Contents

Foreword ......................................................................................................................... 3
Introduction ....................................................................................................................... 4
  Background .................................................................................................................. 5
  The response ............................................................................................................... 6
  Disclaimer .................................................................................................................. 7
Skills, tools and knowledge: ‘where to look’ ................................................................. 8
  Personal development ................................................................................................. 10
  Business management ................................................................................................. 11
  Finance ........................................................................................................................ 12
  Quality improvement ................................................................................................. 13
Guidance: ‘what I wish I’d known’ ................................................................................ 14
  Do I maintain clinical practice? ................................................................................ 14
  The doctor corporate ................................................................................................. 17
  Hitting the ground running ....................................................................................... 19
  Building and working with your team ...................................................................... 22
  HR processes ............................................................................................................ 24
  Challenging colleagues ............................................................................................. 26
  Dealing with the media .............................................................................................. 28
  Wisdom and everything else ..................................................................................... 30
Support: ‘you are not alone’ ......................................................................................... 31
  Resilience ................................................................................................................... 31
  Coaching ..................................................................................................................... 33
  Mentors ....................................................................................................................... 34
  National Medical Director Mentoring Scheme ......................................................... 35
  Informal support networks ....................................................................................... 35
  Your executive colleagues ....................................................................................... 36
Conclusion ..................................................................................................................... 37
  Feedback .................................................................................................................... 37
Current national items of interest ................................................................. 38

Seven day services .......................................................................................... 38
Model Hospital and unwarranted variation (Carter report) .............................. 40
Getting It Right First Time ............................................................................... 42
NICE quality standards and support ............................................................... 44
NICE interventional procedures guidance ....................................................... 45
Foreword

To understand the need for this guide, one must understand the origins and evolution of the medical director’s role. When the role was created in the early 1990s, medical directors provided an advisory service to the board, their roles purely clinical. But time changes all things, including the medical director. Since the role’s inception almost a quarter of a century ago, it has changed in all but name.

The modern medical director is a fully fledged and integral member of the board and expected be fully proficient in the skills for the role. Herein lies the issue. Although the requirements, expectations and job description are different, the way we train our medical directors is not. They are all still consultant doctors, and most doctors only pursue clinical training. The goalposts have moved, but the doctors are still playing on the old pitch.

This situation has led to many medical directors complaining they feel unprepared and unsupported, so it is hardly surprising that many leave after only a short tenure. There is therefore a pressing need for change in how we approach the role.

We developed this guide in response to that need: the need to recognise that just having clinical training is not enough, that being a medical director is a difficult role and above all that medical directors need support – from their staff, their colleagues and the system to which they dedicate their time and energy, and which they drive to improve for the benefit of their patients and staff.

NHS Improvement and the Faculty of Medical Leadership and Management are dedicated to supporting and developing all medical leaders, and we hope this guide goes some way to realising those aspirations.

Dr Kathy McLean
Executive Medical Director
NHS Improvement

Mr Peter Lees
Chief Executive and Medical Director
Faculty of Medical Leadership and Management
Introduction

“Start to prepare, and go for it. It is a challenging but rewarding job which can make a real difference”

Medical director, north of England

Congratulations on your appointment as a medical director. You are about to undertake one of the most important but rewarding roles that any doctor can have.

The medical director and the director of nursing are the principal clinical voices on a trust board, with the primary aim of bringing all the many facets of clinical care into the boardroom. They offer key insights in developing and supporting the trust’s strategic direction, particularly with respect to the safety and quality of clinical services. In addition, they have key corporate responsibilities in supporting and communicating the strategic vision internally and externally.

There is currently no formal preparatory process for medical directors. Many are appointed from within their organisations with the expectation that their clinical training will have prepared them for a leadership role, an expectation which challenges many medical directors.

NHS Improvement and the Faculty of Medical Leadership and Management (FMLM) developed this guide in response to many requests from newly appointed and senior medical directors. It supports NHS Improvement’s commitment to creating a sustainable and ongoing programme that helps medical directors in every aspect of their careers. It also supports FMLM’s core purpose of improving patient care through better medical leadership. This guide follows directly from *The medical director’s role: a guide for aspiring medical leaders*,¹ aimed at clinical leaders who may be considering following a medical leadership career leading to a medical director role.

¹ [https://improvement.nhs.uk/resources/the-medical-directors-role-a-guide-for-aspiring-medical-leaders/](https://improvement.nhs.uk/resources/the-medical-directors-role-a-guide-for-aspiring-medical-leaders/)
Background

When you become medical director, you will get a job description. You may even be given a person specification. What you won’t be given is a ‘how to do the job guide’. It is therefore worth reflecting on what are you trying to be for the organisation.

Dr Brendan Ryan, Medical Director, Tameside and Glossop Integrated Care NHS Foundation Trust

Medical directors are often appointed with the expectation that their clinical training and time spent as consultants will have prepared them adequately for the role. Unfortunately this is often unrealistic and unreasonable, even for medical directors who have previously held associate/deputy medical director or clinical director roles.

Previous research, supported by interviews and surveys of medical directors undertaken by NHS Improvement, revealed that many newly appointed medical directors are well equipped for some aspects of the role – for example, quantitative analysis and benchmarking – but lack necessary skills in other areas. Many felt underprepared in relation to skills such as business management, finance and human resources (HR). A significant proportion felt they would have benefited from more experience and information on relationship management and communicating effectively, both at organisational level and in difficult circumstances. Medical directors also observed that their inexperience with basic management tools meant they could not perform as efficiently as executive colleagues who used these tools routinely.

In addition, many new medical directors remarked on the lack of support in the role, noting a sense of isolation and uncertainty about where or whom to turn to when they needed advice or guidance. This feeling often persisted, even when they became more senior.

The combined knowledge gap and lack of support resulted in a steeper, much more intense learning curve for new medical directors. Apart from the potentially unhealthy stress levels this caused, better preparation would offer a more effective medical director – and much sooner.
That said, seasoned medical directors report that the biggest challenges lie in leadership and not management; after all, internal experts (e.g., finance and HR) exist for the management skills. Successful leadership requires medical directors to create and develop their own team and shoulder significant, corporate responsibilities. In short, leaders have or share a vision and secure the necessary engagement to achieve it.\(^2\) Among medical directors’ many leadership responsibilities are:

- maximising patient safety and improving quality
- medical performance and disciplinary issues
- discharging the statutory duty as responsible officer\(^3\) in line with GMC guidance\(^4\)
- influencing and negotiating at multiple levels
- medical engagement.

**The response**

The purpose of this guide is to provide you, the newly appointed medical director, with support and guidance now and during your early years in post.

We developed the information, guidance, wisdom and support it contains using the latest published research and in collaboration with current medical directors, both newly appointed and more experienced.

The guide is split into four sections:

- **Skills, tools and knowledge: “where to look”** – a list of knowledge sources, competencies and tools identified as useful to newly appointed medical directors, with potential developmental opportunities to help individuals acquire the competency.

- **Guidance: “what I wish I’d known”** – shared learning, advice and guidance from current medical directors on issues that newly appointed medical directors will find useful early in their appointment.

- **Support: “you are not alone”** – a collection of peer-to-peer and group support opportunities for medical directors.


\(^3\) Many but not all medical directors are also responsible officers.

\(^4\) [www.gmc-uk.org/doctors/revalidation/14416.asp](www.gmc-uk.org/doctors/revalidation/14416.asp)
• **Current hot topics** – a summary of the latest important national topics that new medical directors may be expected to be familiar with.

