Medical engagement

Too important to be left to chance

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This paper was commissioned by The King's Fund to inform its review of leadership in the NHS.

The King's Fund

Contents

1 Introduction

The Future of Leadership and Management in the NHS: No more heroes, published by The King's Fund (2011) following last year's Commission on Leadership and Management in the NHS, concluded that the challenges facing the NHS require leaders to engage with staff and those outside their organisations in different ways. This paper will review the evidence which supports the view that securing greater engagement of doctors in management, leadership and service improvement is critical to improving performance. It will also draw on examples of good practice nationally and internationally, as well as offering some frameworks for obtaining and securing greater medical engagement.

Other papers in this series focus on the benefits of greater staff engagement, but it is this author's contention that securing greater engagement of doctors will almost certainly create the sort of organisational culture where all staff feel valued and involved.

Securing greater engagement is a cultural change rather than a structural one, although structural changes may be needed to realise the cultural changes sought. It is not something that can be achieved overnight, nor is it something that executives can impose simply by introducing a new policy and expecting quick results. It requires a highly inclusive approach, with clinicians positively seeking to become more like shareholders than stakeholders. It also requires a different set of behaviours by executives, particularly chief executives.

The NHS has historically had a very strong general management culture, with doctors during the 1960s and 1970s essentially acting in representative roles in both primary and secondary care. The Griffiths Report (1983) introduced the notion of clinical directorates in hospitals, with clinical directors generally being appointed on the basis of seniority, and slowly becoming accountable for use of resources and, more recently, quality and safety.

The past two decades have therefore seen a gradual process of a relatively small number of doctors in both primary and secondary care assuming part-time leadership roles on top of a full clinical workload. Medical directors, particularly in hospitals, now tend to be full-time, and a small number of doctors are taking on responsibility for quality, safety, and service improvement initiatives within hospital trusts, and developing the emerging clinical commissioning groups in primary care. However, as Bohmer (2012) contends working physicians have been ambivalent about taking a leadership role, either with respect to improving current operations or redesigning future services.

What is medical engagement?

Spurgeon *et al* (2011) contend that engagement has recently become a popular, much-used term and, while it is a common denominator in many health reforms, it is rarely defined. Furthermore, there are only a few studies or initiatives which demonstrate what good engagement looks and feels like, and what impact it has on the delivery of health care. This paper aims to contribute to the discussion and offer some advice on how systems and organisations might secure greater medical engagement.

Before exploring some examples of medical engagement in practice, it is worth considering a number of earlier definitions and studies.

Guthrie (2005) argues that physician engagement is one of the key priorities for chief executives, and is one of the markers of better-performing hospitals. He also contends that at a structural level (creating appropriate facilitative arrangements) and a personal level (one-to-one communication) it is possible for executives and managers to build levels of physician engagement.

MacLeod and Clarke (2009) provide an excellent account of employee engagement in the UK and across a range of sectors. They share this author's view that the term 'engagement' has acquired a range of meanings, but no universal definition exists. Nevertheless, they make some important assertions about the concept:

- that engagement is a two-way process involving organisations working to engage employees and the latter having a degree of choice as to their response
- that engagement is measurable, with some variability in the evidence gained by different measurement tools
- that engagement correlates with performance and innovation. While recognising that proving direct causal links is important, they conclude that the consistent nature of the studies of engagement, coupled with individual company case studies, makes for a 'compelling case'
- that engagement levels in the UK are relatively low, and this presents a major challenge given the critical nature of innovation in tackling the recession.

Alimo-Metcalfe and Bradley (2008), exploring types of leadership in mental health teams in the NHS, report that 'engaging with others' was the only significant predictor of performance.

Brook (2010) argues for an international 'call to arms' for physicians to go beyond the immediate concerns of their individual professional practice and to engage in the improvement of health care outcomes for entire communities and populations – that is, leadership that is about *improving health, reducing its variation and doing so in an affordable way* (p 466).

