Medical engagement and improving quality of care

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ABSTRACT

This paper argues that establishment of a positive culture that promotes and enhances levels of medical engagement should be a key objective of medical leadership. Two particular and critical arguments underlie this proposition a) that levels of medical engagement, as measured by the Medical Engagement Scale, is strongly associated with organisational performance, including quality of care; and b) that any aspiration to achieve an organisational culture known as 'clinically led' cannot be achieved without high levels of medical engagement. Medical engagement as a concept is discussed, as well as the need for robust and reliable assessment. Approaches to support organisations enhance levels of engagement are presented as part of the goal to improve overall care quality.

KEYWORDS: Leadership, medical leadership, medical engagement, organisational performance, development strategies, quality of care

Introduction

Over the past couple of decades there have been continuous calls for improved leadership in the healthcare sector. In part, this often seems to be a 'hoped for solution' to the many challenges faced by the sector and the absence of other obvious solutions. Perhaps inevitably there is less clarity about what form this leadership takes and whether the leadership development offered is appropriate and relevant to tackling the demands of the health system. A King's Fund report[1] suggested that a command and control, 'pace-setting' style of leadership predominated and that this powerful style was incapable, consciously or unconsciously, of accommodating the complexities of the working environment whether patient issues or staff seeking greater participation.

A recent review of leadership and leadership development[2] offered a useful summary of the current situation, suggesting that although a degree of consensus was emerging around the need for a more collective distributed or shared style of leadership, the majority of leadership development still focused on enhancing the skill set of the individual leader. They highlighted 'the important contribution of organisation development and not just leader development'.

Although the report cited above is current it is depressingly like any that might have been written 10 or 15 years ago. Leadership as a concept remains subject to fashion and is therefore fickle in its manifestation. Much of the content of programme delivery is at the whim of the preferences of providers and their preferred (largely unevidenced) approaches. This situation is unlikely to change until the health sector decides (as in other more self-contained organisations) what leadership style it wants to adopt and with what particular purpose or outcome. It is however possible to glean three important strands of thinking or challenges that will need to be addressed in the future.

- A collective or distributed leadership model is essential to meet the complexities of the NHS and this requires leadership roles to be seen as a natural element for all clinical staff.[3]
- Leadership will function, not via a small group of leaders, but by the creation of positive, engaging cultures that facilitate the contribution of all staff.[4,5]
- The link between leadership, in its various forms and contexts, to particular types of quality improvement is at best unclear.[6]

It is not possible in this short paper to address each of these aspects. Therefore, a more selective focus will be on cultural aspects, notably how medical engagement is a vital prerequisite to developing 'clinically led organisations'.

From leadership to medical engagement

The issue of medical leadership and health organisations has a long history. Early models (and simpler organisations) had doctors as the person in charge, the hospital superintendent and by some way ahead of others in acknowledged expertise. Gradually, management and managers grew in number and competence until doctors often felt superseded. Today there is a reinstatement of the medical leader but more in a context of shared working with senior managerial colleagues, sometimes described as dualities. This process is described as doctors in leadership roles moving from a rather maverick position to central and influential roles.[16] Dickenson *et al*[7] report some variability in how far this medical leadership process had been embedded, but Veronesi *et al*[8] suggest that the involvement of clinicians on boards had a positive impact on a range of outcomes.

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Accepting that medical leadership has a positive impact on organisational performance, including quality of care, what would indicate an environment where such involvement is encouraged and promoted: a culture that might be described as medical engagement? Indeed it is the contention of Spurgeon *et al*[9] that the creation of enhanced medical engagement should be a primary goal of leaders and medical leaders. In a later section of this paper we offer some ideas as to how organisations might go about fostering such an engaged culture. Prior to that it is important to understand the concept of medical engagement and what we know about how it operates.

Medical engagement

Engagement has become a very popular and widely used term; however, perhaps as a consequence its meaning slips a little depending on who is using it and in what context. Indeed, within a collective movement called Engage for Success, which has had considerable impact in the UK, there seems little appetite for definition and measurement, rather an encompassing sense of the term engagement, so that any form of participation, involvement or interaction between management and staff is a good thing. Others, particularly with a more academic focus, argue that precise definition and associated measurement is essential to enable repeat assessment and the dynamics of the process of engagement to be understood. Nonetheless, the concept is strongly endorsed across the private sector and believed to be clearly associated with various aspects of performance.[10] Macleod and Clarke[11] provide a useful summary across a range of sectors. They suggest that there is no universally accepted definition of the term but, despite this, conclude first that engagement is measurable, although the different tools used account for some of the variability in the concept, and second, that engagement correlates with performance and innovation, and although correlational, that the consistent nature of studies of engagement, coupled with individual company case studies, makes for a 'compelling case'.