**Disclaimer**

This guide refers throughout to multiple developmental opportunities, both open source and commercial. This is in no way an indication of requirement or of NHS Improvement’s endorsement. Alternatives may be available that have not been mentioned, and their omission should not be taken as an indication of preference.
Skills, tools and knowledge: ‘where to look’

“\textit{My experience up to the point of becoming a medical director was a useful scaffold, but ultimately I have learnt on the job}”

Dr Shaz Wahid, Medical Director, South Tyneside NHS Foundation Trust

Medical directors are highly skilled; many take up post with an excellent working knowledge of service improvement and resource management as well as being distinguished clinicians.

Good medical directors are naturally guided by their focus on quality of care, ensuring the care patients receive is safe, effective and personal. When appointed, they have to successfully navigate the shift from their accountability for a smaller group of patients to all the patients their organisation serves. This involves leading, empowering and engaging all the clinical staff in the continuous drive for improvement; it is very different to and far more complex than engaging discrete teams. Success depends on good monitoring systems and courage, sensitivity and skill at handling performance if it falls below acceptable standards.

Experienced medical directors report that holding the safety and quality of care of patients as your guiding principle is invaluable and empowering, even in the most difficult circumstances.

To successfully lead in maintaining and improving the quality of care demands sophisticated knowledge of the organisation’s context. That includes knowledge of relevant policies, procedures and processes, including how to safely introduce innovation, governance, risk management, financial forecasting, impact assessment and deployment. Even though these critical functions may not be familiar to you, you should not expect to work alone. Your executive and other colleagues’ expertise and experience will be invaluable if you can secure their involvement.

Many medical directors talk about their lack of experience in leadership, managerial and business tasks when appointed, and feel as a result their impact on patient care,
improvement processes and leadership was limited. This is normal and, in the correct proportions, essential to learning. However, many rightly argue that appropriate development would have significantly increased their impact early on.

FMLM is the UK inter-collegiate professional home for medical leadership and has defined the Leadership and management standards for medical professionals. These should guide your role as medical director and support your ongoing leadership development. We expect that medical directors will also be interested in benchmarking their performance nationally by becoming fellows or senior fellows of FMLM (FFMLM/SFFMLM).

By collaborating with current medical directors and through prior research, NHS Improvement and FMLM identified training and education likely to benefit new medical directors either before or immediately after taking up their post. This includes:

- **personal development** – leadership, emotional intelligence, communication, resilience, negotiating, influencing
- **business and management** – business essentials, strategy, management tools, risk management, governance, HR management
- **finance** – basics of budgeting, planning, interpreting financial documents, financial terms
- **improvement processes** – improvement science and methodologies, cost efficiency, stakeholder analysis.

We selected resources to help medical directors become competent where they consider they have a skills gap (see tables 1 to 4). This list is by no means exhaustive, nor should these be considered the only options.

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5 https://www.fmlm.ac.uk/about-us/what-we-do/professionalising-medical-leadership-and-management/leadership-standards
### Personal development

#### Table 1: Resources for training and education in personal development

<table>
<thead>
<tr>
<th>Theme</th>
<th>Resource link</th>
<th>Type</th>
<th>Institute</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>Leading with effective communication</td>
<td>Online course</td>
<td>Catalyst (edX)</td>
<td>Free/$50*</td>
</tr>
<tr>
<td></td>
<td>Conflict resolution skills</td>
<td>Online course</td>
<td>University of California, Irvine (Coursera)</td>
<td>Free/£31 per month*</td>
</tr>
<tr>
<td></td>
<td>Managing change and dealing with unsolvable problems</td>
<td>Full-day course</td>
<td>NHS Elect</td>
<td>POA</td>
</tr>
<tr>
<td>Influence</td>
<td>Influencing, persuading and negotiating</td>
<td>Half-day course</td>
<td>360 Training</td>
<td>POA</td>
</tr>
<tr>
<td>Personal impact and influence</td>
<td>Long-term programme</td>
<td>King’s Fund</td>
<td>£1,950</td>
<td></td>
</tr>
<tr>
<td>Resilience</td>
<td>Becoming a resilient person</td>
<td>Online course</td>
<td>University of Washington (edX)</td>
<td>Free</td>
</tr>
<tr>
<td></td>
<td>Psychological resilience</td>
<td>Full-day course</td>
<td>NHS Elect</td>
<td>POA</td>
</tr>
<tr>
<td>Emotional intelligence</td>
<td>Emotional intelligence</td>
<td>Online course</td>
<td>Case Western Reserve University (Coursera)</td>
<td>Free/£31 per month*</td>
</tr>
<tr>
<td>Leadership</td>
<td>Key leadership skills</td>
<td>Full-day course</td>
<td>NHS Elect</td>
<td>POA</td>
</tr>
<tr>
<td></td>
<td>Leadership and Management Guidance</td>
<td>Online document</td>
<td>GMC</td>
<td>Free</td>
</tr>
<tr>
<td>Feedback</td>
<td>360° feedback tool</td>
<td>Online tool</td>
<td>FMLM</td>
<td>£72</td>
</tr>
<tr>
<td>Ethics</td>
<td>Applied clinical ethics</td>
<td>Course</td>
<td>Imperial College London</td>
<td>Variable</td>
</tr>
<tr>
<td>Personal development</td>
<td>Coaching and mentoring</td>
<td>Individual</td>
<td>FMLM</td>
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## Business management

### Table 2: Resources for training and education in business management

<table>
<thead>
<tr>
<th>Theme</th>
<th>Resource link</th>
<th>Type</th>
<th>Institute</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategy</td>
<td>Foundations of business strategy</td>
<td>Online course</td>
<td>University of Virginia (Coursera)</td>
<td>Free/ £63 per month*</td>
</tr>
<tr>
<td>Governance</td>
<td>Introduction to NHS governance (England)</td>
<td>Certified online course</td>
<td>Healthcare Financial Management Association (HFMA)</td>
<td>£50+</td>
</tr>
<tr>
<td>Project management</td>
<td>Introduction to project management principles and practices</td>
<td>Online course</td>
<td>UCI extension (Coursera)</td>
<td>Free/ £39 per month*</td>
</tr>
<tr>
<td>Tools</td>
<td>Project management</td>
<td>Full-day course</td>
<td>NHS Elect</td>
<td>POA</td>
</tr>
<tr>
<td></td>
<td><em>The handbook of quality and service improvement tools</em></td>
<td>Online document</td>
<td>NHS Institute for Innovation and Improvement</td>
<td>Free</td>
</tr>
<tr>
<td></td>
<td>Gap analysis</td>
<td>Online document</td>
<td>Agency for Healthcare Research and Quality (US DHHS)</td>
<td>Free</td>
</tr>
</tbody>
</table>

These lists have been generated using feedback from medical directors. We welcome any additional courses, guides or educational resources that readers have experience of and have felt to be of value.