Stoll *et al* (2011), citing Brook's study, suggest that such system-wide leadership should not be an option for clinicians, but a requirement. They acknowledge that doctors hold considerable power, occupying the moral high ground of patient advocacy and exercising control over deployment of considerable financial resources, as well as being able to resist managerially or politically imposed changes. Citing work by McNulty and Ferlie (2002), they conclude that without medical engagement, care continues to be delivered in isolated clinical pockets, preventing co-ordinated action to produce system improvements, let alone better population health outcomes.

An interesting perspective is offered by Erlandson and Ludeman (2003). They contend that one of the biggest frustrations in health care is the lack of physician engagement and accountability – terms they suggest are frequently used to describe what somebody else should do. They also highlight a common perspective about the different interpretations of physician engagement. They argue that when administrators talk about

physician engagement, they are generally speaking in code for what they would like physicians to do but cannot get them to do; but when physicians speak about engagement, they are speaking in code for what they already give that is not appreciated, valued or supported by the administration. The study concludes that both sides stake out viewpoints, positions and interactions that make real change or collaboration impossible.

Perhaps the nub of the issue is best summarised by Baker and Denis (2011):

> *…transforming health care organizations to improve performance requires effective strategies for engaging doctors and developing medical leadership. Most efforts in the US and UK to develop medical leadership have focused on structural changes that integrate doctors into administrative structures, but these have had limited impact. Recognizing the distributed and collective character of effective leadership, some health care organizations are attempting to create greater alignment between clinical and managerial goals, focusing on improving quality of care.*
>
> (Baker and Denis 2011, p 355)

This perspective is endorsed by Bohmer (2012) who argues that while individual doctor excellence is necessary it is no longer sufficient to generate good patient outcomes. He highlights the way in which processes and micro-systems are largely controlled by practising physicians and hence the importance of their leadership skills and behaviours being exerted to improve overall health system performance.

Spurgeon *et al* (2008) argue that medical engagement cannot be properly understood on the basis of consideration of the individual employee alone. They believe that organisational systems and strategies play a crucial role in providing the cultural conditions under which the individual's propensity to engage at work is either encouraged or inhibited. This led to a definition of medical engagement as *the active and positive contribution of doctors within their normal working roles to maintaining and enhancing the performance of the organisation which itself recognises this commitment in supporting and encouraging high-quality care* (p 214). This definition is particularly relevant as it forms the basis of the development of the medical engagement scale that has been adopted in the NHS and more recently in Malta and Australia (*see below*).

2 What can we learn from international approaches to enhanced medical engagement?

Institute for Healthcare Improvement (IHI)

A major contribution has been made by the IHI, particularly through Reinertsen and Gosfield (2007). Interestingly, they express surprise at how few hospitals have *actually articulated a plan to improve the engagement of their physicians* (p 2). They have developed a framework for how organisations might go about improving levels of physician engagement in quality and safety.

This framework has six key phases.

- Discovering common purpose, eg, reducing hassles and wasted time.
- Reframing values and beliefs, eg, making physicians partners, not customers.
- Segmenting the engagement plan, eg, identifying and activating champions.
- Using 'engaging' improvement methods, eg, making the right thing easy to do.
- Showing courage, eg, providing back-up all the way to the board.
- Adopting and engaging style, eg, involving physicians very visibly and valuing their time.

The full framework is detailed in an IHI Innovation Services white paper, Engaging Physicians in a Shared Quality Agenda (Reinertsen et al 2007).

This model has been used very successfully in a number of US hospitals and has been the basis for much of the IHI's work with the NHS. While some of the activities in the framework may be more relevant to the USA, the general approach should be capable of adaptation to any health system.

An associated checklist presents organisations with the opportunity of rating themselves in terms of key areas of functioning. Depending on the scores, the framework then describes some actions they can take to improve engagement.

McLeod Regional Medical Center, South Carolina

Gosfield and Reinertsen (2010) offer an excellent case study of how the McLeod Regional Medical Center, a 453-bed hospital in Florence, South Carolina, used the IHI framework for engaging physicians to create a culture whereby medical staff engagement has been vital to McLeod's ongoing quality transformation, commenting that *those who have visited them marvel at the enthusiastic, effective leadership and participation of McLeod's doctors in quality, safety and value initiatives – without any significant financial incentives or payments* (p 12). It is worth noting that this is a hospital that employs a predominantly independent medical staff of about 400 doctors. It also won the prestigious 2010 American Hospital Association McKesson Quest for Quality Prize.

