Monitor
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tda Trust Development Authority
Quality. Delivery. Sustainability.

Supporting the role of the medical director

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Thank you to the medical directors who took the time to complete the survey that forms the basis of this report. The results are an invaluable insight into the day-to-day working lives of medical directors and the support they feel should be put in place to grow sector expertise. Monitor and the NHS Trust Development Authority will use the results to inform our learning and development work programmes, in conjunction with appropriate delivery partners.

We hope this report is of interest across the sector: to medical directors, their board colleagues, clinicians aspiring to take on leadership roles in future and others with an interest in advancing clinical leadership.

Contents

Introduction

The role of medical director (MD) on the board of an NHS trust or foundation trust is where clinical and financial governance meet. Effective medical directors are critical to securing sustainable improvements in the quality of patient care, a pressing concern now for trusts across the sector.

Monitor and the NHS Trust Development Authority (NHS TDA) are exploring the development of a range of programmes to support medical directors as a means of promoting well led organisations delivering patient benefit. To find out about the demands of the role in today's NHS, the structural and learning support already available and what additional support they would find helpful, we ran a survey of medical directors in the NHS provider sector from December 2013 to January 2014.

The survey received an unusually high response: 40% of the 265 medical directors we contacted at a range of providers sent full replies. This is a report of the findings, drawing heavily on the respondents' own words.

1. Using the results - what next…?

… for the sector

We want to share the findings of the survey with the sector because they give a clear view of current practice in medical leadership in the NHS across the full range of trusts.

Although Monitor and NHS TDA will address the issues raised with a targeted work programme, the report also has lessons that others might be better placed to progress – for example, on coaching or education and training pathways (although Monitor's work on service line management could support management pathways too).

… for provider boards

The report enables medical directors and their board colleagues to make useful comparisons of practice and allows boards to review their approaches to supporting medical leadership.

... for Monitor and the NHS Trust Development Authority

We are to meet national partners over the coming months to consider the report and explore options with colleagues in the sector to address the issues raised.

At present we are considering offering a version of Monitor's board induction days, currently aimed at chairs and chief executives, to medical directors later in the year. NHS TDA already runs induction events and we will use the survey results to enhance future plans in this regard.

2. Main findings

The medical director role is varied, often broadly defined, and with many demands on it. Given these demands, and the fact that they are likely to grow rather than diminish, the survey has shown that it would be useful for medical directors to have:

- greater role clarity
- clearer training and career pathways
- organisational and peer support - from above, below and alongside
- more acknowledgement of the strategic as well as the operational aspects of the role
- a means of identifying the medical directors of the future and making it a clearer career option that more people will consider.

A high proportion of medical directors are new to the role, and they and their peers would value more mentoring and induction, particularly on corporate responsibilities, adopting a strategic outlook and growing personal resilience. More established medical directors value networking, coaching and board support.

Perhaps unsurprisingly in the current environment, medical directors are most concerned about driving cultural change, leading the profession and quality governance, delivering on quality and the financial challenge.

Those in post appreciate the many challenges, but also report enjoying the role. They come to it in the first place to drive improvements to services and patient care on a larger scale and to ensure a stronger clinical voice on the board, across organisations and in local health economies.

