Clinical Leadership Skills and The Poetic Vision

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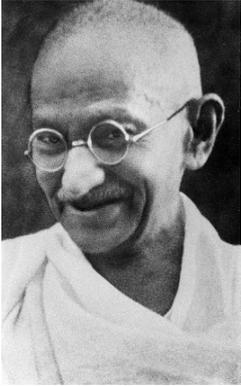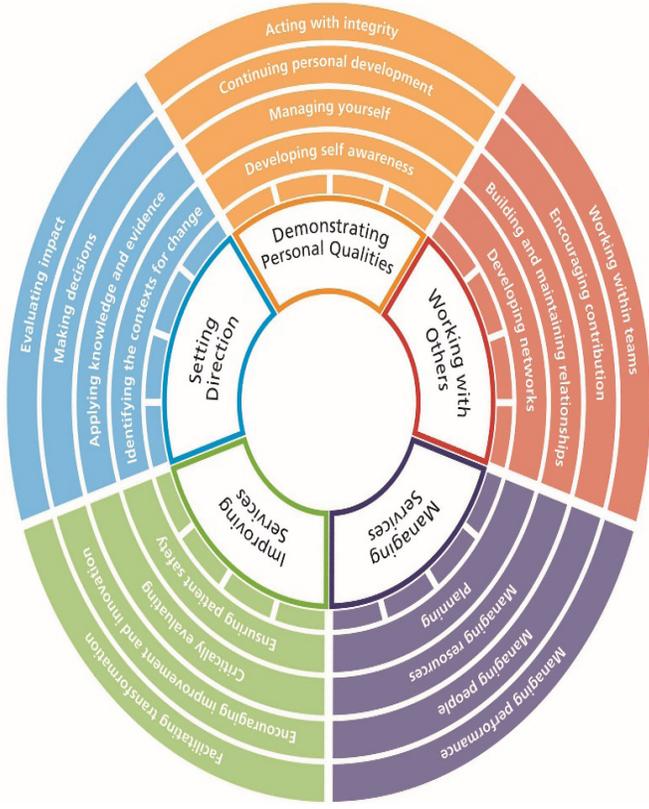
Clinical Leadership Skills

Clinical Leadership is likely to be perceived as a low priority skill for a clinical student or newly-qualified Health Care professional. However, all innovation and major changes in a health service relies on leaders of the future. Leadership is not just the skill in leading others, which is often needed, but also, the ability to follow and help others when necessary. Leadership operates on many levels, it is often seen just as an ability to lead others but the essential core of leadership is to lead yourself to become the healthcare professional you wish to be in terms of education, clinical service, personal aspirations withthe overarching aim of improving the lives of patients and the community. Leadership and management have overlapping competencies they are not synonymous and must not be confused.

Leadership Versus Management

"Management is doing things right; leadership is doing the right thing" **Peter F Drucker**

- **Leadership** takes people in a specific direction, and has vision and awareness of context, innovates, develop, asks why and what, challenges, focuses on people, establishes direction, motivates. Leadership involve power by influence.

- **Management** is enabling people to achieve specific goals via establishment, administrating structures, maintaining governance in committees, implementing accepted new ways of doing things, the goals are achieved through planning and solving problems in real time. Management involves power by position.

Medical Leadership Competency Framework

Personal ideas of leadership will depend on the very many values in leadership that you consider important	The wisdom of geese: a powerful metaphor of human leadership, followership and teamwork.
Images in Clinical Leadership	

From the table below, it is immediately obvious that all clinicians would need to have a degree of competency is most domains.

Managers		Leaders
Build and maintain organizational structures	↔	Build and maintain organizational cultures
Path follow, do things right	↔	Path find, do the right things
Undermined by setbacks	↔	See setbacks as opportunities

Maintain and rely on control	↔	Develop and inspire trusts
Focus on here and now of goal attainment	↔	Focus on the creation of vision about a desired future state
Maintain a low level of emotional involvement	↔	Have empathy with others, attend to meaning and interpretation
Design and carry out plans	↔	Establish a mission and a sense of direction
Administer	↔	Innovate
Ask how and when	↔	Ask what and why
Focus on systems	↔	Focus on people
Do things right	↔	Do the right things
Maintain	↔	Develop
Rely on control	↔	Inspire trust
Short term perspective	↔	Longer term perspective
Accept status quo	↔	Challenge the status quo
Eye on the bottom line	↔	Eye on the horizon
Imitate	↔	Originate

Qualities of Effective Leadership

The above table helps us towards an understanding of what a good leader does. But what makes a good leader? There are several qualities that we all recognise as hallmarks of a good leadership. These qualities include [1]:

- **Self-awareness**
- **Reflective and reflexive**
- **Understanding of change and transition**
- **Ability to teach, train and provide consultancy**
- **Readiness to adapt and innovate**
- **Political astuteness:** Identify power holders, understand their position, work out how their views fit with their position, anticipate problems, find allies, plan and have contingency plans.

Good leadership and especially charisma must never become an excuse for low levels of general clinical competency and inefficiency.