Gosfield and Reinertsen (2010) provide a useful summary of the specific elements of McLeod's methods for engaging and clinically integrating doctors. These include the following.

- **Asking doctors to lead** – The mantra is 'physician-led, data-driven, evidence-based', with every major improvement initiative led by a physician and reporting to the board upon completion.
- **Asking doctors what they want to work on** – McLeod initiates about 12 major clinical effectiveness improvement efforts each year; physicians recommend the list of priorities to the board. *'They are working on things that are meaningful to them, AND to the institution'* (p 12).
- **Making it easy for doctors to lead and to participate** – McLeod provides good support staff to optimise the time that doctors devote to leading any improvement initiative. The key is that McLeod does not waste doctors' time.
- **Recognition for doctors who lead** – Physicians who have led or been involved in improvement initiatives are recognised in many ways, including having the opportunity to present their work to the board for approval and adoption.
- **Support for medical staff leaders, with courage** – Inevitably, many improvements meet with resistance from physician colleagues or other clinical professionals. McLeod provides strong support to doctors leading improvement initiatives when they are confronted by difficult colleagues or other obstacles.
- **Opportunities to learn and grow** – McLeod provides support to those physicians keen to learn more from the research and literature on quality, safety and human factors.

The study concludes that the experience at McLeod emphasises the essential features of engagement and integration – especially the practice of doctors engaging with each other to drive learning, quality and professional satisfaction. This is very much in line with their paradigm that it is *not* about getting physicians to engage with organisations and their projects, but more about *'getting physicians to engage with each other in improving quality, safety and value',* which of course should also be the organisation's strategy.

Ottawa Hospital, Canada

Concern at Ottawa Hospital over the lack of systematic oversight of physician performance has led to a hospital-wide approach to improve physician oversight by incorporating it into the hospital credentialing process, and where physicians and the hospital share responsibility for monitoring professional behaviour. The particularly interesting initiative is the development of the Ottawa Hospital/Physician Engagement Agreement. This lists 14 commitments that the hospital and physicians make to each other. For example, the hospital commits to fostering a culture of care within an academic environment, while physicians commit to championing the development and adoption of organisational processes, practices and policies that drive excellence in quality of care within an academic environment.

The hospital has partnered with Hewitt Associates to develop a physician engagement measure and related engagement driver model. This is based

on a definition of *engagement as a measure of a physician's emotional and intellectual commitment to an organization*. A physician is considered to be engaged when they display all three of the following engagement behaviours:

- consistently SAY positive things about the organisation as a place to practice
- intend to STAY and continue practice at the organisation
- STRIVE to achieve above and beyond what is expected in their daily role.

NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges' study into the relationship between medical engagement and performance

Successive NHS reform reports, including *High Quality Care for All: NHS next stage review final report* (Darzi 2008), have stressed the importance of doctors being actively engaged in leadership and improvement of services.

The NHS Institute for Innovation and Improvement and the Academy of Medical Royal Colleges led a joint *Enhancing Engagement in Medical Leadership* project from 2006 to 2010. Its aim was to encourage doctors to become more actively involved in the planning, delivery and transformation of services and to help the NHS create a culture where doctors are more engaged in the health system.

One element of this project was the use of a medical engagement scale based on the Spurgeon *et al* (2008) definition above, and based on three conceptual premises that:

- medical engagement is critical to implementing many of the radical changes and improvements sought in the NHS, and engagement levels are not universally high
- medical engagement cannot be understood from consideration of the individual employee alone. Organisational systems play a crucial role in providing the cultural conditions under which the individual's propensity to engage is either encouraged or inhibited
- there is a distinction between competence and performance in the context of work behaviour. Competence may be thought of as what an individual can do, but this is not the same as what they actually do; the two together equal performance.