The evidence in the health sector is steadily growing. Prins *et al*[12] found that, in a study of 2,000 Dutch doctors, the more engaged were significantly less likely to make mistakes. Toto[13] demonstrated that engaged physicians can have a direct day-to-day input on the bottom line of hospitals. Additionally Taitz *et al*[14] found no meaningful way to influence variations in practice or care without medical engagement of doctors at a collective and individual level.

The general and rather loose use of the term engagement can result in it being used at times to imply some form of communication process – to engage in a debate. The problem with this type of usage is that it feels rather one-way, done by management to employees,[15] and crucially, in the context of medical staff, it may be seen as communication towards compliance: 'we will continue to communicate until you agree'. This is a form of engagement unlikely to be acceptable to independent-minded medical staff.

Another form of usage is as an action verb where it is taken to mean engage in or do something. This plays to the view of critics who say 'engage in what'. The problem here is that it is the external task or activity that is defining engagement. Therefore change or modification in the external task would appear to alter, potentially substantially, the level of engagement, for example with primary care based commissioning. If commissioning as a process was abandoned or reformed, how do we judge the post change level of engagement? It is so determined by the external task that engagement becomes very volatile and unstable.

It was in the light of these issues that the Medical Engagement Scale (MES) was developed within a national project, Enhancing Engagement in Medical Leadership, run jointly by the Institute of Innovation and Improvement and the Academy of Medical Royal Colleges. This metric sees engagement as an intra-individual concept, involving a motivational state or level of commitment that exists within the individual, and can be applied to a range of tasks or settings. This view is critical to understanding the linkage between engagement and organisational performance. If an individual's reservoir of motivation/commitment can be increased and if this applies to the entire workforce, then it is possible to see how an organisation, by increasing its overall level of engagement, will have also increased its overall 'power' to perform.

The term engagement is here helpful in distinguishing between competence (what an individual is capable of doing) and performance (which involves the exercise of choice to use that competence to address a particular work goal or context). Similarly MES is based on a clear definition of medical engagement:

> *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.*[16]

A vital aspect of this definition is that in practice it recognises the two way nature of the process of engagement – an individual's propensity to engage and the organisational responsibility to create the cultural conditions for engagement levels to grow.

MES was developed on a very large sample of NHS staff (over 20,000) with good reliability and validity data. A full account of the development process is to be found in Spurgeon *et al*.[16]

Medical engagement and performance (quality)

West and Dawson[17] conclude that 'the more engaged staff members are, the better the outcomes for patients and the organisation generally'. This was data derived from the national NHS survey which involved all types of staff. MES in contrast focuses upon medical engagement specifically, using the definition given above. This raises the question in large organisations of whether all staff groups (doctors, nurses, secretaries, porters etc) will respond to the same aspect of organisational efforts to enhance engagement.

MES currently has approximately 10,000 doctors and just under 100 UK trusts on the database. This enables quite specific comparison between engagement levels at each trust. The data have been used to demonstrate consistent positive relationships between levels of medical engagement and organisational performance, as measured by Care Quality Commission metrics in 2008 and 2014 across financial, quality and patient-led criteria.[18] More recent developments relating to MES show that it significantly predicts which medical staff are likely

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to adopt new working practice (UK), and also as a measure of the enhanced level of engagement following leadership development programmes (Canada).

Both of these small-scale applications suggest that a medically engaged culture may support innovation and that there are programmes that may be able to promote enhanced engagement. An important but rather overlooked issue is the level of engagement in junior doctors. Medical engagement is often addressed as if it is a problem, something to be improved. It could be that by understanding the levels of engagement in junior doctors and trying to ensure they are improved, future problems could be avoided. Spurgeon and Wathes[19] reported relatively low levels of engagement in junior doctors as measured by MES, couching it as a failure to invest in an engaged future workforce. Micallef and Straw[20] demonstrated how an innovative programme for trainee doctors could result in enhanced levels of engagement.

Organisational initiatives for enhanced engagement

In the UK a number of publications[21–23] have all expressed the importance of medical engagement in helping to create cultures within health organisations and systems that deliver sustained high-quality, safe and efficient services. Ham[24] contends that 'transforming the NHS depends much less on bold strokes by politicians than on engaging doctors, nurses and other staff in improvement programmes'.