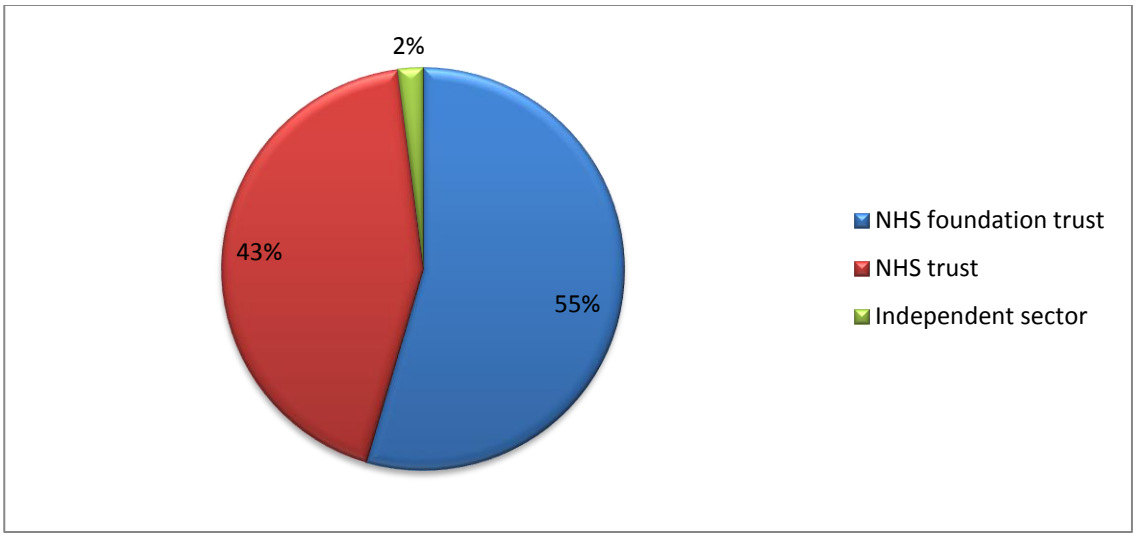
A proportion are keen to explore moving on to chief executive roles as their next career step and many want to continue to contribute regionally and nationally. Career progression after the medical director role is very unclear and may be a significant drawback to taking on the role.

Monitor and NHS TDA will respond to these headline points as part of their growing development work programme. We