Applied Research Ltd had previously developed a professional engagement scale with data on more than 23,000 health care professionals. This scale was then adapted to provide a medical engagement focus, piloting and undertaking relevant psychometric analysis to confirm the reliability and validity of the scales.

The Index of Medical Engagement is made up of a series of sub-scales:

- Meta scale 1 Working in an open culture
- Meta scale 2 Having purpose and direction
- Meta scale 3 Feeling valued and empowered.

An initial set of norms for medical engagement was established and data have now been collected from almost 50 hospitals. These data enabled the extent and nature of medical engagement to be benchmarked and compared with the performance monitoring and regulation assessments by the Care Quality Commission as the independent regulatory body. The standards at that time included:

- operational standards and targets (eg, cancelled operations, meeting waiting targets)
- finance (eg, utilisation of resources)
- user experience (eg, provision of information, treated with respect)
- quality and safety (eg, incidents, infection rates).

At the time of the study, the performance levels were aggregated into overall trust ratings: excellent, good, fair, poor or weak.

The study concluded that there was evidence of a strong association between levels of medical engagement and externally assessed performance parameters in health care providers.

A further study within the project, undertaken by the NHS Institute and the Academy (2011), reviewed the lessons that could be drawn from seven trusts with the highest levels of medical engagement. The report concluded that these organisations had sought medical engagement in management and leadership for various reasons: in some cases, the strong conviction of a senior leader that it was the best way to run the organisation, and in others, a belief that it was the most effective way of working to achieve organisational goals.

All organisations acknowledged that medical engagement was often challenging, but highlighted the consistency of benefits attributed to high levels of engagement – for example, successful initiatives and innovation, staff satisfaction, staff retention, improved organisational performance, and better patient outcomes.

Relationships between managers and doctors varied between organisations; some were historically good and others dysfunctional. In both cases, it was acknowledged that engagement takes time, and that disengagement has the potential to be sudden and precipitous.

All organisations faced challenges and difficulties from both internal and external forces such as service reconfiguration and a restrictive economic climate. The potentially dynamic and shifting nature of engagement requires that there is an awareness of, and sensitivity to, current levels of engagement and which direction they are moving in. In this context, the medical engagement scale is particularly useful. Monitoring levels of engagement requires active listening and discussion of concerns. Understanding of various clinicians' propensity to engage is important so that resources can be deployed effectively to generate engagement – the right individual, the right issue and the right time.

Importantly, all organisations emphasised that engagement efforts should be proactive and persistent, and should be extended to the entire medical workforce, not just those in designated leadership roles.

The medical engagement scale is currently being adapted to provide a tool for assessing the extent of medical engagement in primary care, which

should be particularly useful as the emerging clinical commissioning groups begin to take shape. Clearly, high levels of engagement by GPs and other primary care staff will be critical to realising the benefits sought by the government's reforms around more effective commissioning.

The following summarises the key features of the seven trusts with high levels of engagement, and offers a useful checklist.

