Safe high quality health care: investing in tomorrow's leaders

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Abstract

The agenda for health care in developed countries in the 21st century will be dominated by a vision of quality which seeks to address the deep seated problems of the past. The ability to deliver safe, effective, high quality care within organisations with the right cultures, the best systems, and the most highly skilled and motivated work forces will be the key to meeting this challenge. This is an issue which should be a priority for education and training bodies. The need for health services to give priority to developing health professionals equipped to practise in a new way and thrive in new organisational environments requires a rapid response to reshape curricula and training programmes. Developing leadership and management skills will be essential in achieving this transformation in the quality of care delivered to patients.

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Over the last four years accountability for the quality of care delivered to NHS patients has been entirely recast at both the organisational and the individual practitioner level. This change has been driven by several factors including expectations of those using the health service that in a modern consumer society its standards should be more explicit and transparent[1]; more detailed and far reaching definitions by professional bodies as to what constitutes good clinical practice[2]; and a series of high profile and heavily publicised health service failures that created a sense of crisis.[3–5]

The comprehensive framework for quality assurance and quality improvement in the NHS[6] now embraces explicit standards for the organisation and performance of services in particular fields of care,[7 8] for specific interventions,[9] and for individual practice.[10] A duty of quality placed on every NHS provider as part of health legislation[11] is being implemented at the local level through the clinical governance initiative.[12] Specific strands of the quality framework deal with poor individual practitioner performance[13] and patient safety.[14] Inspection of the adequacy of each local NHS provider's system of clinical governance is undertaken by an independent commission.[15] These radical changes are having a fundamental impact on what is expected of a health professional working in the NHS at the beginning of the 21st century. Equipping today's undergraduate or health professional in the early stages of training to enter this new environment should be a priority for the organisations and institutions responsible for education and training. Yet, traditionally, change in the nature of clinical practice or in the needs of the health service have been relatively slow to feedback to reshape curricula. So much so that it seemed novel and somewhat surprising to see the explicit criteria (box 1) set out by the Department of Health and Higher Education Funding Council committee[16] which called for and judged bids from universities for allocation of 2000 medical school places in England. A customer-provider relationship between the NHS and education providers is a long way from being fully realised. Indeed, the validity of such a concept would be disputed by some.

This paper discusses some of the skills and values that clinical professionals will need if

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> **Key messages**
> - Healthcare systems in many developed countries are producing a common vision of healthcare quality in the 21st century.
> - Similar problems have been endemic in many healthcare systems for decades: underuse of effective interventions, overuse of ineffective or outmoded treatments, variation in process and outcome of care, slow transfer of research into practice, a poor awareness of safety and of the causes of avoidable adverse outcomes of care.
> - Clinical governance (and similar programmes in other countries) are creating health organisations with positive cultures, patient centred policies, effective team working, and strong safe systems to put quality assurance and quality improvement at the heart of the front line delivery of health care.
> - Healthcare professionals of the future will need a much wider range of new skills and competencies to practise successfully in this new world.
> - Developing effective clinical leaders and managers—a weak area in the past—will also be essential to achieving the transformation required.
> - These changes provide a challenge to education and training bodies to rapidly redesign curricula and programmes to ensure that tomorrow's health professionals are fully equipped to meet the needs and expectations of future patients and citizens.

- To develop new doctors who are equipped to meet the challenge of changing health and healthcare needs of patients and populations into the first half of the 21st century.
- To develop new doctors who are able to practise to a very high standard, through being able to appraise and use evidence, to become life long learners, to maintain professional standards, and to be effective team members and leaders.
- To develop new doctors who are committed to and skilled in promoting health, preventing ill health, diagnosing and treating injury and disease, and caring for people with long term illness and disability.
- To develop new doctors who understand the value of partnership and communication, both with their patients, their colleagues, and with members of other professional groups.
- To provide a high quality educational experience in an environment in which evaluation and research are fostered and which gives value for money.
- To demonstrate an active commitment to the admission of students from a broad range of social and ethnic backgrounds to reflect the patterns of populations which are served by the NHS.
- To ensure that the distribution and patterns of training of students effectively increase the home supply of doctors and meet the needs of the populations which are served by the NHS.
- To enhance quality and value for money through collaboration between universities and partnership with the NHS.