will take forward directly any appropriate actions (such as board induction), and bring the results to the attention of wider audiences to ensure that all points made here are duly considered.

3. Respondent profile

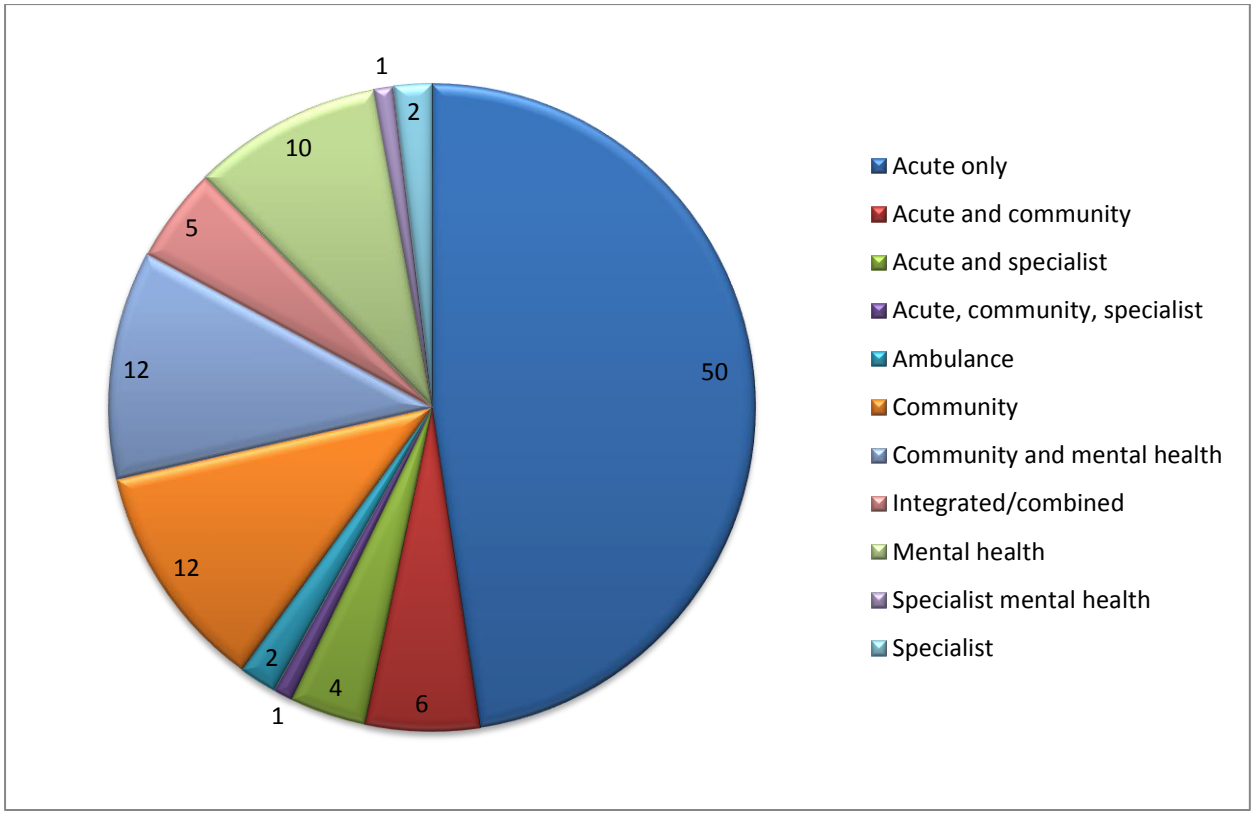
We sent the survey to medical directors in NHS trusts, NHS foundation trusts and the independent sector during December 2013 to January 2014, and received 105 responses.

