Clinical Medicine 2011, Vol 11, No 2: 125–7

Capitalising on leadership fellowships for clinicians in the NHS

Edward D Nicol

ABSTRACT – Clinical leadership has become a primary focus of the NHS with many leadership programmes, particularly those aimed at junior clinicians, being developed. This article illustrates the potential of these programmes but also urges caution when assessing the success of these schemes both from an individual and organisational perspective.

KEY WORDS: clinical leadership, management, NHS Next Stage Review

Introduction

Clinical leadership has become a primary focus of the NHS as the organisation looks to increase clinical engagement in the delivery of healthcare, beyond that of direct patient care, and into strategic healthcare delivery. The recent formation of the National Leadership Council (NLC), that includes highly successful and motivational junior doctors as emerging clinical leaders on its board, suggests that this policy drive is likely to continue.[1] While there are many opportunities open to aspiring health leaders, expectations should be realistic, both for participants and providers, and the potential challenges for junior clinicians should be highlighted alongside the potential rewards.

Background

The chief executive (CE) of the NHS stated that he would like to see at least one doctor shortlisted for all NHS trust CE posts in 2007.[2] This aspiration of clinical leadership was backed up by the previous government with the appointment of Lord Darzi (a practising surgeon) to a ministerial post and the publication of his *NHS Next Stage Review*[3] and associated workforce document.[4]

These pivotal events have led to many opportunities for clinicians, particularly more experienced junior doctors, to explore and experience clinical management and leadership, often at very senior levels of the NHS or wider health economy. However, the timing of this experience and length of tenure of these programmes may lead to particular challenges for those who undertake these prestigious and costly programmes. Unmet expectations, in the face of a strong, conservative and hierarchical culture may paradoxically lead to disengagement of these individuals who are both interested in, and capable of ultimately delivering, the necessary innovation and vision required for the NHS in the challenging times ahead. This personal commentary is intended to illustrate both the potential of these programmes but also to urge caution, on behalf of those who commission, provide and participate when assessing the short-, medium- and long-term success of these programmes.

Individual opportunities and challenges

Many leadership fellowships have been developed to enable identification of potential future leaders and provide a mixture of training, mentoring and clinical experience at acute trust, primary care trust (PCT), strategic health authority (SHA) and national level. Most, but not all, current leadership fellowships are aimed at doctors, predominantly in their specialist training, prior to becoming consultants or fully accredited GPs. These may be either full-time, fixed-term, out-of-training programme appointments (ie Darzi fellowships, chief medical officer's specialist advisor scheme) or part-time commitments that run concurrently with ongoing specialist training, either locally or nationally (ie SHA London Prepare to Lead, South Central SHA specialist registrar (SpR) Leadership Programme, Health Foundation Leadership Fellowship). A number of individuals have also been funded for masters degrees in either business administration (MBA), medical management or leadership and many joined the rapid expansion of junior medical managerial societies such as BAMMbino (the junior division of the now defunct British Association of Medical Managers (BAMM)). More recently over 1,000 junior doctors have signed up to networkwithnoname.net, a new social network aimed at aspiring clinical leaders.

Full-time out-of-programme opportunities

Individuals, often within five to 10 years of qualification have fulfilled key strategic roles within the heart of the Department of Health and the World Health Organization, providing an important clinical voice during the development of health policy both in the UK and internationally. Some have worked with CEs and other board members in primary care and acute trusts, helping shape local service delivery and quality improvement programmes and commissioning strategies, many with considerable influence and success. However, others have been less fortunate; some have struggled to balance the dichotomy of their junior clinical position and lack of clinical experience with their newfound role in the managerial hierarchy while others have found themselves in ill-defined clinical-managerial roles with no precedent or clear terms of reference. Trying to

Edward D Nicol, cardiology specialist registrar, Department of Cardiology, Royal Berkshire Hospital, Reading and honorary cardiac CT fellow, Department of Cardiology, Royal Brompton Hospital and Harefield NHS Trust, London

'influence without authority' has been a challenging, often isolating and ultimately demotivating experience for some. The lack of clear objectives, both personal and organisational, has also hindered some and led to unmet expectations either during or following these fellowships. Peers and fellow clinicians, often in positions of greater clinical authority, who are either not interested in this agenda or who believe the primacy of a clinician is in dealing with individual patients, may be unsupportive and occasionally openly hostile.

It has taken bravery, as well as ambition, for this younger generation of clinician to 'put their head above the parapet' and it is important to acknowledge the anxiety that many junior clinicians express. Junior clinical leadership is both rewarding and exciting but unsupported exposure and isolation can, if not identified and managed, lead to significant anxiety. The importance of supportive and appropriate coaching and mentoring as part of these leadership schemes cannot be overstated in this respect and, if managed well, provides both senior insight but important, impartial and confidential counsel and support.

Part-time in-programme fellowships

Those fellowships that have been incorporated into a full clinical role, providing insight and education into the corporate structure and function of the NHS while individuals continue their usual clinical practice, may have some advantages. These include providing the knowledge and insight from seasoned professionals while allowing individual participants to develop their leadership skills more locally and ironically from a more appropriate authoritative position. It is no less bold a move to push for change in this environment but the perception of clinical colleagues may engender less resistance to innovative change and suggestion and may prove a safer, more productive and successful environment, particularly for doctors in training. Only very few fellowships (such as the Health Foundation and the North West SHA leadership programmes) have incorporated a truly multiprofessional approach to leadership training, although it has been acknowledged by the NLC that this multidisciplinary, multiprofessional approach is likely to allow greater cross fertilisation of ideas between professions. This may also allow the development of networks of healthcare leaders who can assess complex healthcare issues with real and credible holistic insight and access colleagues from different clinical background for their perspectives.

