

The Importance of Clinical Leadership

Sarah Jonas¹, Layla McCay² and Sir Bruce Keogh³

¹Sussex Partnership NHS Trust, UK

²University of Tokyo, Japan

³NHS England, UK

OVERVIEW

- Clinical leadership is vital to the success of healthcare organisations.
- Strong clinical leadership is associated with high-quality and cost-effective care.
- Clinical leadership means healthcare professionals engaging in setting direction and implementing change.
- Effective clinical leadership is collaborative and multidisciplinary
- Clinical leadership is needed at every level.

Healthcare is a huge, important and inherently complex business; every person in the world needs it, every country spends substantial proportions of their gross domestic product (GDP) on it, governments are judged by it, populations are determined by it and almost everyone has a personal interest in how it is delivered. The USA spent 17% and the UK 9% of its GDP on healthcare in 2013. Healthcare organisations also provide employment for a substantial sector of the population; for instance, the UK's National Health Service (NHS) employs 1.4 million people, making it the third largest civilian organisation in the world.

To enable organisations of such magnitude to deliver high-quality healthcare, high-quality leadership and management are vital at every level, from the national to the local, all the way down to the orchestration of individual interactions between patients and healthcare professionals. To be truly effective, this leadership must come not just from professional managers, but from across the clinical professions (Figure 1.1).

What is clinical leadership?

The terms 'leadership' and 'management' are often used synonymously or as overlapping concepts. But as Chapter 2 describes, they are two distinct but interdependent ways in which organisations, groups or individuals set about creating change while maintaining stability. Leadership involves creating a vision, setting strategic

direction and establishing organisational values. Management is more focused on directing people and resources to deliver the strategic aims established and propagated by leadership. A lack of either – leadership or management – makes it difficult for an organisation to effect change or bring about improvement.

Clinical leadership refers to the concept of healthcare professionals, as opposed to professional managers, undertaking the leadership task: setting, inspiring and promoting values and vision, and using their clinical experience and skills to ensure the needs of the patient are the central focus in their organisation's aims and delivery. Clinical leadership is key in both promoting high-quality care and transforming services to meet evolving population needs. And there is a role for clinical leadership at every level in healthcare organisations and systems; leadership is a process, not a position.

Why is clinical leadership important?

Globally, healthcare organisations must balance the need for financial sustainability and competitiveness with the need to deliver safe and effective care. There is mounting international evidence that good clinical engagement is associated with high organisational performance, and that strong clinical leadership leads to care of higher quality (Box 1.1). Effective leadership in healthcare occurs at distinct levels: the strategic, the organisational and the frontline. And just as multidisciplinary approaches benefit face-to-face patient care, drawing on diverse experience and skills can also help achieve high-quality healthcare at these various levels.

Despite the strong face validity of a link between clinical leadership and quality of care, a broad evidence base in this field has been slow to develop. This is largely due to the variability of how clinical leadership is defined and the complexity of healthcare organisations. However, some conclusions can be drawn.

At the organisational level, promising correlations between medical leadership and hospital rankings have emerged in the US (Goodall, 2011), while in the UK, a large-scale review of medical leadership models (Dickinson *et al.*, 2013) found that organisations with high levels of engagement between doctors and managers



Figure 1.1 Truly effective clinical leadership is multidisciplinary. Copyright iStockphotos.

Box 1.1 Evidence for an association between clinical leadership and quality of care.

- High-performing organisations are more likely to have clinicians on the governing board (but the direction of this association is not clear).
- Organisations with high levels of clinical engagement tend to perform better against a range of quality metrics.
- There is an association between distributed leadership and quality of care.
- Teams with low levels of conflict and shared leadership function better and deliver better care.

performed comparatively better than other organisations on available measures of organisational performance. Another UK study examined annual reports, performance statistics, patient outcomes, mortality rates and national patient survey data and showed that higher proportions of clinicians sitting on a hospital's strategic governance board were associated with better performance, patient satisfaction and morbidity rate (Veronesi *et al.*, 2012). Across the world, studies of organisational culture find strong links between high levels of clinical engagement, the distribution of leadership perceived by clinicians working in an organisation and the quality of care achieved by that organisation.

