Board affiliate pilot: leadership and innovation—creating new opportunities to deliver better patient care

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ABSTRACT
Background Leadership and management have become a key facet of medical training. However, there remains enormous variation in the quality and effectiveness of medical leadership training. This article describes an innovative pilot programme that aimed to prove a new method of developing clinical leaders.

Methods We undertook a 12-month pilot integrating a doctor in training onto our trust board in a role called the 'board affiliate'. We collected qualitative and quantitative data throughout our pilot programme.

Results Qualitative data demonstrated a clear positive impact of this role on senior management and clinical staff. Our staff survey results increased from 47.4% to 50.3%. The pilot programme had such an impact on our organisation that we have expanded the single pilot role into two positions.

Conclusion This pilot programme has demonstrated a new and effective method of developing clinical leaders.

WHY CLINICAL LEADERSHIP MATTERS
Clinicians have an important role in healthcare leadership. In our trust, we have observed the power of bringing a clinician’s voice into conversations about the vision and strategy of our clinical services. This is not a new phenomenon. In their report for the King’s Fund, Ham and Berwick highlighted the immense value that junior doctor’s insights and observations bring to the conversation.

‘The knowledge of medical students and junior doctors is ‘gold dust’ and should be mined relentlessly.’¹

The positive impact of employee representation and engagement is also outlined in the 2008 Healthcare Commission. This review identified a link between hospital trusts rated as ‘excellent’ and those with strong employee advocates within their organisations.² Further, Veronesi et al found that the greater the percentage of clinicians on governing boards in NHS hospital trusts, the better that trust performed, the better the patient satisfaction ratings were and the lower the morbidity rates.³ West et al also demonstrate a clear link between trusts that engage their clinicians in service improvement and a significant reduction in their mortality rates.⁴

For many, the link between employee engagement and improved outcomes is not surprising. It reflects the expertise and experience clinicians bring to management conversations, benefiting our services and those who use them. Clinicians matter, clinicians bring something of value to management conversations, and involving them in the running of our healthcare organisations makes our services better and safer for those who use them.

CLINICIAN ENGAGEMENT IN THE UK
Given the evidence supporting the important role clinicians have in healthcare management and leadership, it is interesting to consider data evaluating staff engagement in the NHS. The annual NHS staff survey provides extensive data on staff engagement and workplace environment. The median response rate to the NHS staff survey across the UK in 2020 was 47%. When analysed by subgroup, medical staff were far less likely to complete the survey compared with those in a management role within the NHS. As clinicians, we are very much focused on the provision of clinical care, meeting the needs of those in front of us in an overstretched healthcare service. As a person in a leadership role, this survey provides detail and specifics used to direct strategy and organisational development. Without the insight into both these worlds it is easy to forget the pressures the other is facing. There are inherent tensions between the clinical and management domains that can make it hard to engage with each other effectively. Having clinicians who sit across both domains can help bridge this tension, considering practical solutions and ways of improving how we can work better together.

Looking further into clinical leadership, I have been intrigued by the data about the role of clinicians across very senior management. In the NHS, only 7% of CEOs have medical qualifications, in contrast this group represents more than 30% of the CEOs in the USA.⁵ Being a good clinician does not make you a good CEO and being a good CEO does not make you a good clinician. However, a group of highly educated individuals with an in-depth knowledge of the healthcare system and delivering care to people on the front line seems like an obvious source of future leaders for the NHS. It is hard to understand why we are not using this resource more to the benefit of the NHS. Why are we failing to provide opportunities and training to make this transition possible?

CURRENT LEADERSHIP TRAINING
Over the last decade, medical leadership and management has gained increasing prominence in medical training. The Medical Leadership and Competency Framework (MLCF) was developed jointly by the Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement, first published in 2008.⁶ The MLCF describes
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the leadership competencies that doctors need to become more actively involved in the planning, delivery and transformation of health services. The General Medical Council also published their Generic Professional Capabilities Framework in 2017, outlining the role of doctors as leaders and members of a team. Despite the clear recognition of developing these skills in our clinicians, delivery of leadership training is still widely varied. Lyons et al performed a systematic review of medical leadership development programmes, they found considerable heterogeneity among programme design and delivery. Programmes in the meta-analysis varied in length from 2 hours to 4 years, with a median length of 6 months. Elements that seemed particularly important in effective programmes were, embedding staff from your own institution onto the faculty (p=0.049), focusing work on a specific project and ensuring that mentoring support was provided.

