

The Clinical Leadership Challenge in Primary Care

Bridging Gaps and Navigating Paradox

1. Context

“If you want people motivated to do a good job, give them a good job to do” – Herzberg

Active and fully engaged Clinical Leadership is an essential enabler to the transformation and sustainability of health and care services in the UK. Sustainability and Transformation Plans cannot be delivered successfully without such engagement.

The concept of Clinical Leadership and clinically-led commissioning was at the heart of the development of Clinical Commissioning Groups (CCGs) in England. The early excitement soon dissipated however as the experience has been mixed, with many clinicians feeling disempowered as they experienced the brick wall of the “NHS system”.

The reasons for the mixed experience are many, but a common reason we have observed is that the first wave of Clinical Leaders were mainly appointed for their special interests, with relatively little clarity around their accountability and authority.

CCGs may be changing in shape and role as new care models develop, but the role of Clinical Leadership in Primary Care has, if anything, grown in importance.

So the question now is: how do we engage the undoubted talent, experience and insights of Primary Care Clinicians so they are meaningfully engaged in shaping new care models for local populations?

In this paper we argue that creating “great jobs” that will attract and motivate a new generation of Clinical Leaders in Primary Care is an essential part of any strategy.

To “design great jobs to do” we think it is essential to spot the gaps that need bridging to build successful engagement of Clinical Leadership in Primary Care.

We also think the role faces some inherent paradoxes that need to be faced, and for which Clinicians need to be developed and prepared.

We recognise absolutely that clinical work in Primary Care is much more than Medicine. For purposes of this paper however we will focus on General Practice Medicine as the basic building block for organising Primary Care.

2. Spot the gaps

The “great job” for a Clinical Leader in Primary Care has to bridge five gaps we have spotted in the wider system.

- **The first gap** – the appreciation of the culture of Medicine as a profession and the personal accountability at the heart of clinical work.

Whatever their employment status now or in the future, Clinicians are autonomous practitioners registered with the GMC. Their professional accountability arrangements are a systemic challenge that mean Doctors don’t have to “follow orders” or hold themselves accountable to a “boss doctor” or “line manager” for their clinical practice.

Paradoxically “the system” then relies on that same “professionalism” to influence change in a profession full of autonomous practitioners. How does that work?

Whatever their organisational title, the reality is that professional autonomy means doctors operate as peers in their clinical roles and culture

- **The second gap** is that the training of doctors is designed so they are equipped to solve problems, diagnose and treat disease and help individual people in relatively short timescales.

To quote Dr Nicola Decker, the Clinical Chair of North Hampshire CCG:

Some of the leadership stuff feels therefore less well defined/ abstract and takes a while to adjust to. People therefore feel "safer" with being tasked with designing a pathway - something they can fix/ measure etc...to bridge this gap we perhaps need to get better at defining the leadership role better with measurable milestones that people can relate to.

With the principal exception of Public Health specialists, Clinicians are trained to **provide** care to individual people. Adjusting to a different, population-level focus, takes time, energy, curiosity and an inherent ability to “zoom out” which is fundamentally different to the training that makes them expert in “zooming in”.

That same training equips doctors to diagnose and solve problems in relatively short timescales, while the results of leadership work operate in often frustratingly long time-frames.

- **The third gap** is about understanding the nature of peer relationships in the medical profession.

Executives generally judge the effectiveness of Clinical Leaders on their ability to “deliver their colleagues”, while having little if any power to change the individual professional accountability arrangements in which they operate.

Clinical Leaders in Primary Care are invariably practising Clinicians whose credibility with their colleagues lies in their relationships and their competence in the “day job”. Crucially they are volunteers wanting to make a difference to patient care for a population, but who can generally choose to step back into their full clinical role with individual patients without loss of remuneration or reputation.

Their real power comes in their capacity to influence their clinical peers and colleagues voluntarily to join their efforts to improve the health of the population.

An extension of the peer -relationship culture is that clinicians are used to working with patients and other clinicians in an equal partnership. Working in equal partnership with managers is another new skill to develop which is crucial to successful teams.

- **The fourth gap** flows from the third and is about the perception of value and the reward attached to the role. Interestingly clinicians in leadership roles are usually paid the same as they would for clinical practice – i.e. enough to allow their practices to cover their day job. On the other hand, managers get paid more as their accountabilities increase.

This is not an easy gap to bridge if considered in financial terms only, because pay comparisons will operate in 2 dimensions at least – between clinicians and managers, and

also between “leadership” work and clinical work within the clinical community. In terms of the latter however it may point to the inherent value placed on clinical leadership within the profession (pejoratively seen as driving a desk instead of seeing patients) when in reality such roles require considerable additional training and development, and certainly a lot more public exposure, hassle and stress! Reward of course is more than financial return, and non-financial solutions may need to be imaginatively explored.

- **The fifth gap** is the multiple and labyrinthine “degrees of separation” between General Practice and Sustainability and Transformation (STP) footprints, expressed by layers of organisation/bureaucracy, and different “languages” operating at each level, viz:
 - General Practice.
 - Localities, GP Federations, or Clusters.
 - CCGs
 - CCG Clusters
 - Local Delivery Systems/ local health and care economies
 - STP Footprints.