Figure 1: Respondents by provider type (n=105)



58 foundation trusts, 44 NHS trusts and 2 independent sector providers responded; one respondent did not specify their provider type (n=105). The majority of respondents provided acute services (n=61), though all sectors were represented.

Figure 2: Respondents by services provided (n=105)



The categories above were self-reported. 8 described themselves as integrated/combined, but where it was possible to allocate them to a specific combination (such as mental health and community), they were classified in that category. This left 5 trusts, 2 providing no further description of services, 2 providing integrated health and social care, and a further trust providing primary care and community services.

The turnover of responding trusts was as follows:

Table 1: Turnover of responding trusts

Turnover	Number of trusts
0-£150 million	26
£151 million- £300 million	46
£301 million - £500 million	22
£501 million - £800 million	6
£Over 800 million	5

We asked the medical directors themselves about gender, ethnicity, original specialty and tenure in post. The following figures and tables outline the results.

Figure 3: Gender of respondents

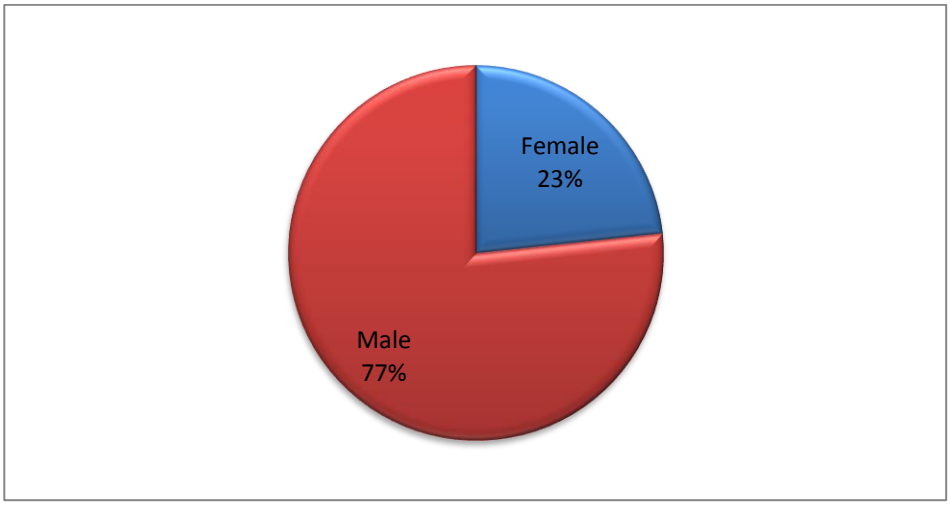


Table 2: Ethnicity of respondents

Ethnic group	Number
Asian/Asian British	11
Black/Black British	1
Mixed/multiple ethnic groups	3
White	85
Prefer not to say	3
Other	3

There was a broad mix of specialisms at the medical director level. Outside general medicine and surgery, anaesthetics, paediatrics and general practice were all well represented. Those with mental health specialties were a mix of adult, child, old age and forensic practitioners.