Please send all submissions to mdguide.nhsi@nhs.net.
## Finance

### Table 3: Resources for training and education in finance

<table>
<thead>
<tr>
<th>Theme</th>
<th>Resource link</th>
<th>Type</th>
<th>Institute</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance basics</td>
<td>Introduction to financial accounting</td>
<td>Online course</td>
<td>Wharton Business School (Coursera)</td>
<td>Free/ £63 per month*</td>
</tr>
<tr>
<td>Corporate finance</td>
<td>Introduction to corporate finance</td>
<td>Online course</td>
<td>Wharton Business School (Coursera)</td>
<td>Free/ £63 per month*</td>
</tr>
<tr>
<td>NHS finances</td>
<td>Introduction to NHS budgeting</td>
<td>Certified online course</td>
<td>HFMA</td>
<td>£50+</td>
</tr>
<tr>
<td></td>
<td>Introduction to NHS cost improvement programmes</td>
<td>Certified online course</td>
<td>HFMA</td>
<td>£50+</td>
</tr>
<tr>
<td></td>
<td>Introduction to NHS business cases</td>
<td>Certified online course</td>
<td>HFMA</td>
<td>£50+</td>
</tr>
<tr>
<td></td>
<td>Introduction to how NHS services are paid for</td>
<td>Certified online course</td>
<td>HFMA</td>
<td>£50+</td>
</tr>
</tbody>
</table>

*Coursera and edX courses can be completed free ('audited' in the case of Coursera). Should you wish to receive a certificate for completion, enrolling on the course with associated payment is required.

+These modules can be used towards attaining the HFMA ‘Introductory award in healthcare finance’ certificate.
# Quality improvement

## Table 4: Resources for training and education in quality improvement

<table>
<thead>
<tr>
<th>Theme</th>
<th>Resource link</th>
<th>Type</th>
<th>Institute</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td>Quality improvement made simple</td>
<td>Online document</td>
<td>Health Foundation</td>
<td>Free</td>
</tr>
<tr>
<td></td>
<td>Guide to quality improvement methods</td>
<td>Online document</td>
<td>Healthcare Quality Improvement Partnership (HQIP)</td>
<td>Free</td>
</tr>
<tr>
<td>Methodologies</td>
<td>Institute for Healthcare Improvement (IHI) open school: model for improvement (PDSA)</td>
<td>Online toolkit</td>
<td>IHI</td>
<td>Free</td>
</tr>
<tr>
<td></td>
<td>Experience-based co-design (EBCD)</td>
<td>Online toolkit</td>
<td>King’s Fund</td>
<td>Free</td>
</tr>
<tr>
<td>Tools</td>
<td>The handbook of quality and service improvement tools</td>
<td>Online document</td>
<td>NHS Institute for Innovation and Improvement</td>
<td>Free</td>
</tr>
<tr>
<td></td>
<td>Project stakeholder analysis</td>
<td>Online document</td>
<td>Imperial College London</td>
<td>Free</td>
</tr>
<tr>
<td></td>
<td>Specific tools to support change A valuable repository of resources that support both improvement and project management</td>
<td>Online toolkit</td>
<td>US DHHS</td>
<td>Free</td>
</tr>
</tbody>
</table>
Guidance: ‘what I wish I’d known’

We created this section with help from current medical directors. It contains their thoughts and suggestions: a ‘what I wish I’d known’ guide. All the topics here either will have crossed your mind or are likely to do so soon. They are personal but important decisions that every medical director needs to make for themselves depending on their personality, *modus operandi* and their leadership style.

This guidance and advice are to stimulate personal reflection and tell you about the experiences of those who have already undertaken the journey.

Do I maintain clinical practice?

This question is probably the most commonly asked, and one that faces all new medical directors: do you maintain clinical practice or do you focus solely on your leadership and managerial duties?

> Use the advice of experts around you and be prepared for the workload

Medical director, north of England

There is no right or wrong answer, but you must be absolutely clear that whatever you decide is safe for your patients and safe for you. The decision whether or not you maintain clinical practice has many variables. Ultimately it will depend on a discussion and agreement with the chief executive on what the organisation needs from you and what you are prepared to commit to. It is not necessarily a decision you have to make straight away as long as you have thought through how to maintain safety and quality in your practice. Many medical directors who have given up clinical practice have not done so immediately. As more have faced this question, the cumulative experience has revealed shared insights and trends.
Advantages of maintaining clinical practice

- **Patient perspective**: face-to-face clinical interaction with patients is a powerful way for you to be directly influenced by what patients want. Citing personal patient stories is a powerful tool to use at board level.

- **Ear close to the ground**: a direct link to colleagues on the front line of service allows for unfiltered and first-hand experience of what the issues are.

- **Personal satisfaction**: you may feel that caring for patients directly provides you with a sense of accomplishment and this is conducive to satisfaction at work.

- **Exit strategy**: maintaining clinical practice means that it would be easier for you to return to full-time clinical practice at the end of your medical director tenure, should you wish to.

Advantages of full executive role

- **Full commitment to the role**: the medical director position is highly valued and respected; your position on the board is not a light responsibility. Many medical directors believe that you can truly do the role justice only if you are full-time. No other executive position is part-time.

- **Scheduling**: the medical director’s workload is challenging and dynamic; if by doing clinical work you are constantly cancelling and rebooking appointments or meetings, you will harm the care of your patients, the confidence of your stakeholders and possibly your executive impact.

- **Immersion**: being fully immersed will result in a better working and learning environment and better relationships with your own team and the executive team. These are important sources of support, as we discuss later. Also, no matter how broad your clinical practice, you need to remember that, as a clinician, you are seeing only a portion of the organisation.

- **Visibility**: a medical director must be visible to the whole organisation; clinical work in one department does not offer this in itself. You need time to walk the floor and talk to all staff.
Insights from current medical directors

- **Credibility**: the prevailing reason that medical directors continue clinical practice is to maintain credibility with colleagues. But this should not be the deciding factor. Your credibility as a medical director is determined by your performance as a medical director: ‘a good doctor does not necessarily a good medical director make’. The danger of a split post is that your performance in both will be affected as you will never truly be immersed in either.

- **Organisation size**: in a small organisation (one site, <100 consultants) it may be possible to maintain clinical practice and develop meaningful relationships with all the staff and stakeholders. In larger organisations, especially over multiple sites, this will be extremely difficult if not impossible.

- **Patients first, always**: if you operate in a split role you must always put your patients first, which means that you must establish well-planned contingency arrangements. Even so, there may be occasions when you have to leave or cancel meetings, or defer decisions for clinical emergencies. Ensure that your chief executive, your executive colleagues and the stakeholders you engage with are aware of this requirement.

“I don’t really agree that keeping a clinical practice is vital to maintaining credibility with colleagues. There is a risk this sort of message reinforces the view of some doctors that management and leadership roles are not bona fide career posts because there is no direct patient contact. Many doctors work in positions in which they have limited or no direct contact with individual patients – for example, those in public health, pathology and pharmaceuticals – yet we still consider them credible.”

Professor Stephen Powis, Medical Director, Royal Free London NHS Foundation Trust

Dr Paul Harrison has been a medical director at the Dudley Group NHS Foundation Trust for 11 years, and has only recently stepped down from his clinical duties after taking up the role of acting chief executive. Asked about his experience he said:

“I am fortunate that I work in a moderately sized trust and in a specialty (haematology) that gives me the flexibility to carry on some clinical activity while performing my role as medical director. I also have a very supportive team of consultant colleagues, which has allowed my clinical work to be carried out flexibly to fit in with my medical director commitments. The clinical role allowed me to be on the shopfloor and meant that the board-to-ward link was always maintained, something that was important to me. The problem is that the medical director role has evolved so much over the years that now the time commitment and responsibilities make it very hard to maintain clinical practice. To summarise, I think the ability to have a dual role as medical director and a practising clinician depends a lot your specialty and its revalidation requirements, your organisation’s size and the support that you have available from clinical colleagues and in your role as medical director.”
The need to be corporate is the biggest difference medical directors cite when comparing their role to previous clinical leadership experiences. Being corporate is not just about attending board meetings; it is about taking responsibility for others’ actions, making difficult decisions and working within the constraints of the system around you to deliver the best results you can.