By their very nature, STP footprints are high-level “strategic” entities dealing with “zoom-out” issues such as population wellbeing and health inequalities. With the exception of specialists in Public Health, clinicians are trained to treat individual patients, which means STP-thinking is not their natural territory or language.

3. Spot the dilemmas and paradoxes

One of the most fundamental dilemmas for Clinical Leaders is the inherent conflict between the role of representing the Membership of the CCG (their peer GPs) and how the system sees them as a “boss doctor” charged with achieving the corporate objectives of the CCG or the Locality.

As a result some Clinical Leaders want to separate out the representative and executive roles – to be either one or the other – when the truth is that they have to be both. It’s not a dilemma to solve by separating the roles, they are polarities to manage because the system architecture has set them in a dynamic inter-dependence.

In brief, you can’t have one without the other.

The perception of inherent conflicts of interest for GP Leaders who are in Practice partnership roles is a clear challenge to trust and the personal integrity of leaders, but it’s also a paradox because GPs risk losing credibility to influence their peers without their clinical roles. It is difficult to see how this could be designed out of a Clinical Leadership job in Primary Care, but is nevertheless a paradox professional managers by and large do not have to manage

Another challenge to trust arises when a Primary Care Clinician is expected to exercise leadership across a system populated by clinical professions who have often viewed each other with historic suspicion or low mutual trust - GPs/medical directors/consultants/nurses/AHPs etc.

All of these are real challenges to the skills and influence of Clinical Leaders, but can be managed if they are genuinely surfaced as issues and addressed with leadership development interventions.

4. Design a great job

Our proposition to start bridging the multiple gaps is to design “great jobs” where there is a proper alignment between role expectation, capacity to deliver, and the dexterity to manage the inherent tensions and paradoxes of the roles.

We think a “great job” has 5 essential design features:

- Purpose: a meaningful role, contributing to a higher purpose. That shouldn't be hard in the clinical professions!
- Influence: meaningful status & accountability.
- Clarity: a significant job with clear aims, outcomes and relevance.
- Autonomy: scope in the role to plan, deliver and evaluate the work
- Fairness: the role is fairly rewarded and recognised.

5. Meaningful work, aims and objectives

The types of roles needed locally may differ from area to area, but the key point here is to make the roles as concrete as possible in terms of focus and intended outcomes, without over-prescribing the ways and means.

Meaningful work is work with a clear purpose, recognised boundaries and achievable expectations for the individual.

Roles have to be meaningful also for the organisation paying for them. They have to fulfil a purpose that could not otherwise be fulfilled if the role did not exist.

For CCG and STPs to engage Primary Care leaders genuinely they need to pose concrete questions and challenges that Primary Care leaders can fix and measure meaningfully at their level of the system, not at the abstract level of the STP.

To use the example of a Clinical Lead for a geographic Locality, we have found the core purpose to be 2-fold, embracing the representative-executive dilemma.

- From the perspective of the GP Community, the Clinical Lead is the channel for peer engagement and 2-way communication between the GP community and the CCG.
- For the CCG the Clinical Lead is the focal point for leading Primary Care development and sustainability, leading the planning, delivery and evaluation of new models of care, aligned with local population needs.

This dual purpose allows the development of clear aims and objectives. For example:

- Through engagement and consultation with local Practices and Community Services, to co-create a locality – specific model of sustainable primary care.
- To ensure the integration of primary care practice into key programmes of wider-system work in Primary Care – e.g. IMT, education, research, Medicines Management, pathway development and STP workstreams.
- To ensure the alignment of operational plans and locality ambitions.

These broad parameters clarify the intention behind the role without over-specifying the detail or activities, leaving the more granular detail to local discretion and flexibility.

6. Meaningful titles & accountability

The title of any role infers status, authority and capacity for decision-making. For many people it is a shorthand description of a job and communicates power and position.

Director titles especially should be used with care in Clinical Leadership – the title infers power and authority to direct people and services, and accountability for results and resources. This is not to say it shouldn't be used, just that it should be used with care to reflect the authority and power of the role. Below the level of Clinical Chair, the Clinical Lead title may be more accurate for most roles because it is a leadership role rather than a managerial position.

The complication with the accountability model for Clinical Leadership is that Clinical Leads cannot hire and fire GP colleagues from their day jobs. The error is to try and apply that same model to the Clinical Leadership roles.

In Clinical Leadership roles the accountability is most likely to be to a Clinical Chair, recognising it is accountability **for the role** and not for their clinical practice. It is helpful to make the distinction clear and explicit in any role description.

7. Conclusion

Whatever the organisational forms developed over the coming years, Clinical Leadership in Primary Care will be critical in developing a sustainable future for health and care in the UK.

Good role design won't bridge all the gaps we've identified in this brief paper, but if Clinical Leadership in Primary Care is going to have a sustainable impact, it is essential to design great jobs, with role descriptions that are concrete and targeted, with less abstraction and more "measurable stuff" that Primary Care clinicians can relate to.

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