Box 1   Overall objectives adopted by the Joint Implementation Group for increasing medical school intake in England.[16]

they are to practise safely, to a high standard, and to be able to work effectively in a health organisation committed to clinical governance. This is an important issue for clinical curricula across the world as quality and patient safety rise to the top of the agenda in the healthcare systems of many countries. The ultimate challenge is to produce leaders at all levels—clinical, educational, within professional bodies—who understand the transformation required and help to deliver it.

Quality: the chasm and the mountain top
Despite the improvements in the health of the populations of industrialised countries during the 20th century, the widening of therapeutic opportunities, and the gains in quality of life from new technologies and new drugs, formidable problems remain; so much so that the influential Institute of Medicine in Washington likened the challenges shown in its recent assessment of quality problems in the US healthcare system to a "chasm".[17]

Many of the quality problems are endemic within healthcare systems in different countries of the industrialised world, including:

- underuse of interventions of proven effectiveness;
- overuse of inappropriate, outmoded, or ineffective treatments or tests;
- unjustifiable variations in process and outcome of care;
- slow transfer of evidence of benefits derived from research into front line practice;
- variation in access to care with barriers for the most disadvantaged;
- relatively high levels of adverse outcomes arising from unsafe practices, incidents, and medical errors.

Policies and initiatives to address these deep seated problems have been a feature of strategic thinking—international as well as within country—during the late 1990s and the beginning of the present century. There have been three big themes.

Firstly, the recognition that much clinical decision making was not well grounded in medical science led to the evidence based medicine movement[18] which has had a profound influence on the philosophy of medical practice, education and training, and the development of information technology. It has also led to an increasing emphasis on establishing evidence based clinical guidelines to encourage greater standardisation in the approach to diagnosis, treatment, and care of patients with specific diseases. It has promoted wider thinking about knowledge, how it is managed, and how it could be used to improve the quality of clinical care. It is in this area of quality that health care connects to other service and industrial sectors where innovation in knowledge management has proved to be a key success factor.[19]

The second broad area of activity has been the drive to create health organisations that embrace the concept of continuous quality improvement. In the late 1980s there was a great deal of interest in the quality improvements achieved in other sectors by using quality management as an organisational philosophy. Features of this approach included: commitment to leadership from the top; empowerment of staff; teamwork; prevention (rather than correction) of adverse outcomes; analysing, simplifying and improving processes; and strong customer focus.[20] Although embraced by many hospitals and health plans around the world, including in Britain, these ideas did not provide a unifying focus for quality assurance and quality improvement at the local health organisation level within the National Health Service until the advent of clinical governance.[21 22]

The clinical governance initiative, aimed at producing health organisations that are truly patient centred—for example, by tackling cultural change, by establishing clear systems and methods for assuring and improving quality and by promoting teamwork and high standards of practice—is addressing the fundamental challenge of achieving the transformation of the organisations[12] that provide health care.

The third main theme in modern thinking about the quality of health care is patient safety. This is a long neglected area. Analyses of the

scale of avoidable adverse outcomes of medical care have shown that it is a much greater problem than previously realised.[23] The recognition that the solution is to create and design safe systems which reduce the likelihood of medical error and its impact when it does occur (as it inevitably will), as well as to learn from mistakes, has been a major turning point.[14 24]

Programmes are now being introduced to create safety cultures within NHS organisations and to reorientate practice to recognise sources of risk and ways to minimise it.[25]

Centring on the patient

Rudolf Klein[26] argued back in 1973—before the acceleration of consumerist attitudes of the 1980s—that the traditional "charismatic authority" of doctors was being replaced by the idea of "demonstrated competence" and accountability: "*once a doctor, or any other professional, can no longer shelter behind the mystique of his calling, attention is directed at what he does rather than who he is*".