Much less has been written about how organisations achieve the cultures whereby doctors seek to be much more engaged in the planning, delivery and improvement of services, and where the organisation's executives genuinely seek this greater involvement. A fundamental difference in approach over the past few years is evidenced by organisations ceasing to transform doctors into managers, but rather encourage doctors to influence priorities by working in partnership with managers on improvement projects.

As Reinertsen *et al*[25] observe, referring to the USA, physicians have a deep need to contribute to improving the situation – to be part of what's right, rather than what's wrong with the health system. They refer to the vice president of medical services at McLeod Regional Health, South Carolina (winner of the prestigious McKesson Quest for Quality Prize in 2011 for their work on medical engagement), commenting that their improvement work is physician led, evidence based and data driven. The 2012 King's Fund Report,[26] *Leadership and engagement for improvement in the NHS: together we can*, summarises, 'There is an important message here – the key thing is not to get doctors to engage with the organisation *per se*, so much as to engage with their peers in improving quality'. There are many more oft-quoted examples of high-performing organisations in the USA where medical leadership and engagement has been a critical factor eg Intermountain Healthcare, Kaiser Permanente, Virginia Mason Medical Center etc. However, there are also an increasing number of NHS hospitals who can equally demonstrate high-quality, safety and fiscal performance, as well as high levels of patient and staff satisfaction, through sustained commitment to creating cultures that value the involvement of doctors as 'shareholders' in the running and improvement of services. Given the evidence of the relationship between staff (particularly doctors) engagement and performance, future hospitals have to create cultures similar to those that are demonstrably performing better than others. It should not be an optional extra but central to raising the quality of care to all patients, irrespective of where they are treated.

The King's Fund report *Medical engagement: a journey not an event*[27] studied four NHS organisations with acknowledged high levels of medical engagement and performance. The organisations shared a common goal of creating cultures where staff engagement was seen as a critical component 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'.

Each of the four trusts studied were at a different phase of cultural change but some key messages were developed.

- Cultural change takes time and needs to evolve in a sustainable way; there will be pain along the journey.
- Doctors need to be motivated to make wider contributions, and general managers need to provide support working in genuine partnership.
- Medical engagement and leadership needs to be seen as part of wider cultural change, where it is embedded into the organisation and system and not as a one-off initiative.
- Medical engagement is unlikely to occur unless it is part of an overall and sustained organisational commitment from the board to the ward around quality, safety, service improvement and engagement.
- Mutual respect must be present between managers and clinicians working in close partnership. It is not about whether medical leaders or general managers should be dominant; it is about being clear on vision, values and aims, and working together with colleagues to achieve common goals.
- While patient-focused cultures are the common denominators, organisational structures that have doctors in key roles at divisional and departmental levels supported by managers are also key, with full responsibility and accountability for quality and fiscal performance.
- Selection of consultants and all senior managerial and leadership roles are made against a set of organisational values. All new consultants participate in orientation and leadership development programmes, ie the importance of being involved more widely than just their clinical contribution is reinforced by approach to selection and the early months in the organisation.
- Appraisal and revalidation is taken seriously, and consultants identified with the potential to assume greater leadership responsibilities are identified and offered further leadership development in-house, regionally, nationally and internationally, as appropriate.
- Education and training is seen as an integral element of the trust's culture and every opportunity is given to junior doctors to participate in or lead service improvement and leadership programmes.

The four NHS organisations studied in the King's Fund report demonstrate what can be achieved by a sustained focus on motivating doctors to be more engaged, as part of a wider approach to creating collective cultures that provide the foundation for the delivery of the highest possible care.

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As Keogh[6] stresses 'the quality of clinical leadership always underpins the difference between exceptional and adequate or pedestrian clinical services which in aggregate determine overall effectiveness, safety and reputation'.

Conclusion

This paper has argued that medical leadership has moved from an advocated position to one of expectation, even if not yet universally implementated. Evidence suggests that this medical leadership is associated with organisational effectiveness which in itself is mediated by establishing a positive culture, particularly that built around medical engagement. This concept too has in itself been examined in terms of its usage, assessment and link to various aspects of performance/quality.

Medical leaders would do well to view the establishment of a medical engagement culture as a key goal. General principles have been outlined here. The recent paper by Snell *et al*[28] provides a good framework for embedding physician leadership. The new short form of MES also provides a flexible tool by which organisations can assess progress in their pursuit of medical engagement. ■

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