Competencies in Clinical Leadership

Statements and document from learned bodies in relation to clinical training now emphasize the need for development of leadership skills. Tomorrow's Doctor (2009), by the General Medical Council (2), specifically articulates the role of leadership in:

"It is not enough for a clinician to act as a practitioner in their own discipline. They must act as partners to their colleagues, accepting shared accountability for the service provided to their patients. They are also expected to offer leadership and to work with others to change systems when it is necessary for the benefit of patients."

Competencies for clinical leadership are difficult to define. The Medical Leadership Competency Framework (MLCF) was developed in 2006, with the undergraduate version published in 2010 (3). The MLCF is part of a wider UK project to promote medical leadership, which was commissioned by the Academy of Medical Royal Colleges and delivered by the NHS Institute for Innovation and Improvement. The MLCF is applicable for all doctors and incorporates undergraduate, postgraduate and continuing practice training and development. The MLCF describes the leadership competences doctors need to become more actively involved in the planning, delivery and transformation of health services. The MLCF incorporates the following five domains: -

- **Personal Qualities:** Developing self-awareness, managing yourself, continuing personal development, Acting with integrity.
- **Working with others:** Developing networks, Building and maintaining relationships, Encouraging contribution, Working within teams.
- **Managing Services:** Planning, managing resources, managing people, Managing performance.

- **Improving Services:** Ensuring patient safety, critically evaluating, Encouraging improvement and innovation, Facilitating transformation.

- **Setting Direction:** Identifying the contexts for change, applying knowledge and evidence, making decisions, Evaluating impact.

The skills accrued, it is hoped, would result in greater competence in any sphere, whether in a large team at a national level or small team in a local specific service. All these competencies also have a vital function at the level of the individual student or clinician. The competencies are generic and can apply to most clinical posts and also have substantial potential for use in undergraduate education. In July 2010 a further document, Guidance for Undergraduate Medical Education: Integrating the **Medical Leadership Competency Framework** was produced, to support medical schools in the integration of leadership competencies into undergraduate curriculum. The MLCF is built on the concept of shared leadership. This is:

"Where leadership is not restricted to those who hold designated leadership roles... (but also). where there is a shared sense of responsibility for the success of the organization and its services. Acts of leadership can come from any individual in the organization, as appropriate, at different times" (MLCF 2010).

What do we do in Human Healthcare?

Having discussed what, the generic skills and qualities a competent leader in healthcare is expected to have was relatively easy. The answer to the question posed in this sub-heading is surprisingly difficult to locate in the available literature or within the outputs of learned societies and institutions. The table below offers a summary of points made in several tutorials and interactive lectures with trained or training healthcare professionals. This is by no means an exhaustive or a definitive definition. It is necessary to define what we do or should do in Human Healthcare so that our clinical skills and competencies can specifically focus on delivering these outcomes.

What do we do in Human Healthcare?

In human healthcare we work to relieve suffering, morbidity and mortality by preventing illness, treating disease, rehabilitation, and appropriate end-of-life care.

For this work, high standards of clinical care and competence are considered to be:

- Being kind, acting in an ethical manner and ensuring human rights.

- Regarding patients as individuals and respecting their dignity.

- Personal continuous professional development and continuous innovative development of services taking into account local conditions.

- Working effectively in partnership with patients/careers on decision making.

- Addressing health inequalities.

- Promoting health in individual patients, local communities and the wider public.

- Working well and effectively with other healthcare professionals particularly in sharing best practice to reduce duplication of effort.

- Managing services optimally with leadership & follower-ship skills.

- Teaching, innovation and research.

- Being cost efficient and cost effective but always clinically governed.

An Algebra of Effective Healthcare: The POETIC vision

The shift towards more integrated public services, espoused in the 2010 White Paper "Equity and Excellence: Liberating the NHS", requires that health professionals of the future must increasingly work effectively with and alongside other health and social care professionals, stakeholders, community organizations and professional, regulatory and statutory bodies. Most healthcare professionals tend to work within specific professional domains and also have a duty to implement reports and guidance from their learned societies (4,5).

This has the potential to lead to a vast array of reports and guidance that needs to be implemented with very little attention given to the overall intended vision. In the West Midlands (UK), a multi-disciplinary clinical pathway group considering long-term conditions derived a model for effective healthcare: the POETIC vision. The vision encompassed what the team saw as an enabler

for all those involved in healthcare, manager and clinicians alike, to help create an outstanding service that improved the care and the lives of people. Such vision statements are not unusual; however, the acronym provides a structure and vision for what we might aspire towards to enable a shared approach to health service delivery and education.

This approach promotes a holistic platform derived from health and educational philosophies and is intrinsically linked to the way in which health and public services are designed, shaped and delivered. It provides all stakeholders (patients, careers, healthcare professionals, volunteers groups and charities, industry and social enterprise (including pharmaceuticals, delivery and devices), educational institutes, managers, politicians, students, local communities) with a simple acronym which incorporates

an approach to healthcare delivery, teaching and learning, and innovation.