Figure 4: Speciality of the respondents

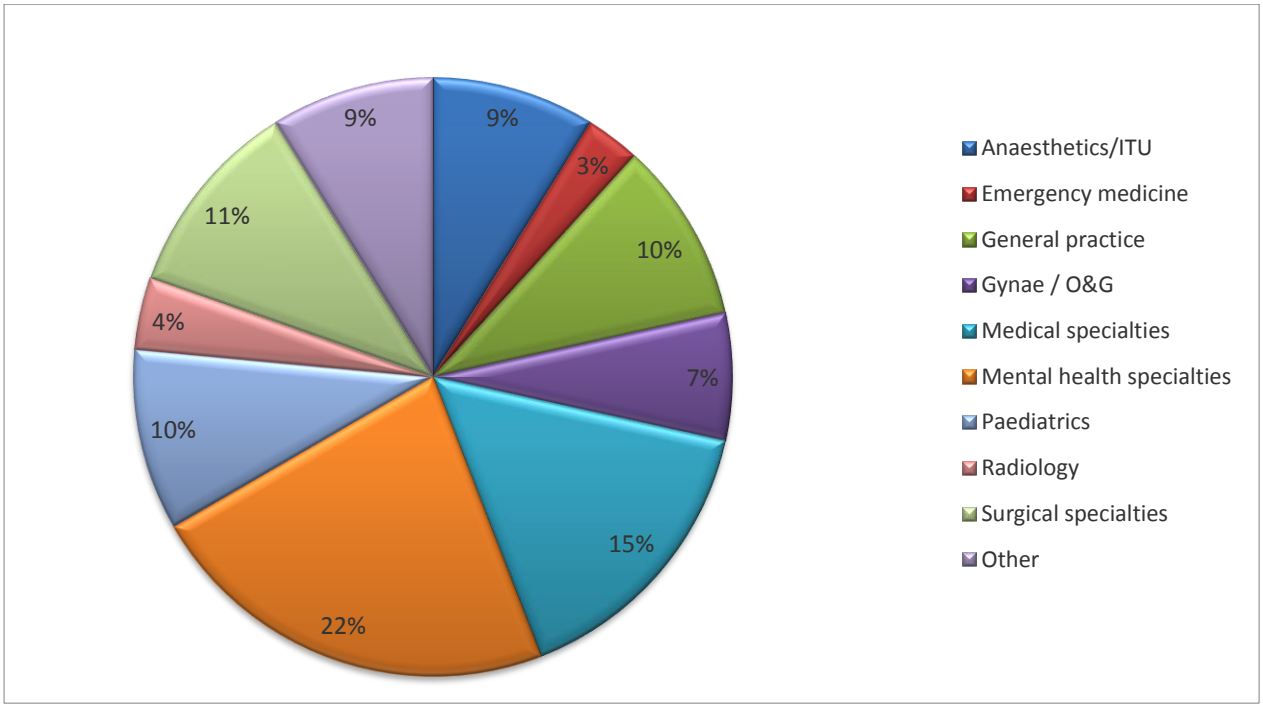
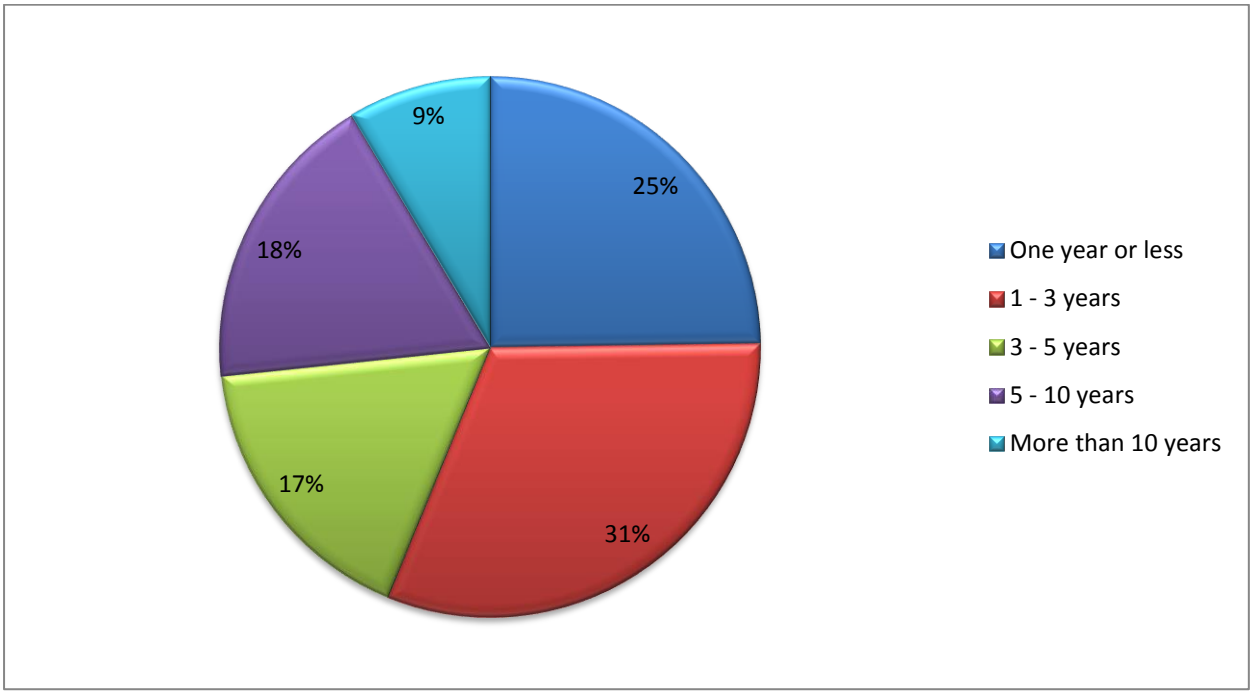