Culture

An organisation’s culture is a set of shared values, beliefs and assumptions through which staff operate daily; in short, it is how your organisation does things. It is vital that you understand your organisation’s culture and actively shape it, not least by being visible, approachable and regularly walking the floor and talking to staff. Although the culture reflects how the organisation, and therefore its staff, deal with day-to-day work, it is particularly apparent when dealing with incidents and their aftermath: do the staff react in an open, transparent and learning manner, or are they defensive and blame-oriented? The duty of candour requires all staff to be honest, open and transparent. However, it is up to the board and you as the medical director to ensure the organisation supports and nurtures such a culture through appropriate leadership and clinical governance. Finally it is important to note that good leadership operates through a positive culture. Your organisation will employ thousands of staff making many thousands of decisions daily. Despite your accountability, you can have no direct part in most of those decisions, but creating the right culture is a strong force in ensuring that staff make the right decisions.
Clinical governance

You and your organisation are accountable for enabling clinical excellence to flourish by ensuring the quality of services constantly improves and high standards are safeguarded. Clinical governance can encompass an array of issues from mandatory data collection, risk management, information governance and serious incident reporting to declaring conflicts of interest.

Serious incidents and how they are handled give an insight into how effectively your organisation’s clinical governance and culture operate. You need to make sure staff can raise concerns in a safe and constructive manner; that investigating concerns is systematic and transparent and good records are kept. Effective organisations learn from incidents and concerns, and have systems to share that learning with the rest of the organisation. An open, no-blame organisation breeds transparency and honesty in staff. This may lead to more reporting of incidents, which in turn leads to improved safety and quality, increased learning, greater staff satisfaction and faster improvement that enhances quality of care for all patients.

Corporate responsibility

As a board member, you represent the organisation and therefore have a responsibility to the groups or individuals it affects – your patients and staff above all but also the local population. You are highly visible and are required to act at all times in a manner consistent not only with the values of your organisation but with the Nolan principles of public life.6

Resource management

As an executive, you will have access to many resources, with HR being the most important. Agree early with your fellow executives and directors how you can cross directorate lines to make use of their personnel. Often the issues and problems you have to deal with will involve areas where you and your immediate team will have no expertise, and you will need to negotiate to get the right people into the room whether they are in your team or not. Ask your director colleagues: “How do I approach your people when I need them?” It is far better to clarify operational issues early rather than risk stepping on toes down the line.

Parity

As the medical director, you bear the mantle of leadership for all specialties and they will in turn seek guidance and direction from you. Any biases which may have developed over the course of your clinical years must be put to one side. The consultant body will scrutinise your every decision for evidence of favouritism. You must strive to be fair, objective, logical, evidence-based and consistent in your approach, and you must have the courage to draw the line when you need to. No matter how hard you try to be all of these things, you cannot please everyone all the time.

Hitting the ground running

During your first few days and weeks you may be forgiven for trying to ease into the role, or you may not be. Remember that the systems around you are still operating as normal and will probably not make any concessions. Below, you will find tips that previous medical directors suggested would help the early embedding process.

What are you accountable for?

One of your earliest tasks on taking up your post will be to identify exactly what your responsibilities are (your job description), what you are accountable for (your portfolio) and get an idea of how these are performing. There will inevitably be ‘hidden’ issues and concerns that you were not privy to in your previous role. Set up a meeting with the chief executive and/or other executive colleagues early and have an open debate about the current issues that need addressing. Understand the history behind them but also what was done to resolve them. At the end of the meeting you may wish to agree some high-level objectives. Then get beneath the numbers: it is difficult but rewarding, as it will give you a mechanistic understanding of your task and your responsibilities. Find the right people to talk to: the process owners and the agents of change – only then can you start making a difference. The chief executive should hold regular meetings with you. These are critical to success as they provide an opportunity not only for progress reports but two-way feedback and updates that could affect the work.
Are there any legacy issues?

Make it a priority to identify the longstanding and outstanding issues yet to be dealt with; they are likely to be overwhelmingly HR and disciplinary problems. You have inherited the problem, and even though you were not the cause, it is now your responsibility to deal with it. Move to a position of owning it and fixing it. This will not only show leadership but send an important early signal that you are not afraid to tackle challenging issues. All eyes will be on you as you start, and if there are issues your predecessor should have tackled and did not, you will be judged on what you do about them.

Walk the floor

“Get out and get to know people so you can understand their problem and have the power to do something about it.”

Dr Tina Kenney, Medical Director, Buckinghamshire Healthcare NHS Trust

This will be a significant challenge given all your priorities. Yet it is crucial and will always be time well spent. The more that staff see and interact with you, the more they will trust you, open up and talk about the real issues affecting them. Walking the floor allows you to link with services you may not have had much exposure to, giving you the organisation-level overview critical to making an impact. Importantly, do not produce any report on an area or department you have not visited. You will not know all the details without talking to the staff or visiting the service, and a report written in absentia will alienate the staff and be of limited worth to the organisation. The Care Quality Commission (CQC) specifically asks staff about the executive’s visibility during its inspections; it is wise to set a precedent from the start and be creative: for example, en route to a meeting, leave early and call in somewhere; get your executive colleagues to do the same.

Walking the floor with executive colleagues can send an important message of unity as well as increasing their exposure in areas where they may feel less comfortable than you. Many successful organisations have formal, executive-level, weekly ‘walks’ to enhance their understanding and use their executive influence to overcome barriers that staff experience in their day-to-day work or as part of improvement processes. Do not underestimate your influence on staff if you are seen to be personally involved in overcoming problems they experience.
Communicate

Identify the media available for you to communicate with staff and patients, and use them as best you can; the more visible you are to your staff and patients, the more familiar you will seem to them. All organisations will have some form of periodic communication with their staff in the form of a newsletter or bulletin; is there scope for you to add a regular section? Social media are a powerful way to engage patients and staff. But be aware that they are in the public domain and completely open. Twitter is potent, especially for younger generations, and allows rapid two-way communication. Blogs and video-blogs can be effective, especially if they are regular and provide content of interest to patients and staff, such as successful quality improvement projects, prizes, awards and new initiatives. Remember that anything published may be picked up by local media too.

Workload and being prepared to say no

Be aware of your workload: it will inevitably grow rapidly. As you settle in and hopefully become successful, more people seek your help. Be honest about your capabilities and limitations: say no when you need to. It is far better to prevent an expectation than deliver something late or below standard. Inevitably you will be unable to say no to many, perhaps most, requests, and you will need a competent, reliable team around you to cope with all the demands. Be selective about what only you can do and bring in others when you are not essential.

Delegation

Not all matters require the medical director’s personal touch; tasks can be delegated to deputies or even to clinical or divisional directors. If you trust that their personal and professional qualities align with your own and with the organisation, delegating responsibility and decisions to them should logically follow. Not only does this give you more time, it fosters a team environment, engaging others in decision-making who would perhaps not have had the chance. But remember that your team members and deputies will only feel confident making decisions on your behalf if you are consistent in your approach. Much like the registrar picking up the

“The single biggest problem in communication is the illusion that it has taken place.”

George Bernard Shaw
practice of their consultants, your deputies will learn how you deal with situations and emulate you.

**Note keeping**

Always keep notes of your meetings and discussions: you never know when you will have to refer to them, and you will be astounded at the amount you would otherwise forget. This is crucial when tackling disciplinary issues or issues which may have legal consequences.