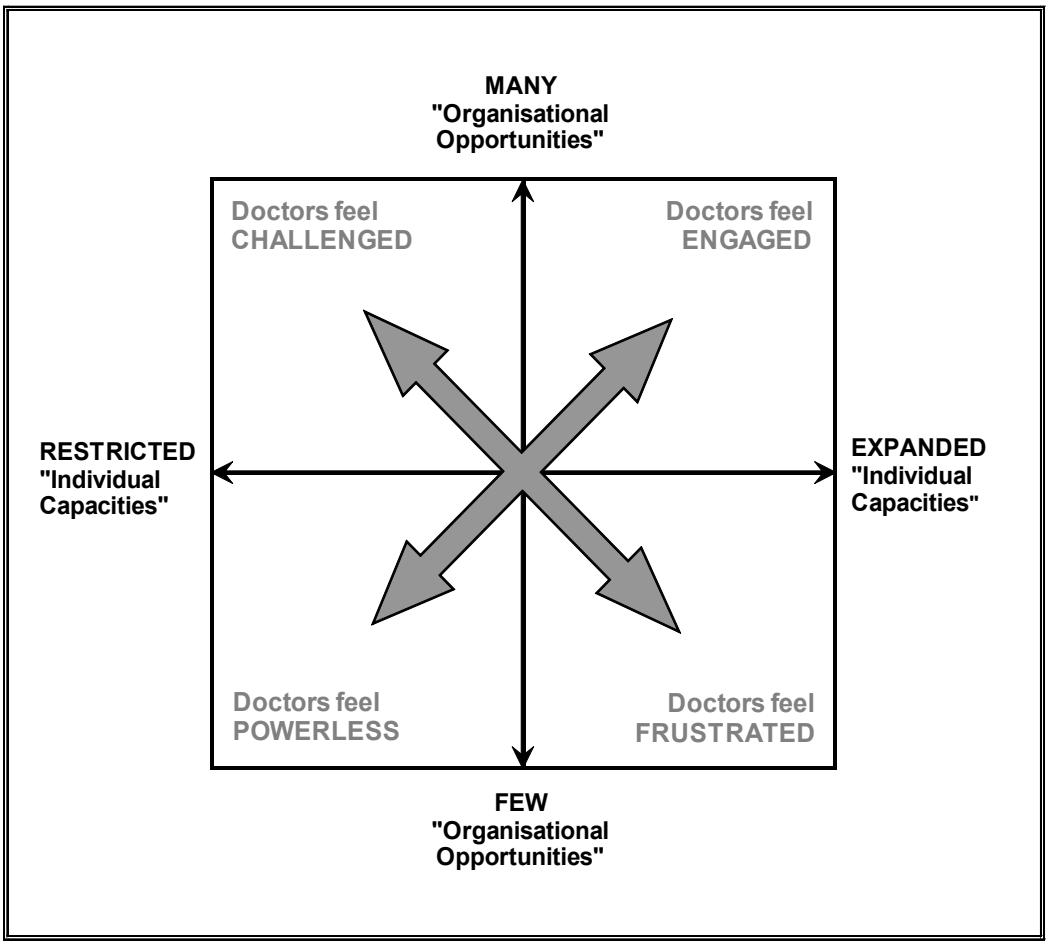
- Leadership, eg, stable, top-level leadership that promotes and fosters relationships and leads by example.
- Selecting and appointing the right doctors to leadership and management roles, eg, appointing on the basis of leadership competency.
- Promoting trust and respect between doctors and managers, eg, creating shared goals around quality.
- Clarifying roles and responsibilities, eg, doctors and managers working together to shape and develop services.
- Effective communication, eg, developing relationships through open and honest communication.
- Setting expectations about professional behaviour, eg, ensuring issues relating to unprofessional behaviour and patient safety are dealt with quickly and decisively.
- Providing support and development, eg, investing in leadership development for doctors at all levels.
- Developing a future-focused and outward-looking culture, eg, encouraging best practice.

3 Securing medical engagement: no longer an optional extra

There appears to be widespread support among politicians, policy-makers and executives that securing greater medical engagement at all levels and parts of the system – and indeed across the system – is critical to the next phase of improving health outcomes. What is not so easy is to create the kind of cultural change needed to achieve such a fundamental shift in the way we organise and run health organisations and systems. It is also about engaging with all medical practitioners, not just the few in primary, secondary and tertiary care that hold formal leadership roles.