BEING A CLINICIAN

My work as a doctor is a privilege and a joy. When I graduated from the University of Leeds nearly 12 years ago, I was excited to take on the challenges of my clinical role. I progressed into anaesthetic training with the same level of enthusiasm for clinical work. Unlike some of my (maybe more insightful) colleagues, I had not really thought beyond my role as a clinician and how else I might contribute to the NHS in the future. Like all doctors in training schemes, I had undertaken various projects, teaching and auditing, seeking to improve care. In part, this was a requirement, in part, I genuinely enjoyed the opportunity to gain greater understanding and insight into how our services run and have a say in how we could make them better.

In 2020, I was invited to take part in a pilot project at Buckinghshire Healthcare NHS Trust. This pilot changed the way I view myself and the role of clinicians in the NHS. Our board affiliate pilot project created an innovative role, integrating a clinician into our trust board. This had not been trialled in an NHS organisation before.

THE BOARD AFFILIATE ROLE

The board affiliate pilot ran for a 12-month period from February 2020 through to February 2021. The board affiliate role was designed to mirror that of a non-executive director, bringing experience and knowledge, broadening representation and scrutinising the actions of the board. In my role, I attended monthly board meetings, with access to all board paperwork and active participation in the discussions and updates that wrap around these meetings. I also sat on the finance and business performance committee, again with full access to the papers and participation in discussions at the monthly committee meeting. In addition to these two monthly meetings, I ran a trust-wide quality improvement project called the Trainee Leadership Board (TLB). The TLB is a project that was first introduced in Oxford in 2018 by Stegen et al. The TLB is an experiential learning process that facilitates healthcare professionals to work as a group on a real-life problem that their trust is facing. Our group spent 14 weeks considering patient flow through our hospital and exploring possible solutions. The group spoke with key stakeholders, with those already working on this issue within the trust, and looked at examples of good practice from other healthcare providers. The project culminated in a presentation of the TLB’s findings at trust board meeting. One final element of the board affiliate role was to publicise what we were doing, we wanted people to know about the project and what it meant for our organisation. I wrote a monthly blog, was active on Twitter and presented at national and local meetings, raising awareness of this role. I was supported in everything that I did by enthusiastic mentors throughout the process and met with them regularly over the 12 months of this pilot scheme.

It can be hard to fully grasp the culture of a group until you are embedded in it. One of the specific insights I have gained through my experience as board affiliate is the willingness of senior leadership to question, reframe and review data to better understand the issues they are facing. The importance of this openness to learn and change has come about, in part, through major failings of leadership in the NHS. As we evaluated this programme at the end of our 12-month pilot, it was clear that this had been a success. Qualitative feedback was overwhelmingly positive.

‘The experience of the direct input from a doctor in training to the board has fundamentally changed our view & knowledge of the Trust.’

‘It is hard to overestimate the impact it has had. An invaluable, highly trained and potentially overlooked resource.’

‘The role creates an important feedback loop.’

Quantitative data demonstrated that communication was improved between clinicians and very senior managers and trustwide staff engagement was increased from 47.4% to 50.3%. The programme was so effective that our senior leadership decided to expand the programme to incorporate two board affiliates. These roles were opened to medical doctors, nurses, midwives, psychologists and allied healthcare professionals. We have been in discussion with NHS bodies with a view to spreading this model to help develop other future clinical leaders.

WOMEN IN LEADERSHIP

As someone who identifies as a woman, one of the key issues that I reflected on in my board affiliate role was the impact of gender on NHS leadership.