International evidence also shows that clinical leadership is also a key variable in the effectiveness of healthcare development and change implementation in an organisation (Greenhalgh *et al.*, 2005). Of particular importance is the presence of clinical champions who are willing to lead by example (Soo *et al.*, 2009).

At the level of clinical and nursing teams, meta-analyses of research consistently indicate that across sectors, shared leadership

and participative management in teams predict team effectiveness, including empowerment and self-efficacy, whereas team conflict is, not surprisingly, connected with poor performance (d'Innocenzo *et al.*, 2014; Wang *et al.*, 2014).

The development of clinical leadership practice

Historically, healthcare management has been described as 'management by consensus', where administrative, medical and nursing hierarchies co-existed but had no power over one other. Administrators made administrative decisions, doctors made medical decisions, nurses made nursing decisions and central funding bodies, including government, made funding decisions. More recently, increases in costs and the complexity of healthcare have made this model difficult to maintain.

Globally, countries have taken different approaches to the leadership and management of healthcare, with many countries employing doctors (or, less frequently, other health professionals) in senior leadership roles. In the UK, however, the government-commissioned Griffiths Report (1983) led to the introduction of general management in the NHS. This involved formalising management arrangements, creating boards and appointing clinical and medical directors to manage particular service areas with the intention of aligning clinicians with the objectives of the organisation; however, this was not always achieved. Throughout the 1990s, there was a growing recognition that clinicians needed to be actively engaged in the leadership and management of health services in order that change might proceed unimpeded. By the next decade, it had become apparent that clinical engagement was not only necessary to prevent the derailing of managerial initiatives, but a vital prerequisite for effective direction setting and

change management. The prevailing view today is that high-performing healthcare organisations tend to be clinically led, with strong partnerships between clinicians and professional managers, and a shared commitment to clinical quality.

Leadership and healthcare professionals

Health organisations have always experienced an inherent tension between central control and clinical autonomy. Mintzberg (1992) describes healthcare organisations as ‘professional bureaucracies’, where significant organisational decisions are made at the periphery by individuals with a relatively free rein – as opposed to a ‘machine bureaucracy’, such as a government department or a factory, where organisational decisions are made centrally, directed by a middle tier of management and enacted by a large group of workers operating under instruction.

An essential feature of the professional bureaucracy is the need for leadership to come from *within* in order to engage that group in enacting the vision for change. A lack of effective leadership can lead to anarchy as significant decisions involving the whole organisation can be made at the frontline without regard for overall organisational strategy, while such strategies may not be ‘heard’, paid attention to or implemented on the frontline. However, activated successfully, the professional bureaucracy can drive excellence in a way that a machine bureaucracy cannot. Embedding clinical leadership at every level is important to ensuring that the multitude of decisions made at the frontline in large healthcare systems on a daily basis add up to concerted action aligned with the organisation’s goals.

Today’s growing interest in a joined-up strategic approach in healthcare organisations, incorporating clinical leadership at every level, derives from a number of success stories from around the world where clinicians are already actively engaged in the running of health services to achieve significant quality improvement (Box 1.2).

Clinical leadership – the policy response

Perhaps the most systematic interest in clinical leadership from a national perspective has taken place in England. Government policy, detailed in *High Quality Care for All* (Darzi, 2008), placed quality improvement at the heart of the NHS and, importantly, highlighted clinical leadership as a key factor to achieve this. A number of national leadership competency frameworks followed, articulating the detail of what was required of clinical leadership (Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement, 2008; General Medical Council, 2012). A Faculty of Medical Leadership and Management was founded in 2011, followed by an NHS Leadership Academy in 2012. Subsequently, serial public inquiries, reports and reviews of service failures in England have continued to emphasise the importance of clinical leadership in the delivery of high-quality care, and have embedded clinical leadership as a principle for healthcare delivery. The evolving thinking about the role of

Box 1.2 Case studies: Clinical leadership in action.

Kaiser Permanente, USA

Clinical leadership is central to the structure and function of Kaiser Permanente, a US health management organisation. Its doctors are essentially partners in the business, transcending the traditional barriers between clinicians and managers, and closely aligning priorities and strategies to create a joint mission. Clinicians are actively encouraged to take on senior management roles, and quality improvement projects are seen as internally generated rather than externally imposed.