**The next generation**

Take notice of upcoming medical leaders in your organisation and try to nurture their development. Involve them in decision-making and give them opportunities to lead. You will not always be the medical director; succession planning benefits not just the organisation but you personally. Equally you will want to rely on a pipeline of good clinical directors, associates and deputies. It is your responsibility to support the growth and development of that pipeline. The junior doctors in your organisation have a wealth of talent and experience – it is wise and valuable to engage with them directly and through your director of education.

**Building and working with your team**

A supportive, trusted and efficient team is vital to your performance as a medical director, making your role manageable and allowing you to concentrate on what only you can do. It is important to attract colleagues with complementary skills to lead areas within your portfolio, such as education. The larger the organisation, the larger and more diverse this team will need to be.

**Identifying resources and requirements**

It is important to be clear about your priorities for roles in your team as staffing is a challenge in most organisations. If you think you require additional staffing you will have to follow a process that will include a business case and discussion with your chief executive. In some organisations it may not be appropriate for the medical director’s team to have all the roles mentioned below.
**Associates or deputy**

These are important positions and are likely to be among your closest confidants, so take time and care in appointing them. You will need to be able to work effectively with them, and their values must align not only with your own but your organisation’s. Trust is critical, and you will need to be prepared to support them in public even if you disagree with them in private.

**Personal assistant/secretary**

A good secretary or personal assistant (PA) is essential. They need to be able to filter and prioritise the information that comes to you. Diary management will be a major and ongoing challenge, and they must strike the right balance between your need to be accessible yet free enough to actually do the job. You must be involved in the appointment process to ensure the right ‘fit’ and that they have the appropriate skills to manage your office. It is likely you will inherit a PA, in which case make it a priority to spend time to understand each other, explain your preferences and define your *modus operandi*. Part of that will be to agree on how you prioritise – an excellent question to guide you and your PA should be: “what difference will it make if the medical director attends?”

A good, well-established PA will have a huge amount of knowledge of the organisation, which you would be wise to value and access.

**Business/general manager**

Having a good manager as part of your team is invaluable. If you have one, consider yourself fortunate; if not, speak to your chief executive and board and try to get one appointed. A manager is invaluable in facilitating your team’s day-to-day activities and ensuring that projects and strategies you are leading are managed well, communicated, implemented and finished on time. They are your project manager and will often forge valuable links to other corporate teams such as finance and HR. A good working relationship with your manager will allow mutual challenge and high levels of trust (and ability), enabling you to delegate significant amounts of work.

So you have chosen your team and they are a powerhouse of skill, talent and enthusiasm. A team without leadership, however, will not be effective, regardless of potential. Trust your team members, use their strengths and support them in
overcoming their weaknesses. Remember that most will have a career path, whether in medical leadership or management – it is important that you help them develop so they can progress. Good leaders appoint people better than them, if they can.

**HR processes**

Many medical directors say they were unaware that HR issues would take up so significant a part of their time. This includes senior medical appointments, disciplinary issues, performance issues and other difficult situations. One medical director drew a chart when asked what they wished they had known before starting.

*Figure 1: How medical directors spend their time*

Gaining a working understanding of HR processes and regulations was identified as a critical part of the job. Many medical directors said this would have resulted in an easier transition and more effective start to their tenure.

Building and maintaining a close working relationship with the HR director is as essential as surgeons working with anaesthetists, and should be a high priority for any new medical director. They are the experts, and seeking their advice or direct support is wise in all but the most minor issue if you do not want to spend large amounts of time in employment tribunals or court.

Disciplinary issues, concerns and complaints go hand-in-hand with HR and are often the most difficult things you have to deal with. Although each case will be unique, the approach you and your organisation take should be standardised and within the current legal and professional frameworks. The [NHS National Clinical](https://www.england.nhs.uk)
Assessment Service (NCAS)\textsuperscript{7} helps resolve concerns about doctors’ professional practice and is a good starting point when concerns arise.

You must also fully understand *Managing high professional standards in the modern NHS (MHPS)*.\textsuperscript{8} This outlines the legal framework for how to handle concerns about doctors and how these are escalated in cases of disciplinary or dismissal proceedings. It is absolutely critical that you adhere strictly to the processes in MHPS as failure to do so will invariably result in cases being brought against you – cases you will be likely to lose if due process was not followed. See Table 5 for more resources identified as valuable by other medical directors.

\begin{quote}
The key with disciplinary proceedings and challenging doctors is to know that I can call HR and when to call HR.
\end{quote}

Medical director, south of England

\begin{table}[h]
\centering
\begin{tabular}{|l|l|l|l|}
\hline
Resource & Type & Institution (hyperlink) & Cost \\
\hline
Understanding and using MHPS effectively workshop & Course & NHS National Clinical Assessment Service & Variable \\
\hline
NCAS case manager training workshop & Course & NHS National Clinical Assessment Service & £3,300 \\
\hline
Managing doctors in difficulty and difficult doctors & Conference & Healthcare Conferences UK & £438 \\
\hline
Mastering professional interactions & Full-day course & Medical Protection Society & Free (members)/ £150 \\
\hline
\end{tabular}
\caption{Resources for understanding HR processes}
\end{table}

\textsuperscript{7} \url{http://www.ncas.nhs.uk/}
\textsuperscript{8} \url{http://webarchive.nationalarchives.gov.uk/20130124065523/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4103344.pdf}
Challenging colleagues

“Being a medical director is a contact sport. You can’t be a medical director by text or email. You must be out there creating relationships, engaging with and motivating people. Of course, sometimes you also have to challenge – this is when the role can become harder and the time spent in engagement can pay off.”

Dr Paul Harrison, Medical Director, The Dudley Group NHS Foundation Trust

The medical director has the responsibility of working with medical colleagues during times of co-operation and times of challenge and difficulty. The former is rewarding; dealing with the latter is an aspect of the role for which most medical directors feel unprepared.

You must always remember that each case is unique and needs treating with the diligence, confidentiality and attention it deserves. Issues are usually complex and, in addition to following due process, require significant judgement on your part – so be prepared for some sleepless nights. Nevertheless, some important universal insights have been gained from medical directors with experience of these issues.

Everyone is accountable

Do not blame or punish an individual for a system failure. Instead encourage a no-blame culture based on learning from mistakes. This not only improves morale and engagement among those affected but results in all staff feeling able to discuss issues that may put patients at risk. An open culture of reporting may initially increase serious incident reporting as the hidden problems previously ignored become visible. Although this will seem daunting, you must persevere; the short-term negative impacts will pale in comparison to the long-term benefit for patients and staff from the shared improvement and learning experiences.

Hold up the mirror

Presenting professionals, especially clinicians, with evidence and data will result in self-reflection and ownership of the situation, even if the initial response is ‘we are special’.
Remove emotion from logic

Always base your argument in fact, but still see the person behind the issue. The source of the problem may be emotional rather than logical.

Evidence

With disciplinary issues, ensure you have collected all the evidence and pay attention to the detail. There will be people in the organisation skilled at conducting investigations. Always ask yourself whether patient safety is an issue and act on your conclusion proportionately and with the appropriate haste. Ensure all staff are treated fairly and the process is transparent. Preferential treatment for any reason will cost you your colleagues’ respect.

Fairness

Always try to make sure you are fair and transparent. It will take a while for people to decide about you, and because events that define your tenure will come up infrequently and often unannounced, it is important to always maintain fairness and equality. During any incident, doctors will watch to see if you side with them – so will managers and other staff. Many doctors see the medical director as their representative – you are not – but equally, you will not survive long if you do not have their confidence.