Figure 5: Length of tenure of the respondents



4. Roles and responsibilities

We asked medical directors to list the top 3 aspects of the typical medical director role, to help us determine the issues facing trusts and specifically the calls on medical director time. We used a grouping exercise to quantify and prioritise the aspects of the role most in demand. The table below ranks the top 10 aspects.

Table 3: Top aspects of the medical director role

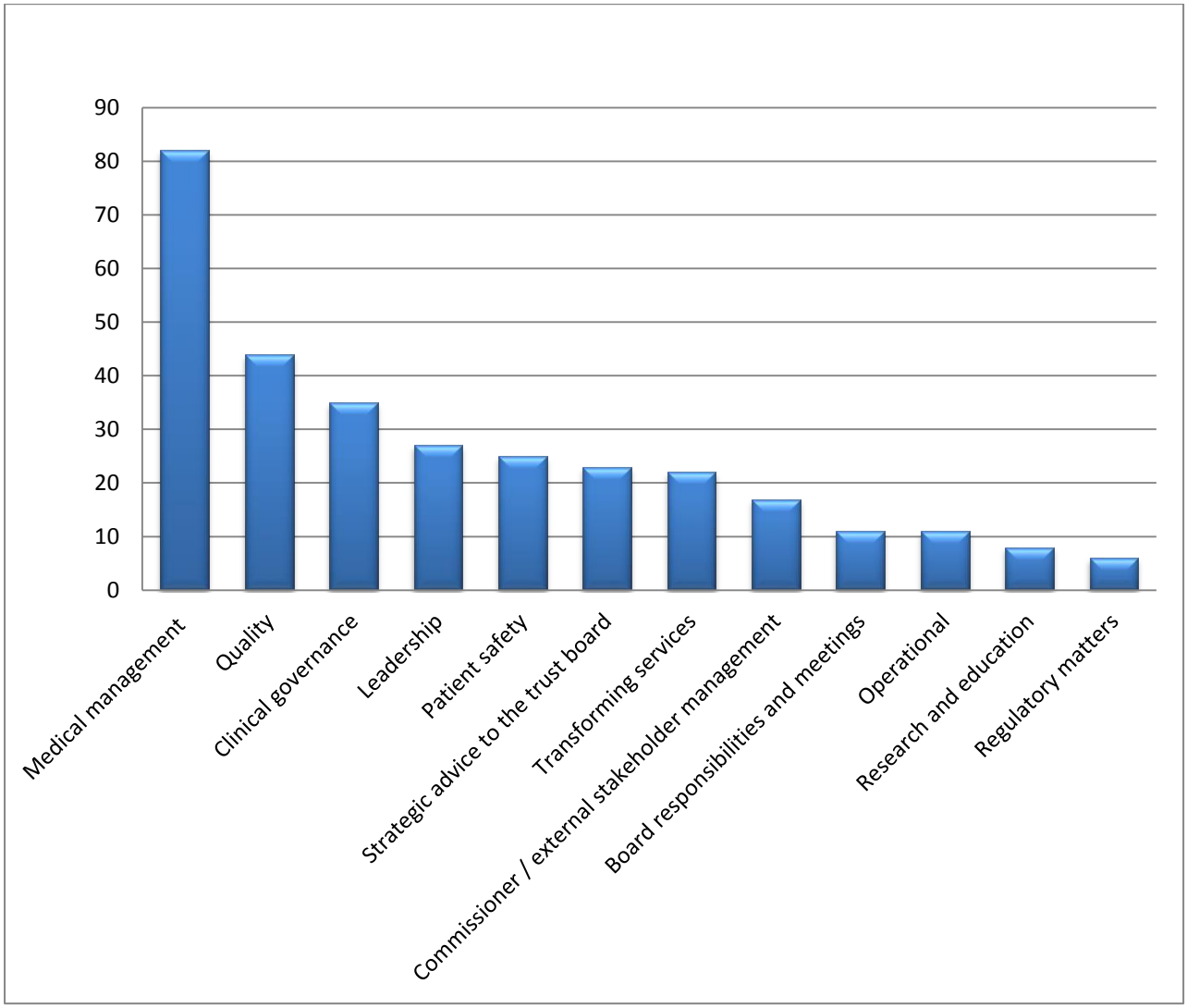
Rank	Aspect of the role most in demand	Number citing this aspect as the top priority
1	Quality	20
2	Medical management	19
3	Leadership	14
4	Patient safety and experience	12
5	Strategy	11
6	Clinical governance	10
7	Board responsibilities/meetings	5
8	Commissioner/external stakeholder management	4
9	Regulatory matters	3
10	Transforming services (redesign/reconfiguration)	2

Many of these issues are clearly linked, and not as ‘neat’ as the categories suggest. For example:

- **quality** includes quality improvement, quality assurance, quality and safety, clinical improvement
- **medical management** covers appraisal, revalidation, responsible officer work, dealing with concerns, performance management, recruitment and other workforce issues
- **leadership** covers clinical leadership, development of clinical leadership and cultural change.

The issues that featured most commonly across everyone’s list of ‘top 3s’ (by number of incidences) are outlined in the figure below.

Figure 6: Most commonly cited aspects of the medical director role



Other areas of the role that were not necessarily in everyone's top 3 but were significant included: work with neighbouring trusts, GP engagement, Caldicott Guardian responsibilities, medicines management, Academic Health Science Network/ Collaboration for Leadership in Applied Health Research and Care work, innovation and providing cover for vacant clinical director posts.

Specific extra responsibilities included:

- responsible officer (this was the most common extra responsibility with the majority reporting that they led on this, though a few did not)
- pharmacy lead/accountable officer for controlled drugs
- Caldicott Guardian/information governance lead
- lead for clinical coding
- chair of the clinical procurement group