The accountability of health professionals within a state system of care and the status of patients was thrown into relief by controversial events in the NHS in Britain in the 1990s. The serious shortcomings in the standards of care provided by the children's heart surgery service in Bristol showed the extent to which patients' and parents' needs were not central to decision making or the culture of the service.[27] The removal of children's organs after post-mortem examination at Alder Hey Hospital in Liverpool and other centres without the knowledge or consent of parents[28] was another example of an institutionalised philosophy that it was acceptable to take decisions on behalf of families rather than with them.

Reports of individual cases where doctors were accused of behaving in a God-like manner[29] led to further questioning of the power of patients and the respect that should be accorded to them. To the dismay of many health professional bodies as well as rank and file practitioners, these scandals were portrayed by the media not as parochial events but in terms which suggested a more general culture of paternalism. In a period when a great deal had already been done to create a new style of relationship between health professional and patient, the sense of crisis engendered an added impetus for further change.

In the National Health Service tomorrow's citizens will see themselves as true potential consumers of a service which they, as taxpayers, fund. Tomorrow's patients will expect to be accorded respect, to be empowered with information to enable them to make informed choices, and to become an equal partner in decisions about their case. In the field of chronic diseases this shift in emphasis goes even further with patients being enabled to become "experts" and to have greater autonomy in managing their care.[30]

This is an exciting agenda which many healthcare professionals have already embraced, but new skills and competencies will be required to provide all with the capability to practise in a new way.

Quality and the individual practitioner

As a result of the move to make quality assurance, quality improvement, and patient safety a core part of health care, many of today's doctors, nurses, and other health professionals are working in a new kind of organisational environment and are subject to a framework of accountability that would have been alien to their counterparts even 20 years ago.

In the National Health Service, for example, most health professionals now work within a medium sized or large health organisation either in the primary, secondary, or community sectors. The organisation is managed. The individual practitioner is accountable through the corporate management structure and bound in (albeit informally) to meeting the goals and contractual commitments of the organisation. The practitioner is part of a team increasingly led by a clinical manager and shares accountability for meeting the team's service delivery goals. The health organisation itself is subject to a statutory duty of quality so has implemented a programme of clinical governance to fulfil this duty, focusing on culture, systems, methods for quality assurance, and quality improvement. The individual practitioner is expected to play an active part in these local clinical governance arrangements.

In addition to this framework of accountability arising from the health professional's position as an employee of the health service, he or she is also subject to professional codes of practice. These set out variously rules of ethics and conduct, values and qualities of good practice, guidelines and protocols for the treatment of particular groups of patients.

This places expectations on newly qualified practitioners which many are largely unprepared for. Traditionally, education and training programmes have placed a priority on developing knowledge and skills in the clinical aspects of practice. Other areas have often been seen as relatively unimportant, the "softer" end of the spectrum dismissed pejoratively as "nonclinical", the requisite skills to be picked up experientially along the way.

There is little doubt that this traditional way of viewing clinical practice is outmoded, out of line with the staffing needs of a modern health service, and out of touch with consumers of health care.

The health professional of the future will need to have core skills and competencies in the diagnosis, treatment and care of illness, but much more. The ability to form genuine partnerships with patients, the ability to work effectively in multidisciplinary teams, the ability to recognise the causes of unsafe practice and act on them, the ability to assess quality of care and identify ways of improving it, and the ability to communicate, inform and educate are only some of the skills which will be required in the future.

Medical leadership and management

Fundamental change of the kind required needs leadership. For many health professionals, beyond caring for individual patients, they will find themselves in positions of leadership

of teams providing care. There are others who will take up wider leadership roles—leading whole health organisations (or large functions within them), leading national policy or programmes, leading professional bodies which have a clear role within the overall healthcare system.