Overall, the POETIC Vision is an "*algebra*" of effective healthcare. The idea of an algebra was inspired by a book tile by Arundhati Roy. The POETIC Vision is summarized in the table below. Diabetes Care is used as an example to elaborate the idea clinically but can be applied to most clinical services and conditions.

Excellent Leadership in healthcare has the potential to create a world-class service for our patients, current and future, that improves the lives of patients, careers and the community as a whole. This is a difficult challenge but a mantle that we must all take up in great or small measure.

	POETIC vision	Notes in relation to Diabetes care
P	Patient-centered and safe Public health driven Prevention-focused Professionally-inspired	1. Patient education and care planning essential to effective care. Care must be individualized and patient-led. The central of the career is emphasized. Care should be culturally-sensitive. 2. Remember HCPs, on average only provide 3 hrs of direct care a year, the other 8757 hrs are self-care or care by family and others! 3. Diabetes remains a major Public Health challenge consuming 10% of NHS resources. 4. Health inequalities must be addressed alongside prevention strategies, especially as 90% of Type 2 Diabetes can be prevented by addressing lifestyle factors. 5. Inspired Professionals will always deliver higher standards. Supporting and promoting innovation is essential.
O	Objectives clear Outcome driven:	• Patient Related Outcomes Measures would include reduction • in diabetes interfering with everyday life and employment, reducing admissions for hypoglycaemia and DKA, improving emotional well-being. • Specific complications such as CVD, renal failure, amputation and blindness need and can be prevented.
E	Evidence based: informed by clinical audit, quality assurance, research and evaluation of innovation	• Clear guidelines have been produced by well-recognized bodies especially NICE based on the many well conducted randomized-controlled trials that have taken place in diabetes care such as UKPDS, CARDS, STENO-2, Diabetes Prevention Programme. Further research desirable. • Clinical Audit is a major driver to improved care with the emphasis on implementation of audit finding and repeating the audit after a period of change to improve standards to create a constant dynamic of improvement.
T	Team delivered: multi-disciplinary, well trained and accredited	• Diabetes Care requires of coordinated partnership of many HCP, for example: nurses, healthcare support workers including administration staff, doctors, pharmacists, dietitians, podiatrists. • The team should be train together and be accredited by external review.
I	**Integrated:** Across all health and social care sectors	• Partnership oriented: especially through sharing of good practice. • Effectively integrating primary and secondary care, community organisations and health, education and social care agencies. • The patient and career should be facilitated in "navigating" through these agencies for their specific health needs.

C	Cost efficient and effective but Clinically governed*	• Although there are many expensive treatments in Diabetes Care that are effective and need to be used, it will be most cost effective to use these where there is greatest clinical benefit. • Organization of care should be considered in detail and will often lead to greater effectiveness and cost-efficiency. • A multi-factorial approach is best at reducing complications. Thankfully, the most effective treatments (for type 2 diabetes) are generic: BP (ACE-I, ARB), Cholesterol (statins), Glycaemic control (metformin), CVD prophylaxis (Aspirin).

POETIC Vision: An Algebra of Effective Healthcare

*Clinical Governance: Formal definition in the NHS: "A framework through which NHS organizations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." [6,7].

Conclusion

The GMC Good Medical Practice document outlines the core duties and responsibilities of doctors in UK Clinical Practice. Another major focus is the shift towards more integrated public services meaning that health professionals of the future must increasingly be prepared to work with and alongside other health and social care professionals, stakeholders, community organizations and professional, regulatory and statutory, bodies.

In the West Midlands, a multi-disciplinary clinical pathway group considering long-term conditions (8), led by the lead author Vinod Patel, derived a model for effective healthcare: the POETIC vision. The vision encompassed what the team saw as an enabler for all those involved in the management of such conditions to help create an outstanding service that improved care and the lives of people. Such vision statements are not unusual, however, the POETIC acronym also provides a structure and vision for what we might aspire towards in medical and healthcare education, this enabling a shared approach to health service delivery and education.

The POETIC vision is:

- **P: Patient-centered, Public health driven, professionally inspired,**

- **O: Objective clear, Outcome driven:** sets out what we want to achieve and why

- **E: Evidence based:** informed by audit, quality assurance, research and evaluation of education and health innovation

- **T: Team oriented:** multi-disciplinary, well trained, supported by inter professional education initiatives

- **I: Integrated, Innovative:** effectively integrates across primary and secondary care, community organizations and health, education and social care agencies

- Innovative - supports and promotes innovations

- **C: Cost efficient but Clinical governed:** Healthcare resources must be used to their full potential efficiently avoiding waste.

The POETIC approach promotes a holistic educational experience derived from a health and educational philosophy intrinsically linked to the way in which health and public services are designed, shaped and delivered. It provides all stakeholders (educational leaders, managers, teachers, students, local communities and service users) with a simple acronym which incorporates an approach to teaching and learning. It provides a framework for an educational philosophy, curriculum development, lesson planning or research evaluation and for working with students on planning and evaluating health services and innovations.

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