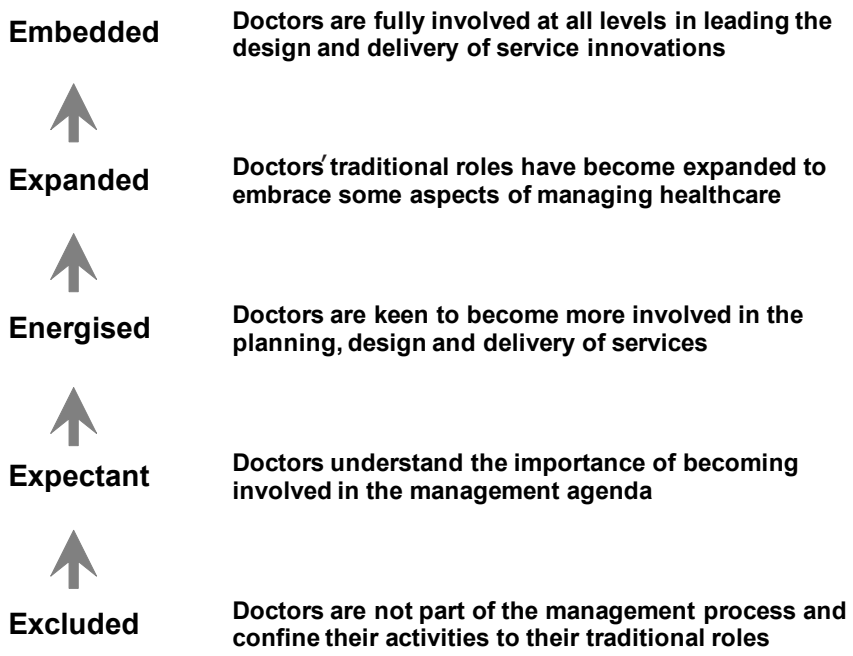
The key to creating a culture of medical engagement is encouraging and empowering doctors to take the lead on a wide range of service improvement initiatives and to be much more involved in setting the overall direction for services and across systems. The diagram below, based on the medical engagement scale model, emphasises the interaction between the individual doctor and the organisation. Clearly, the goal is to create the combination of factors that lead to doctors feeling engaged (that is, the top right quadrant).

Figure 1: Medical engagement model



Another way of viewing the extent of medical engagement is to consider it as a continuum (*see* Figure 2).

Figure 2: The continuum of medical engagement



In parallel with moves to create a more medically engaged culture, there are many initiatives being taken at national, deanery and local levels to encourage postgraduate trainee doctors to acquire relevant leadership competences. The Medical Leadership Competency Framework (MLCF) developed by the NHS Institute and the Academy (and now an integral part of the new NHS Leadership Framework) requires all doctors to acquire an agreed set of relevant leadership competences. A few doctors have taken time out of their specialty training to undertake a clinical leadership fellowship programme. This can include leading a service improvement project with senior trust managers supported by development interventions, including mentoring, action learning and undertaking a postgraduate programme in leadership. A number of trusts and deaneries are seeking to integrate learning about leadership and service improvement for all junior doctors by incorporating it into locally based training programmes, in conjunction with other managers.

There are now a number of programmes where junior doctors and graduate management trainees or other managers are undertaking some form of joint leadership development. For example, a paired learning initiative involving clinicians and managers at Imperial College Healthcare NHS Trust has improved outcomes and helped enhance quality and productivity (Klaber *et al* 2012).

GPs and hospital consultants tend to remain static for the remainder of their careers and thus build up a long-term understanding of the needs of their local communities. Ideally, both groups of clinicians should work together to have a shared view of the improvements required. All too often, organisational arrangements hinder such integrated and engaged

approaches and the current health reforms in the NHS in England provide potentially more restrictions to this vision. Nevertheless, all clinical commissioning groups and trusts have opportunities to create a more medically engaged culture, both within their organisations as well as across systems, provided there is the will to do so. The changed membership of clinical commissioning groups to include some specialist input, and the establishment of clinical networks, senates and Total Place initiatives, provide organisational opportunities, but real engagement needs to be much more than that.

The international examples cited earlier, as well as the much more often studied and published examples of Kaiser Permanente, Intermountain Healthcare and the Veterans Health Administration, for example, offer some insights into what can be achieved through greater medical engagement, and how to do it. As the study by the NHS Institute and the Academy (Atkinson *et al* 2011) showed, there are trusts that are typified by relatively greater engagement than others, with more positive performance outcomes. The study also offered some advice on the steps that could be taken to start the process of cultural change, from strong general management with some medical leadership, to one of strong medical engagement in partnership with supportive clinical and non-clinical leadership.

Perhaps the most persuasive argument for securing greater engagement is summarised by Taitz *et al* (2011) following a survey of 10 high-performing hospitals in the USA to determine how they engage their physicians in quality and safety. They commented that *most respondents defined engagement as physicians working to reduce unjustifiable variations in care, considering the processes and systems in which they care for their patients* (p 3).