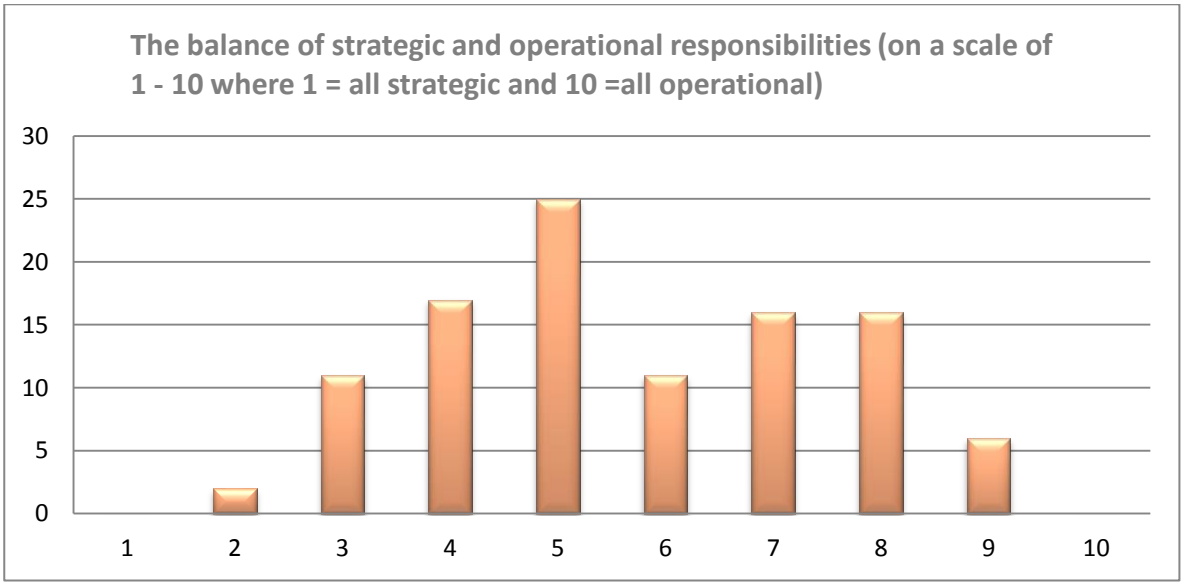
- transformation programme lead
- executive director for research and development
- infection prevention and control
- lead for electronic clinical record implementation.

The strategic medical director, their leadership team and the board

In the discussions held in scoping this work, medical directors mentioned that boards, and non executive directors (NEDs) in particular (especially when new to the role), could view the medical director role as primarily operational and a link with the consultant body. This potentially undervalues their strategic contribution, though when the NED/medical director relationship works well it is felt to be a valuable partnership.

We asked where medical directors felt the balance of their responsibilities was on the strategic-operational spectrum. The results are outlined in the figure below.

Figure 7: Balance of strategic and operational responsibilities in the medical director role



The average balance of strategic-operational was 5.9 in favour of the operational, though most appear to have a noteworthy strategic component to their role.

We asked medical directors about the leadership team under the MD role but there was considerable variation in the clinical structures, titles and role descriptions, so comparison is difficult. Some (3) reported no support; some (15) reported no deputy, assistant or associates, going straight to clinical directors/leads; while some (2) were being revised/developed. Sample configurations include:

- 3 deputies and 6 associates
- 4 associates and 10 clinical directors

- 1 deputy and 5 associates
- 3 associates and 10 clinical directors
- 1 deputy, 2 associates, 6 clinical directors and a director of medical education
- 2 deputies, 2 associates, director of medical education, 6 divisional leads
- 3 divisional medical directors on the board (non-voting), 22 clinical/education directors, including one for responsible officer duties, quality and service line management
- 3 half-time deputies, no medical divisional leads, 25 clinical directors, 60 clinical leads.

The supporting team were often given one or two programmed activities (PAs) to reflect their responsibilities rather than being full-time roles.

The portfolios of associates and deputies often included:

We asked what direct support there was for the medical director – for example, administrative support, a business manager, 'backfill'[1] support (either clinical or managerial), or any other resources.

All respondents had a personal or executive assistant, of varying time commitments. Most were whole time; others had an assistant shared with another executive director.

24 had a business manager, normally in the 8A – 8D pay band

[1] Backfill is use of colleagues' time to compensate clinically for time spent on medical director duties or vice versa.

There was no clear picture of how backfill worked, but respondents commented:

- “Good colleagues cover when I am not available, both managerially, and I have to cancel my clinical work if away”
- “Clinical backfill for vacated sessions”
- “I relinquished most of my clinical sessions 20 months ago to allow the appointment of a new consultant”
- “One of the associate medical directors backfills managerially”
- “Not at present but clinical backfill being recruited”
- “One of the associate medical directors covers me when I am away. When I take annual leave he reduces his clinical activity to enable him to cover the role”
- “medical = deputy and clinical directors; clinical/managerial = director of nursing and heads of governance and audit”
- “not required”.