Strategic questions and challenges

There remain several unanswered strategic questions with regards the current leadership focus. Firstly, what is the ultimate aim of these leadership programmes? Is it to raise the calibre of future clinical leaders who remain in clinical practice; those who will fulfil senior clinical managerial roles; those who aspire to national and international health management or a combination thereof? Secondly, are we sure we are focusing on, and selecting, the right individuals for these programmes and is the major focus on trainee doctors the most appropriate strategy given the concerns over lack of authority and clinical credibility that have stifled and disengaged some? Thirdly, how do we capture and disseminate the learning and experiences of these fellows and are there mechanisms, such as networks and alumni, that may facilitate meaningful dialogue and further leadership action? Fourthly, what weight do we give to these fellowships as compared with health MBAs or masters qualifications in management and leadership, or clinical leadership or managerial experience, gained elsewhere? Finally, over what period, and how do we assess return on the significant investment that has been dedicated to these programmes?

Return on investment

One of the greatest challenges for those who commission and deliver these programmes is trying to prove their benefit and value for money. If an individual junior clinician fulfils a role that would otherwise have required more senior managerial commitment or the expense of external management consultancy then this may be relatively straightforward but this is rarely the case. The reality is that the important knowledge, skills and attitudes that individuals gain during these fellowships may not result in immediate tangible outcomes. Furthermore, it will be difficult to determine the causal relationship between a previous fellowship and future clinical managerial success as motivated individuals have managed to secure high profile and influential posts prior to the inception of these programmes. While it is likely that the cadre of potential clinical applicants to senior managerial posts may be more informed and more prepared for these roles, this lack of evidence will be brought to the fore in times of financial austerity where each and every investment possibility will likely be judged on their short-term outputs.

The future

The NHS medical director, among others, is clear that clinical leadership and innovative practice will be the bedrock of an organisations ability to withstand the financial constraints the NHS will face in the coming years. It is apparent that an increasing number of organisations including the royal colleges, the Open University, BMJ group and others will continue to develop and deliver postgraduate clinical managerial and leadership qualification programmes to those that are willing to find the necessary finance. What is less clear, however, is the future of NHS-funded leadership training and whether the lack of clear outcomes or objectives of current schemes will lead to the decline of these programmes in the coming years? What is evident is that the opportunity for clinicians, particularly doctors, to gain a more corporate NHS education has expanded significantly in the past few years. The need for more multidisciplinary programmes is self-evident if the health service is to deliver effective strategies while negating the usual tribal

tendencies that have historically bedevilled the NHS. The NLC should have a pivotal role in the development of this agenda and will have to grapple with many of the issues outlined above. The issue of wider non-clinical generic health service education that includes training of the structure and function of the NHS, NHS finance and human resource issues are applicable to all of us working in the NHS and the argument for a structured strategic 'bottom up' educational approach for all healthcare workers may also have merit. Exploring the potential of leadership models from other public health sectors, such as the armed forces, may have merit.[5]

Conclusion

If we are to capitalise on the investment we have already made in this pathfinding generation and further develop the engagement of clinicians (from whatever discipline) in health service management and delivery we must be clear in our strategic aims and also clear of both the strengths and limitations of our programmes thus far. There is an evident need for qualitative and potentially quantitative research into the potential benefits and outcomes of these programmes and to develop an evidence base to show that these investments have had an effect. This will be far from straightforward. Most importantly, however, we must provide adequate support and guidance, particularly to more junior clinicians, if we are to place them in these challenging positions. The consequence of disengagement, apathy and resentment fuelled by unmet expectations would undermine all the gains potentially made. Management and leadership are skills that take a lifetime to master and we should not rush to judge the success of these programmes, but we must make sure we are investing wisely.

Provenance statement

This article is based on the reflection of the author, who has completed both the multidisciplinary Health Foundation Leadership Fellowship 2007–9 and the 2009/10 NHS London Prepare to Lead scheme. The author has held appointments as a clinical advisor to both the Healthcare Commission and Department of Health and has been involved with the chief medical officer's department as part of the expert working group and subsequent implementation group seeking to reduce deaths from venous thromboembolism in hospitalised patients. The author holds a diploma in management and attained the vocational chartered manager status through the Chartered Management Institute. He also has an academic interest in leadership both within and outside the health sector and is completing a health MBA dissertation on 'The challenges and opportunities of Lord Darzi's leadership agenda'. EN is the sole author and guarantor of the article.

References

1 Department of Health. *National Leadership Council*. London: DH, 2009.
2 Day M. The rise of the doctor-manager. *BMJ* 2007:335:230–31.
3 Darzi A. *High quality care for all: NHS Next Stage Review final report*. London: DH, 2008.
4 Department of Health. *A high quality workforce: NHS Next Stage Review*. London: DH, 2008.
5 Nicol E. Can the NHS learn from Military Medical Leadership? *JSL* 2009. www.hsj.co.uk/home/clinical-leaders/nhs-clinical-leaders-take-a-leaf-from-the-militarys-book/5001387.article

Address for correspondence: Dr ED Nicol, Royal Brompton Hospital and Harefield NHS Trust, Sydney Street, London SW3 6NP.
Email: e.nicol@rbht.nhs.uk