illustrate this important role, look no further than the pressing timetable for reforming the training of future medical staff proposed by Dr Kenneth Calman, Chief Medical Officer. The concerns of the educational and professional accreditation bodies as we come into line with European medical training are the dominating considerations in the present debate and action. But collectively the Medical Directors of Trusts could substantially determine the shape and make-up of the future medical employment market in this country. They need to do
their best to ensure that future educational systems produce the variety of doctors that the NHS will need, both in terms of expertise and expectations.

With the groups we explored three aspects of the person-to-job fit.

1. WHAT IS THE JOB ?

We found some common elements in the descriptions of the jobs Medical Directors are asked to do:

Planning medical services, advising on medical developments, ensuring that contracts are medically sound and allocating money for equipment.

Leading on medical standards, having responsibility for complaints policy and clinical risk management, and encouraging medical audit.

Selecting and supporting the clinical directors and leading them in managing particular services with budgetary, information and quality responsibilities.

Shaping medical staffing policy through job plans for doctors, revising junior doctors' hours, selection procedures, training funds and medical discipline matters.

Ensuring the development of the medical staff, including research programmes and medical education as well as continuing clinical and management education.

Liaison with key doctors outside the Trust, including GPs, Public Health Directors and other Medical Directors.

Taking responsibility for some aspects of the public image of the Trust, dealing with the media and the local community particularly where clinical matters are to the fore.

Medical Directors are accountable to their Chief Executive Officer (CEO) for most of their management work and are accountable to colleagues on the Board for their independent medical advice. They maintain their clinical work because often this is of primary interest to them, because it enables them to retain credibility with their medical peers (most CEOs look for peer support as a key criterion in making this appointment) and because future career paths are not clear for new Medical Directors.

Medical Directors often do not have direct managerial responsibility for any staff or area of business outside of their own clinical practice. They do not hold Clinical Directors accountable in a financial sense. Indeed they usually have no formal authority over other doctors; they are not their employer or "boss".This accountability is usually to the Chief Executive or Director of Operations on the Board. Medical Directors have to achieve change through influence, leadership and persuasion. They may be seen to have power over other doctors through their control of doctor's job plans, contracting for work and the allocation of development funds. Medical Directors often retain the position of chair of one or two key committees in order to enhance their influence and to ensure that they hear and are heard by their medical colleagues.

Medical Directors are key conduits in the organisation carrying messages and representing ideas in both directions between the Board and senior managers and the medical staff. However, they are usually not Chairmen of Medical Staff Committees since this role provides a separate voice for doctors in the Trust and potentially releases the Medical Director from representing the Trust's doctors...hence their independent medical advice.

2. WHO ARE THEY ? - THE PERSON SPECIFICATION

People who have become Medical Directors are a diverse group, as are the organisations that they serve. The person sought to do the job was commonly required to have the following characteristics:

at least two years experience as a consultant, often much more,

having the support, or acquiescence, of medical colleagues for performing this role,

management experience, often as a Divisional chairman or clinical director,

financially aware, accepting the need for budgetary control and the reality of rationing in healthcare,

energy, such as, crises or opportunities for particular clinical services, attacks in the media or pressure from purchasers.

Beyond these initial and ad hoc demands, many Medical Directors agreed that there were four broad priorities which they wished to address:

**** To reconfigure clinical services in radical ways.***

This means particularly encouraging the Board to refocus upon clinical matters as a priority, and to provide leadership on appropriate reforms of clinical care for that particular setting. Examples given were: moves towards integrated patient care systems, hospital at home, new services arising from the uptake of clinical technologies, the pursuit of day care surgery, the development of nurse practitioners, the use of audit and critical incident analysis and the development of clinical protocols.

For most clinical specialists, their primary concern is to maintain and develop a particular service or range of services to a relatively small section of the community, for example, children, or people with heart disease. The Medical Director must have an additional (if not alternative) perspective to the clinician's familiar one. That additional perspective is a broader one which seeks to improve the portfolio of services offered to the wider population served and also to address the changing market for health intervention and care.

Put starkly, Medical Directors have the potential to achieve more for the health of a community through their management role in reshaping services to the community, than through their hands-on clinical work, because of its wider impact. This suggests that they may also do more damage by getting things wrong or by not focussing energies appropriately. Developing effective partnerships with other Directors, and perhaps particularly the Executive Director (nursing) on the Trust Board, will be very important. Some of the difficult aspects of this reshaping work involve identifying those services which will contribute significantly in the future and ensuring that they are well developed and also taking care with people and issues in areas where disinvestment is indicated. This is difficult territory and will need considerable toughness, personal skill and a robust network of personal support.