Communicating in difficult circumstances

Generally, face-to-face meetings or discussions are best, regardless of the occasion, followed by telephone conferencing and finally, written word. With difficult conversations, this is especially true: all your challenging conversations should be done face-to-face. In these situations, only use telephone or video conferencing in extreme circumstances, and never email. Always keep a contemporaneous record of the discussion.

Handling resistance

There are as many ways of dealing with resistance as there are communications experts to teach you about them. The basis, however, is essentially the same: empathise, explore and summarise the issues, respond to concerns but assert your position and finally invite feedback. It is also useful to have identified your boundaries beforehand: what is your desired outcome (intent), at what point do you
compromise, and finally what your walk-away point is – set it and be prepared to follow it through.

The issues encompassed by the term ‘challenging colleagues’ are many and varied. They include incidents, complaints or concerns but also drugs, alcohol, bullying, sexual harassment and even violence. Many medical directors think these cases may occur once or twice a year; the reality is they may be much more common. Your relationship and professional front with the HR director will be instrumental in dealing with these issues in a manner that is efficient, effective and above all maintains the confidentiality and trust of those involved.

**Dealing with the media**

One of the less obvious aspects of being a medical director is that it is usually the first time you will deal directly with the media. A notepad, microphone or even a camera can be thrust in front of you at short notice or without you even knowing. The media are usually keener to talk to the clinician than the manager, so you may bear the brunt of all media activities. It is therefore vitally important that you rapidly develop an effective relationship with your communications team and learn from it about press deadlines and how journalists operate. If you have not had media training, enrol as early as possible.

Every trust has its own strategy and approach to communications. The communications team is responsible for co-ordinating the trust’s news internally and externally, from newsletters and events to local news stories and social media.

**Media interview terms**

- **On the record** – everything you say can be quoted and attributed to you. The recommendation here is that you only do this with a member of your communications team present and that full transcripts are always kept.
- **Non-attributable** – everything you say can be used but attributed to non-trust sources – for example, ’sources close to the issue’ or ’people familiar with the situation’.
- **Off the record** – an agreement that nothing can be used in print. The information may be used to guide articles in a specific direction.
- **Background** – an agreement that the information given cannot be used for any purpose.
Communications teams manage relationships with the media and will advise about who the local journalists are and how you can engage with them. It is especially wise to build a rapport with the local press. Although not widely acknowledged, it can sometimes be enormously helpful in difficult circumstances if you have built trust. It is, however, always a relationship to be wary of, and remember there really is no such thing as an off-the-record remark to a journalist.

"If you don’t give them positive stories, they will eventually print negative ones"

Mr Peter Lees, Chief Executive and Medical Director, FMLM

Your communications team should be your first point of contact if you spot an emerging issue. The sooner you speak to the team, the sooner it can help you mitigate any risks or help manage how you communicate about particular issues.

Remember, the public will see you as the voice of the trust; you are representing yourself, your colleagues, your organisation and your patients. Not taking the time to understand how communications works at your trust can land you in deep water.

By setting up a good working relationship with your communications team, you will be able to better understand how your work can tie in with the organisation’s messaging and spot opportunities to promote positive stories.

"There is nothing like ‘off-the-record’ remarks for a medical director. You say something in confidence and someone will tell it to someone else. Be careful"

*The medical director transition guide, FMLM*
Wisdom and everything else

- Develop a relationship with your governors and non-executives, find out their influencing factors.
- Don’t underestimate the value of a well-resourced deputy.
- Don’t expect or try to be liked.
- Sometimes you will feel alone and isolated, so find a support network that suits you.
- If you’re going to enjoy being a medical director, you need to commit to it.
- Sometimes you will get things wrong; say sorry when you do.
- You can’t fix everything; don’t try to.
- You will upset people.
- Talk to the other medical directors around you; they are in the same position as you.

FMLM: Medical director transition guide 2013

- The relationship with your director of nursing is critical; your agendas are frequently shared or overlap and you often cross-cover.
- It should be about strategy, but you find it’s often about internal management.
- You have to have an open, honest dialogue with people.
- Don’t try to do everything; you will fail.

Hunter Healthcare: What makes a top medical director?

- Sometimes you will feel alone and isolated, so find a support network that suits you.
Support: ‘you are not alone’

Starting any new role is a daunting prospect, but the transition to the medical director’s role is particularly challenging as it is usually unlike anything you will have done before. Medical directors often experience feelings of isolation and lack of support during their early years, and in some ways this is inevitable and right; your role demands some professional distance from your consultant colleagues. Support networks are available, but often not where you are used to finding them. Often they are not – and cannot be – within your own organisation.

Fellow medical directors locally or more distant can be invaluable, of course, in helping you think through complex problems. But it is also reassuring to discover you are not the first to feel the role’s stresses and strains. The wise medical director seeks out strong support networks early on. NHS Improvement and FMLM can help with this, as well as offer access to coaches and mentors. Medical leadership conferences (NHS England, NHS Improvement and FMLM) are also a good opportunity to meet like-minded colleagues grappling with familiar issues.

Seeking and utilising support is not a sign of weakness nor of failure. Rather, by not recognising the support structures available to you and the guidance others can provide, you are setting yourself up for difficulties, if not failure.

Resilience

“The process of effectively negotiating, adapting to, or managing significant sources of stress … [and the] capacity for adaptation or ‘bouncing back’ in the face of adversity”


Personal resilience is essential. Your role is complex and challenging, which will inevitably result in personal and professional stress. The sources of these stresses can come from anywhere. These can include but are not limited to:

- **self**: isolation, workload, time pressures, working within constraints, difficult decisions
• **team**: accountability, criticism from colleagues/patients, spending less time with family

• **environment**: media, politicians.

Your ability to deal with these stresses is based on multiple factors. Some of these, such as previous life experiences, cannot be changed; but others such as your environment and support structures can be, and it is in your interest to ensure they are set up to best support you in your role.

"Practically, resilience means having the right team around you, having robust organisation policies and governance structures and having the relationships in place so that you feel confident dealing with anything that comes your way."

Professor Stephen Powis, Medical Director, Royal Free London NHS Foundation Trust

Multiple tools provide measures of personal resilience. The [Brief Resilience Scale](https://ogg.osu.edu/media/documents/mbstream/brief resilience scale.pdf) (Smith et al 2008) is a useful rapid tool to assess your ability to deal with and bounce back from stress. High scores indicate robust resilience; low scores indicate the need for more personal development.

Regardless of your rating, resilience will improve with experience, but some suggested methods that may help in developing or accelerating personal resilience include:

• **self**: directed learning, reflection, prioritisation, mentoring/coaching, family time

• **team**: effective and supportive team, delegation, support networks, critical friend

• **environment**: shared learning, no-blame culture.

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9 [https://ogg.osu.edu/media/documents/mbstream/brief resilience scale.pdf](https://ogg.osu.edu/media/documents/mbstream/brief resilience scale.pdf)
Coaching

The goal of coaching is the goal of good management; to make the most of an organisation’s valuable resources


Coaching is a developmental process where a trained individual supports you to achieve precise personal or professional goals – it is a relationship of equals. In its purest sense, coaching helps you to make the right decision but it is not about giving advice. Coaches provide a safe space for you to open up and discuss your concerns, your challenges and your feelings, all in strict confidence. First, you need to want to change or improve. You set the agenda and need to give your coach permission to challenge and support you to make your own decision and achieve your goals. Coaching differs from mentoring: in the latter you are effectively seeking the counsel of someone who has ‘been there before’ – sometimes termed ‘older and wiser’. Mentors can give advice, but again the wise will employ coaching techniques to help you to make your own decisions.