There are a number of qualities which are central to leadership at any level (box 2). A leader must be able to inspire and be seen to have integrity. These qualities will develop more easily by someone who works in a team, who learns effectively, and who communicates and explains policy. A leader who sees quickly to the heart of a problem will be able to position himself or herself and be able to gauge situations correctly.

It is particularly important that difficult decisions are not ducked regularly. Someone who averts the gaze or opts for a quiet life gradually loses the respect of her or his peers. So too does someone who undermines senior colleagues, plays games, manipulates, or who is not corporate or loyal to the organisation. A reputation for deviousness is as damaging to a clinical leader as a reputation for high levels of complications of treatment is damaging to a clinician. Even if people do not agree with a leader, they will respect her or him if they take tough decisions that no one else has been willing to take and if they manage the situation fairly and effectively.

Increasingly, as more and more health organisations are managed organisations, the majority of health professionals will at some time in their careers hold formal management roles. Here too core leadership skills are essential, but so too are a range of more specific skills and competencies (box 3).

The approach to developing these skills in the National Health Service has been very patchy in the past. Most health professionals have taken on senior management roles with little training or induction. For example, routes to a Medical Director role (a key post within the management structure of NHS hospitals) in the past have been diverse—the hospital senior consultant giving it a few years to retirement; the doctor persuaded to take it on at the peak of his/her career, diverting their clinical or research energy towards the management role

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- A leader should have a clear vision, a plan for how it will be delivered, and should communicate it effectively.
- A leader should have a set of values and a style of management which others can understand clearly.
- A leader is not necessarily a manager but most of leadership involves being a manager of change.
- A leader must have a team (in complex organisations more than one team) through which he or she delivers the plan: keeping on course, motivating, putting together the right people, handling highs and lows.

Box 2   Qualities central to leadership.

A clinical manager should:

HAVE INSIGHT INTO THE:
- issues in most clinical areas
- key skills and philosophies of other health professionals
- roles of all local agencies relevant to health
- needs of patients and carers
- way in which information can be used
- nature of clinical risk
- limits of what is affordable and achievable
- culture of the organisation itself

POSSESS CERTAIN ATTRIBUTES:
- leadership and inspiration
- high integrity
- team worker
- learns effectively
- communicates and explains
- sees quickly to the heart of a problem
- builds networks and coalitions
- seldom avoids the difficult
- displays sense of duty and loyalty

BE HIGHLY SKILLED IN:
- implementation of clinical governance
- mentoring and giving feedback
- complex problem solving
- organisational change
- involving service users and carers
- assessing new innovations and developments
- working across professional and organisational boundaries
- management of resources
- certain key management procedures
- using evidence and information

Box 3   Qualities of a clinical manager.

but envisaging returning to full time clinical practice; someone reluctantly drawn from the ranks when the job is difficult to fill (perhaps a medical committee chairman or similar); someone who wants to spend the second part of their career almost full time in management; someone who has not had a conventional career path and likes doing something different.

This is a haphazard way of developing leaders. Truly effective leadership and clinical management demands a more systematic approach to creating the leaders and managers of the future both in medicine and other health professions. In addition to education and training programmes, some fundamental issues also need to be addressed, including:
- giving people time to do the job and support when in post to learn and develop in their roles as leaders and clinician-managers;
- having some idea of what the concept of career progression is in a clinical-managerial career and particularly addressing the entry and exit points;
- ensuring that more women and those from ethnic minority backgrounds are able to take on managerial roles;
- valuing and recognising the clinical leader and manager within each health organisation.

Conclusions

Health care in the 21st century will require a new kind of health professional: someone who is equipped to transcend the traditional doctor-patient relationship to reach a new level of partnership with patients; someone who can lead, manage and work effectively in a team and organisational environment; someone who can practise safe high quality care but also constantly see and create the opportunities for improvement. This vision can only be realised if systems of education and training adapt quickly to this changing world. Educational bodies, those who lead them, and those who work within them must build on their traditional strengths of innovation in curriculum design and educational and training methods to address these challenges.

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