**** To develop and support their consultant colleagues.***

Medical Directors felt that one area in which they could contribute substantially to the Trust would be in the development of the clinical staff. This means particularly helping and challenging colleagues to understand how the environment has changed and will change, to strive for quality and effectiveness in their clinical work, and to become more aware of, and involved in, the management of services. The types of work to be encouraged in the organisation might involve team-building, coaching clinical directors, reviewing skill-mix and consultants' job plans, supporting the development of multi-disciplinary clinical teams, establishing helpful and acceptable models of performance review and appraisal and local pay bargaining. Alongside these positive elements, again, there are difficult issues which may need to be addressed such as establishing fair and acceptable means of dealing with clinical colleagues whose performance is not acceptable or whose skills become redundant. The Medical Director may have a key role to play in shaping the medical workforce in their Trust and consequently, the range of employment opportunities for medically trained people in future.

**** To strengthen professional and political networks internally and externally***

New ways of working and a new environment will call for different relationships with others inside the organisation and outside. Examples might be extending the use of shared care plans with other health professionals, developing better mutual understanding between clinicians, contracts managers and accountants, or in cooperative relationships with general practice or the media. For some, working in networks with new colleagues may be be very challenging to long held attitudes and behaviour; for others, the change may not be radical. In due course, much of this work may be done at the clinical practice level as clinical directorates liaise directly with purchasers, other professions and agencies, but the opportunities and tone of these contacts may well be established by those in leadership roles.

The Medical Director and the Executive Director (nursing) may have key respective roles to play in establishing good working relationships between agencies.

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having the support, or acquiescence, of medical colleagues for performing this role,

management experience, often as a Divisional chairman or clinical director,

financially aware, accepting the need for budgetary control and the reality of rationing in healthcare,

having good interpersonal skills, especially negotiation, and being a team player,

committed to patient care and to improving medical standards,

strategic thinker, innovative and practical,

capable of managing self, both time and stress,

wanting to make their NHS Trust work in the new NHS environment.

Of course, people in post only partially fulfil this requirement. Their satisfaction in role will be partly determined by their fit with these expectations. Success in post is also significantly affected by the commonality of expectations, the reality of opportunities, and the extent to which the individual suits the tasks lined up. When asked for reasons why they want the role of Medical Director and what is most difficult about the role, the following types of response were often given:

They like :

The next challenge in the management of clinical services.

The opportunity to affect things radically and for good.

The opportunity to influence top managers who don't understand clinical practice.

To have insights into the broader picture of healthcare.

They dislike :

The pressures on their time and the discomfort of colleagues having to cover for them

Clinical colleagues not understanding their role or believing it to be no more than "the doctor's representative"

Uncertainty about their future careers.

3. WHAT SUPPORTS AND INCENTIVES ARE AVAILABLE ?

Within our group were Medical Directors of Community Service Trusts, Acute Hospital Trusts and Teaching Hospital Trusts with revenue budgets ranging between £25-220m. The terms under which Medical Directors were performing that role varied considerably. Within our group we found that:

Medical Directors work between 1.5 and 4.5 days per week in this role and work the equivalent of 6 or 7 days per week in total to maintain their clinical practice. A few Medical Directors are full time in this role with no clinical practice.

They are paid between nothing and a merit award equivalent extra for fulfilling this role.

They have contracts for between 1 and 5 years for the role with the usual term being 3 years.

They usually have no staff, and have secretarial support varying between none at all and most, or all, of a personal assistant.

Most have no budget, although some have small funds for study leave, management education for doctors, locums or audit work.

WHAT ARE THEIR CONCERNS ABOUT LEAVING THINGS THIS WAY?

There were six general concerns which can be stated baldly:

There is too much to do

It is difficult to do anything worthwhile

There is a danger of being the "representative doctor"

There is a loss of personal constituency now, being neither in the management, nor the clinical camp

There is no vision for career futures for Medical Directors

The health sector is becoming more turbulent and colleagues are more distressed.

CHECKLIST: HOW IS IT FOR YOU?

Against this picture, what is your experience of being the Medical Director yourself or of working with an NHS Trust Medical Director as a senior colleague? What would be your responses to the questions posed in this introduction:

What is the job?

What is the person specification for the job?

What do I like & dislike, or think is helpful about it?

What supports and incentives are provided to do the job?

Are the concerns listed above, mine, or do I have others?

What opportunities are there to adapt or change the role?