Veterans Association, USA

The Veterans Association (VA) is a public sector healthcare provider for US military personnel. In the 1990s, its reputation for quality care was low; it has since transformed itself into an organisation esteemed worldwide for the success of its quality improvement initiatives. These changes were led by a medical chief executive and included clinical leadership as a central premise. Today, the VA is a leader in clinical quality and has shown that clinical leadership is associated with high-quality care, and with lower-cost care.

Orygen, Australia

Orygen, based in Melbourne Australia, is a clinically led, not-for-profit centre of excellence for youth mental health. Offering a combination of clinical services, research and policy analysis with strong clinical leadership, Orygen has been a global leader in generating interest in early intervention in psychosis.

clinical leadership in healthcare is summarised in an excellent series of internationally relevant publications by the UK health policy think-tank, the King’s Fund (Fig 1.2).

The future of clinical leadership

Clinicians have often been deterred from taking up leadership roles due to a lack of remuneration, professional recognition and respect, formal training or career pathways for these roles. In particular, a culture of antimanagerialism has arisen in some organisations, where clinicians may unhelpfully refer to their colleagues who participate in clinical leadership as ‘going over to the dark side’. Leadership can also be perceived as a somewhat nebulous concept, and in a world of evidence-based practice, the study of leadership can be seen as non-rigorous and unscientific. It is up to clinicians to further develop the study of this vital discipline and recognise and reward the true importance and power of clinical leadership.

Throughout the world, healthcare systems are increasingly expensive and complex, and the imperative to continuously improve care quality has taken centre stage. The impetus for clinical leadership to align forthcoming healthcare reforms with the needs of the patient has never been greater. The task for clinicians will be to grasp the opportunity and help lead future change through effective clinical leadership.



Figure 1.2 Evolving thinking about clinical leadership. Source: King's Fund, 2011–2015.

References

- Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement (2008) *Medical Leadership Competency Framework*, NHS Institute for Innovation and Improvement, London.
- Darzi A. (2008) *A High Quality Workforce: NHS Next Stage Review*, Department of Health, London.
- Dickinson H, Ham C, Snelling I and Spurgeon P. (2013) *Are We There Yet? Models of Medical Leadership and Their Effectiveness: An Exploratory Study*. Available at: www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1808-236_V07.pdf (accessed 29 September 2016).
- D'Innocenzo L, Mathieu JE, Kukenberger MR. (2014) A meta-analysis of different forms of shared leadership – team performance relations. *Journal of Management*, **20** (10), 1–28.
- General Medical Council (2012) *Leadership and Management for All Doctors*, General Medical Council, London.
- Goodall AH. (2011) Physician-leaders and hospital performance: is there an association? *Social Science and Medicine*, **73**, 535–539.
- Greenhalgh T, Robert G, Bate P *et al.* (2005) *Diffusion of Innovations in Health Service Organisations: A Systematic Literature Review*, Blackwell, Oxford.
- Griffiths Report (1983) *NHS Management Inquiry*, Department of Health and Social Security, London.

- Mintzberg H. (1992) *Structure in Fives: Designing Effective Organisations*, Prentice Hall, Harlow.
- Soo S, Berta W, Baker GR. (2009) Role of champions in the implementation of patient safety practice change. *Healthcare Quarterly*, **12**, 123–128.
- Veronesi G, Kirkpatrick I, Vallascas F. (2013) Clinicians in management: does it make a difference? *Social Science and Medicine*, **77**, 147–155.
- Wang D, Waldman DA and Zhang Z. (2014) A meta-analysis of shared leadership and team effectiveness. *Journal of Applied Psychology*, **99** (2), 181–198.

Further resources

- Dickinson H, Ham C. (2008) *Engaging Doctors in Clinical Leadership: What Can We Learn from the International Experience and Research Evidence?* University of Birmingham, Birmingham.
- Hamilton P, Spurgeon P, Clark J *et al.* (2008) *Engaging Doctors: Can Doctors Influence Organisational Performance? Enhancing Engagement in Medical Leadership*, Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement, London.
- King's Fund Leadership Development. Available at: www.kingsfund.org.uk/leadership (accessed 29 September 2016).
- Mountford J, Webb C. (2009) *When Clinicians Lead*. McKinsey Quarterly. Available at: www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/when-clinicians-lead (accessed 29 September 2016).