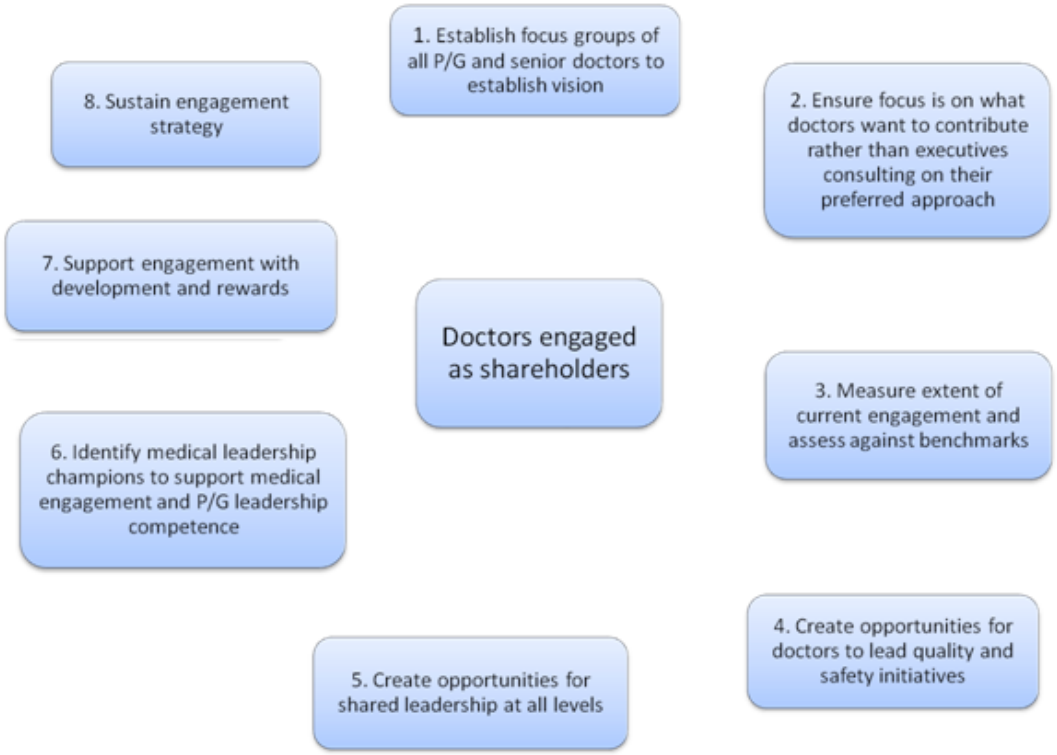
Given that doctors have the greatest influence on variations in health care outcomes, it is imperative that organisational and system-wide cultures are created that have doctors at the centre of sustained programmes to improve quality, safety and value. The tragic consequences for patients where there is low engagement and, indeed, dysfunctionality between clinicians and non-clinician executives are all too well known. Medical engagement is not, therefore, an optional extra but the key ingredient to enhancing clinical performance and patient satisfaction.

Drawing on the various national and international studies, frameworks and perspectives referred to earlier, how might NHS organisations and systems proceed to create a culture whereby doctors are more engaged in leading improvements in health and the delivery of health care? The key has to be that doctors want (and are encouraged) to take centre stage and accept increased responsibility. The role of non-clinical executives should be to positively support this change in culture and accept that in doing so, power will shift from general managers to clinicians, but with significant benefits to patients and populations.

The following framework is offered as a starting point for NHS organisations and systems to consider as part of an overall strategy to achieve greater engagement.

The powerful evidence for the relationship between medical engagement and clinical and financial performance is growing nationally and internationally. Engagement is too important to be left to chance. It needs an explicit strategy that is relevant and rewarding for clinicians and is likely to give the

Figure 3: A framework for achieving greater medical engagement



biggest return on investment in terms of improvements in quality, safety, clinical outcomes and value. However, such a cultural change needs to be inspired by clinicians and strongly supported by executives and non-executives.

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