A RANGE OF ROLES TO CHOOSE FROM

In our discussions with Medical Directors the variety of conditions and types of role have been a source of interest and discussion about whether there should be some standardisation. The general conclusion has been: that knowing the variety of arrangements which exist, is helpful; but that a national formula imposed upon Trusts would not be. The value of knowing what others are doing, is that it helps to identify the range of contributions that a Medical Director could make.This emphasises the necessary choices that must be made about what a particular Medical Director will do, and the need for these to be clarified for the the individual and with the Chief Executive, Board and clinical colleagues.

SO WHAT ARE THE PRIORITIES FOR MEDICAL DIRECTORS?

As described, there is a general feeling that Medical Directors have too much to do and spend too little time on the important things that they could do. Our discussions identified a number of strategic areas that a Medical Director could identify as being, of personal interest, of crucial importance to the local healthcare setting, or even a national issue in which the part played by their Trust would be important.

IN THE BEGINNING....

Implicit within this was the recognition that Medical Directors in new Trusts (and therefore in new roles) are embroiled in the business of setting up the Trust's systems, structures and relationships. There may be some considerable adjustment required in understanding the wider business and positioning of the Trust, sorting out working relationships internally with senior colleagues and externally with other agencies, and in their own balance of work. There may also be personal challenges to address about career futures, about the tensions between success for the Trust, health in the local population, and the development of a particular clinical practice. There may also be some personal tension in balancing where one's future allegiances and credentials are seen to lie. New Medical Directors do well to begin thinking early about where their next step might be within the organisation and who would be prepared to succeed them!

During this set-up period, which some felt may last for two years, there is a great deal to learn, but also some things to avoid. Finding a place within the Board and in the relationships between senior management and clinical colleagues may require recognising and challenging some traditional and unproductive behaviours and attitudes. **From their experiences, our groups spoke of this early period as likely to contain struggles on one or more fronts, and of their considerable relief in finding that others are struggling too!**

During this phase, Medical Directors recognised the need to be vigorous in delegating and sometimes leaving aspects of the job they could do, in order to find and attend to the work that is really important and in which they can make a material difference. In general, the Medical Directors were convinced that they needed to be less involved in day to day problem solving in clinical services whilst retaining contact with a wide range of front-line staff. It was widely regarded as important to build the concerns and ideas of front-line staff into the strategic development of the organisation.

In this respect the role and work of the Medical Director needs continuous negotiation and clarification with senior colleagues. Alongside this focussed agenda, all Medical Directors will face local and national issues which appear and require immediate and often intensive

energy, such as, crises or opportunities for particular clinical services, attacks in the media or pressure from purchasers.

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**** A New Order to be established?***

Progress on any or all of these strategic goals probably requires success in some measure on another key activity, that is, the remoulding of traditional perceptions of reward and status within the medical group. The circumstances which confer recognition upon medical staff have a long and well established tradition. Beds and operating sessions, junior staff, car parking, merit awards, dining facilities, chairs of key committees, research and development funds, offices and secretaries, study-leave and conference opportunities all play their part. An environment which calls for flexibility and new styles of service, perhaps with professional boundaries more blurred, requires that these currencies and their basis for valuing work, for saying "thankyou" or "well done", for recognising seniority or providing security all need to be re-examined.

ADVICE FROM COLLEAGUES

We have several key comments for any Medical Director which arise from discussions with the groups we have met.

Think through and agree key strategic goals, with timescales where appropriate, and publicise these.

Develop an effective relationship with the Chief Executive.

Arrange delegation, which may mean coaching and supporting others for a while.

Raise the profile of clinical issues on the Board

Coach and develop clinical colleagues especially Clinical Directors.

Develop internal and external networks.

With, and through others, review and develop clinical services.

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WORKSHOPS

The role of Medical Director is still developing as Trusts and individuals sort out what is required and what is possible. Opportunities for Medical Directors to meet and to find that others are grappling with similar opportunities, confusion and frustrations is reported as being of the great benefit. The variety of circumstances in which Directors can meet is growing, but many are still isolated. Through this bulletin we hoped to share some of the discussions occurring in our programme, to stimulate further thinking and debate, not just for Medical Directors but also for senior colleagues who work alongside them. Our discussions will continue throughout 1995 with three scheduled programmes exploring four themes:

work on current problems

speculations about future demands on health systems

priorities for Medical Directors

models for more effective inter-personal work

If you would like to participate in these workshops with others close to your own experience, please contact Ray Flux to discuss the 1995 programmes or apply directly to the King's Fund College on 0171 - 727 0581. We hope that further issues of this bulletin will follow.

Dates for programmes in 1995 are:

27 February - 1 March and 15 May

17 - 19 May and 4 September

2 - 4 October 1995 and 10 January 1996

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