Across the NHS workforce, 77% of all employees are women. As a hospital doctor, I was particularly struck that despite 45% of the medical and dental workforce being women, only 37% of consultant roles are held by women. Gender disparity is marginally better in senior management roles, with 47% of very senior management roles held by women. However, only 29.5% of medical directors are women, statistically it seems I am unlikely to follow this path. Sitting in the board affiliate role, I have had the privilege of time and space to consider in greater depth what these data mean and how as a system we can address this. The issues of discrimination are complex. Again, in my board affiliate role, I have had the opportunity to consider national data on Workforce Race Equality and Workforce Disability Equality. Understanding how the systems we work in impact our delivery of care is key to being a successful leader and manager within the NHS. This is an issue for everyone, whether you are a woman or a man, disabled or able-bodied, white or coloured and heterosexual or LGBTQ+. As a person embedded within this system, I have my own perspective to contribute and much to learn from others, but there is a need to change and a need to make this better. Through the board affiliate role, our trust was able to bring this different voice into conversations, bringing a different perspective and broadening representation. Clinicians must be part of this dialogue; it is not something we can ignore.
As someone who identifies as a woman, I feel uniquely positioned to address some of these gender issues and consider how we can reduce discrimination within our system. I have been incredibly grateful to others for sharing their vulnerabilities and perspective on how their protected characteristics have given them a unique view on how we can make things better. These issues are important not just because it is morally right to address them but also because research shows that a motivated, included, and valued workforce helps to deliver high-quality patient care, increased patient satisfaction and improved patient safety. By addressing inclusivity, discrimination and bias we make our care better.

**TAKING A DIFFERENT APPROACH TO RECRUITMENT**

With an awareness of the importance of inclusivity, another exciting aspect of our board affiliate pilot was the opportunity it gave us to reduce bias in our recruitment processes. Recruitment can reinforce bias within systems and can fail to identify the candidate with the greatest potential for success in a post. Our leadership and organisational development team created a new, evidence-based, approach to recruiting individuals to successive board affiliate roles. This approach used anonymised questions, work sample tests and structured interviews to reduce the bias in our process. It was a fascinating insight for me as a doctor in training to be involved in the shortlisting and interview process. The new approach to recruitment felt refreshing and has huge potential to open opportunities for both the individuals applying and the organisation appointing them. This recruitment process is currently being analysed, but early results demonstrate a significant reduction on the bias within our system.

**THE BOARD AFFILIATE ROLE: A LEARNING OPPORTUNITY**

It is hard to overestimate the impact the board affiliate role has had on me. The opportunities for growth and development in this experiential, immersive, role have been immense. I was funded to work in this role for 20% of a full-time role, which equated to 1 day each week. One of the strengths of this pilot was this regular input over a 12-month period, enabling time to gain greater insight and understanding of a complex system. Another important element of the learning process was that this was not a theoretical scenario, or a thought exercise, I was discussing real issues that directly impacted my patients, my colleagues and myself now. The COVID-19 pandemic brought much of this into sharp focus. As a clinician caring for people at their sickest in our emergency department and intensive care units, I was one of the few members of the board who had a legitimate reason to be in our clinical environments. The year 2020 highlighted how dynamic and fast-paced our healthcare system can be. My ability to talk directly at board level, bringing the perspective of a clinician straight from the ‘front line’ was important. It also signalled to our staff that their voice mattered and that this is a learning organisation, one that is fostering a compassionate culture.

After a year in the board affiliate role, my perspective on my future role in the NHS has been fundamentally changed. As a clinician, I have developed greater insight into how I fit into both my local organisation as well as the larger NHS. I have also gained a deeper knowledge of NHS governance and structure. I have begun to learn a new language, one that speaks in financial, strategic and management terminology. All of this is key to understanding how to navigate the complex channels of an organisation. It is key to making improvements and changes in the system we work in, making it better and safer for those who use our services. I do not know what the future holds, but it is clear in my mind that clinicians matter beyond their role on the front line of healthcare.

Each of us has a role and a contribution to make, for me this is recognising that my years of clinical training have helped me develop many traits of an effective leader. I am excited about using these beyond my direct clinical care for patients to make our services better.

**REFERENCES**