“Coaching was really important for me. It took me from a place where I was not prepared to be a medical director, to being a medical director; having a coach gives you the wisdom to use the tools you have been given.”

Dr Ruth Charlton, Joint Medical Director, Epsom and St Helier University Hospitals NHS Trust

Many medical directors found coaching to be a valuable way of guiding their development, whether by identifying skill gaps or through difficult discussions about personality traits, communication methods or dealing with difficult situations. Many remarked that their coaching sessions became exceptionally useful in helping them adopt a non-defensive stance towards critical comments.

Choosing the correct coach is important, and the chemistry will not automatically work: if that is the case, you have to be honest and move on. Good coaches recognise this and will contract with you at the beginning and make this point clear. They may also suggest a natural break after a set number of sessions; staying with the same coach for a long period can fall into the trap of over-familiarity, where challenge can become less objective. Professional coaches undergo accredited training and continuing ‘supervision’. It is usually wise to choose someone who has
done this and is keeping their skills up to scratch. Coaching registers are relatively common, and the NHS Leadership Academy and FMLM provide examples.

**Mentors**

Mentoring is a dynamic, supportive relationship between two individuals that exists to develop the mentee, either in their current role or for the future. Mentoring differs from coaching in that it takes a holistic view of the mentee, is an ongoing relationship and the mentee usually sets the agenda, with the mentor providing support and guidance.

Medical directors who had had mentors often stated it was incredibly beneficial. Knowing that they have, and are able to use a safe space to articulate problems, vent frustrations and receive advice from a critical friend was hugely reassuring and valuable.

NHS England offers an excellent introductory document for mentees and mentors. *A guide to mentoring* (available on the NHS Improvement hub)\(^{10}\) explains the background, benefits, roles, responsibilities and expectations of both mentors and mentees.

We recommend you review this document before choosing your mentor as it identifies qualities you should look out for, what you should expect from the relationship and how you can formalise this in the form of a mentor-mentee compact. This is not a legal document but an agreement describing each party’s expectations and importantly the terms of the relationship. How often do you meet? Do you make a summary of the meeting? If so, who does it? Is everything confidential? What about contact out of hours?

\(^{10}\) [https://improvement.nhs.uk/resources/guide-to-mentoring/](https://improvement.nhs.uk/resources/guide-to-mentoring/)
National Medical Director Mentoring Scheme

Finding a mentor can be difficult, especially if you are unfamiliar with your local area or region. NHS Improvement recognises this and has developed a mentoring scheme for medical directors by medical directors.

The aim of the Medical Director Mentoring Scheme (MDMS) is to connect would-be mentees with suitable mentors. All mentors on the scheme have been identified by their peers as ideally suited for the role through a combination of experience, personal qualities and knowledge.

For more information, please contact us at mdguide.nhsi@nhs.net.

Informal support networks

“During difficult times, I will call other local medical directors to talk, and consequently I receive calls from them when they have issues. Having that support has been the difference between a bad situation and a terrible one.”

Medical director in the Midlands

Many medical directors use informal networks between each other for support as often the pressures that one faces are likely to be shared by their counterparts. These local networks are based on mutual respect, confidentiality and an understanding that the role is often difficult and support is hard to find.

Through collaborations and meetings, you will frequently meet local counterparts and often develop professional and personal relationships with them. This informal network should be nurtured as a source of support. Do not be afraid: it is more than likely the other medical directors are in the same position as you and would appreciate an offer of support and be prepared to reciprocate it. Often knowing you can pick up the phone and call someone for advice is itself a powerful source of comfort.
Your executive colleagues

Often cited as a source of support by senior medical directors, your executive colleagues will, more than anyone, be familiar and sympathetic to your cause. They are a collection of professionals from differing backgrounds who should work to the same vision as you through a shared strategy. It is important to note that many of the challenges you will face are complex, characterised by the fact they have no simple solution and, by definition, cannot be solved by one person. Your executive colleagues’ experience will offer the best chance of reaching the right solution and one which you may not have considered. Many medical directors remarked that the relationships they developed with their executive colleagues were some of the strongest, most rewarding and supportive they have ever had. The resulting unity of the executive team not only helped them cope with the job but allowed them to overcome the personal and organisational challenges they faced during their most difficult times.

“I have always worked hand-in-hand with my various medical director colleagues. We will often cross-cover each other on appropriate issues, meet regularly, provide a good sounding board for each other, decide priorities and support each other. We may not always necessarily agree, but we work to presenting a measured and united clinical front at the board and subcommittees for the benefit of patients and staff.”

Professor Hilary Chapman, Chief Nurse, Sheffield Teaching Hospitals NHS Foundation Trust
Conclusion

The medical director’s role is highly dynamic, requires a great breadth of skills and can be testing and challenging; however, it is also one of the most important roles you are likely to undertake in your career. Your influence with colleagues and impact on patients, staff and the local population should not be underestimated.

A successful medical director demonstrates leadership, inspires colleagues, governs fairly, networks effectively and continuously develops their skills, all in the pursuit of, and with the aim of, delivering high quality and safe care for their patients. You will be tested. You will at times feel out of your comfort zone, and you will occasionally stumble. However, you will have realised by now that this is not unusual and you do have support from local, regional and national sources.

The NHS needs effective and transformational clinical leaders. NHS Improvement and FMLM are committed to supporting new and current medical directors to become those clinical leaders and to feel prepared to address the challenges of a modern national health service. We hope this guide has been a useful resource and has given you the tools and support you need to overcome any challenges preventing the delivery of high quality care for all, now and in the future.

Feedback

This document is intended to be a dynamic guide to the medical director’s role, so we would appreciate your feedback on ways to improve it.

Feedback allows us to maintain the guide as an up-to-date resource and ensure it is directly influenced by the people it is designed for – you, the medical director.

If you have any comments please email us: mdguide.nhsi@nhs.net.
Current national items of interest

This section summarises topics currently of national importance. It was written by members of the teams working on each initiative, and includes links to further reading.

Seven day services

The NHS and its staff offer 24/7 care to patients across the UK. While that care is always accessible, there is large variation between the availability and quality of services nationally. The aim of the seven day services (7DS) programme is to address these variations in access and quality of care.

The 7DS programme consists of two major streams, primary care and in-hospital care. Given your role as a medical director, this summary focuses on seven day hospital services (7DHS).

Most trusts already deliver services in life-threatening emergencies 24 hours a day, seven days a week. Our commitment is that all patients who require urgent or emergency care in hospital will receive the same quality of assessment, diagnosis, treatment and review on any day of the week. This is underpinned by 10 clinical standards, of which four are prioritised due to their impact on outcomes for patients:

- every patient is seen by a consultant within 14 hours of admission to hospital
- patients should have seven-day access to urgent and emergency diagnostic tests
- patients should have seven-day access to consultant-directed interventions
- those who need to can expect to see a consultant every day to ensure their care is progressing.

We have seen benefits for trusts leading the way on 7DHS. Among them are:

- reduced bed occupancy
• improved patient flow
• greater efficiency
• reduced pressure on staff on a Monday
• more opportunities for staff development and new job roles
• higher quality care and experience for patients
• more effective delayed transfers of care processes.

Delivering the four clinical priorities seven days a week brings strong clinical and performance benefits. Although some resource allocation is needed, the benefits greatly outweigh any additional spend.

Reducing the variation that patients experience over the weekend does not simply affect Saturdays and Sundays. We also have a chance to look afresh at how services are delivered during the week, optimising and improving systems and processes in a way that benefits patients and provides new opportunities for staff. Our aim is that all trusts will meet the commitment to 7DHS by early 2020.

For more information on the 10 clinical standards and other helpful resources please visit https://improvement.nhs.uk/resources/seven-day-services/

Seven Day Services Team
June 2017
Model Hospital and unwarranted variation (Carter report)

As well as helping providers improve the quality of care, NHS Improvement’s operational productivity directorate helps ensure trusts are deploying staff productively, managing the NHS estate efficiently and getting the best deals on supplies. Lord Carter’s review of NHS productivity in acute trusts found that reducing unwarranted variation in every area of the hospital could save the NHS at least £5 billion in efficiencies by 2020/21. Our operational productivity programme is now supporting all trusts to implement Lord Carter’s 87 recommendations to reduce variation, make savings and efficiencies and improve services.

Under the leadership of the National Director of Clinical Productivity, Professor Tim Evans, we are working closely with medical directors to improve how their medical staff are deployed. By ensuring the right people are in the right place at the right time through effective job-rostering and leave-planning, the aim is to improve clinical efficiency and productivity to constrain pay bill expenditure, and work with the GIRFT (Getting It Right First Time) programme to improve patient outcomes. Trusts that have implemented e-rostering have shown a reduction of 10% to 20% on medical locum spending as well as a reduction of 75% in consultants’ rota-planning.

As of April 2017, we have collected data from the 136 acute non-specialist trusts on their consultants’ up-to-date annual job plans, which clearly set out the sessions allocated to clinical procedures, patient-facing time and quality improvement. This data is to help medical directors identify

Model Hospital

Model Hospital is a digital information service designed to help acute trusts identify opportunities to improve their productivity and efficiency. They can see how they are performing individually as well as how they compare nationally and to smaller peer groups. Anyone working in a provider can access the Model Hospital by logging in or registering at https://model.nhs.uk

Designed to be easy to navigate, anyone in the NHS from board to ward can use it to view hospital activity data from five perspectives:

- board-level oversight
- clinical service lines
- operational
- people
- patient services.
opportunities to improve how their doctors are deployed. This annual data is uploaded onto the Model Hospital, alongside other metrics that help identify where productivity improvements can be made, such as being able to ascertain whether the number of DCC (direct clinical care) per FTE (full-time equivalent) is adequate for the activity demands faced by the trust.

NHS Improvement’s clinical workforce teams working in partnership with the trusts will take part in a ‘deep dive’ improvement programme. The programme is engineered to explore the benefits of effective job planning and electronic rostering on the quality of care delivered and clinical productivity. The goal is to demonstrate that trusts can benefit from systems that highlight the efficient and effective use of their clinical workforce.

Operational Productivity Communications
May 2017
Getting It Right First Time

Getting It Right First Time (GIRFT) is a national programme designed to improve medical care in the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

Importantly, GIRFT is led by frontline clinicians who are expert in the areas they are reviewing. This means the data underpinning the GIRFT methodology is being reviewed by people who understand those disciplines and manage those services daily. The GIRFT team visits every trust with the specialties it is reviewing, investigating the data with peers and discussing the individual challenges they face.

After all the reviews have been completed, the clinical leads oversee the creation of a national GIRFT report into their specialty. The report presents the original data, GIRFT’s findings, examples of best practice and an action plan of proposed changes and improvements. Crucially this action plan provides detailed evidence of the benefits changes can bring and is supported by an implementation programme managed by GIRFT.

GIRFT began as a pilot in orthopaedic surgery led by Professor Tim Briggs and hosted by the NHS Royal National Orthopaedic Hospital NHS Trust (RNOH). Following the pilot’s success, the GIRFT methodology was rolled out to more than 30 medical specialties, and the programme is now a partnership between the RNOH and NHS Improvement’s operational productivity directorate.

Professor Briggs’ original report, which coined the term ‘getting it right first time’, was published in March 2015. It included a raft of recommendations, many adopted by orthopaedic trusts, and has delivered real benefits:

- adopting cemented hip replacements for patients aged over 65 led to a 10% increase in the use of this method, saving an estimated £4.4 million a year
- reduced length of stay for hip and knee operations freed 50,000 beds annually

• trusts moved to more ring-fenced orthopaedic beds, reducing cross-infection

• localised consolidated working between trusts increased, sharing resources and maximising the number of procedures carried out

• 75% of trusts renegotiated the costs of implant stock and rationalised their use

• greater awareness of costs led to reduced use of expensive ‘loan kit’

• litigation claims fell from 1,758 in 2013/14 to 1,505 in 2015/16

• a GIRFT ‘pricing letter’, providing transparency in the prices orthopaedic trusts pay for prostheses, is now used by consultants selecting implants

• in 2016 the British Orthopaedic Association used GIRFT principles in published guidance to ensure best practice among its members.

For more information visit www.gettingitrightfirsttime.co.uk and follow GIRFT on Twitter and LinkedIn.  

GIRFT Communications Team  
March 2017
NICE quality standards and support

Senior clinicians will know that the role of the National Institute for Health and Care Excellence (NICE) is to improve health and social care through evidence-based guidance, and most will know about the guidance produced by NICE. Medical directors are expected to ensure their organisations have systems to support the dissemination and uptake of new guidance. NICE also offers support in implementation, financial planning and audit and quality improvement. Every piece of guidance is accompanied by tools and resources to support implementation, including tools for baseline assessment, clinical audit and resource impact.

NICE quality standards set out priority areas for quality improvement in health and social care. These are accompanied by quality standard service improvement templates for providers and clinicians to measure progress against nationally derived standards. NICE guidance and standards represent best practice, and adherence to them is used by regulators to benchmark services. CQC uses NICE products to inform the questions that inspectors ask of providers. As such, being able to demonstrate adherence by using the NICE implementation resources will benefit providers and clinicians during inspection.

At a regional and local level, NICE has a field team of implementation consultants that works with organisations across health, public health and social care to help put guidance into practice. Providers are encouraged to engage with the field team to support implementation.

https://www.nice.org.uk/standards-and-indicators
https://www.nice.org.uk/about/what-we-do/into-practice/nice-field-team
NICE interventional procedures guidance

The NICE interventional procedures (IP) programme\(^{19}\) produces guidance on the safety and efficacy of interventional procedures to support safe innovation in the NHS. Providers are expected to have governance structures\(^{20}\) for introducing any new procedure into their organisation. These structures should ensure that any healthcare professional considering using a new interventional procedure seeks prior approval. If the procedure is the subject of published NICE IP guidance, the organisation should consider whether its proposed use complies with that guidance before allowing it to be undertaken. If the procedure is not the subject of published NICE IP guidance but falls within the IP programme’s remit, the medical director or a nominated deputy should notify\(^{21}\) NICE of the procedure.

The IP programme aims to protect patients’ safety and support clinicians, governance committees and trusts to manage clinical innovation responsibly. Achieving this aim depends on effective engagement between NICE and the NHS via trusts’ medical directors or their nominated deputies.

NICE  
May 2017

\(^{19}\) [https://www.nice.org.uk/About/What-we-do/Our-Programmes/NICE-guidance/NICE-interventional-procedures-guidance](https://www.nice.org.uk/About/What-we-do/Our-Programmes/NICE-guidance/NICE-interventional-procedures-guidance)  
NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. We offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, we help the NHS to meet its short-term challenges and secure its future.

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The Faculty of Medical Leadership and Management (FMLM) is the professional home for medical leadership in the UK, with a membership incorporating doctors and dentists from the most senior medical leaders to trainees and medical students. The primary objective of FMLM is to improve patient care by setting the leadership and management standards for medical professionals and supporting doctors to become better leaders.

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