Other support included:

- directorate support
- administrator for revalidation
- governance unit
- human resource (HR) manager/medical staffing manager
- two senior managers, two junior managers
- shared support team with director of nursing.

Time commitment

We asked about the time commitment given to the medical director role in contracts.

Most medical directors working a programmed activities-based contract worked 10, 11 or 12 such activities, though there was one incidence each of 13, 14 and 15. Others had a part-time commitment.

Table 4: Allocation of programmed activities in medical director job plans for the medical director role

Min	Max	Mean	Mode	Median
4	11	7.7	8	8

Figure 8: Number of programmed activities for the medical director role

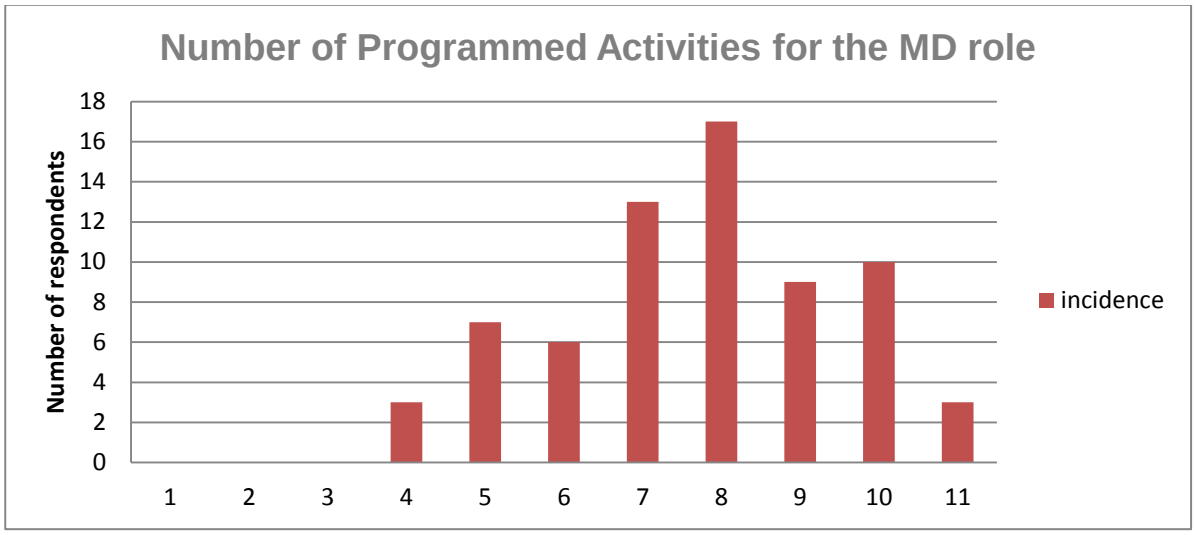


Table 5: Incidence of clinical programmed activities

We also asked whether medical directors had retained a clinical commitment; 78 responded that they had and 37 did on-call. Of the 72 who quantified their clinical commitment, the distribution was as outlined opposite.

Most medical directors (92%, n=97) had agreed objectives with the chief executive.

Clinical PAs	Incidence
1	7
2	23
3	7
4	11
5	13
6	6
7	2
8	1
9	1
10	1

Stepping up and adapting to a board role: differences and challenges

We asked about the biggest challenges for medical directors coming on to a board, and how this differed from earlier clinical management roles with no executive responsibilities. There was a vast range of responses: some who had held management roles in the past found it more challenging than they had expected; while others found it more straightforward. The main points are summarised in quotes below under some thematic headings:

Understanding how the board works and the breadth of individual and corporate responsibility:

- "Understanding board functions, business, governance and how decisions are made across the whole organisation – and the medical director role in that"
- "An executive director who is medically qualified, rather than a consultant physician who is the medical director"
- "Management as the main job, and changes in accountability – steep learning curve in legal and human resource issues"
- "Being the medical bottom line - having to give assurance"
- "Managing the board and non executive director dynamics - upwardly managing non executive directors"
- "Being the constant on a transitory board"
- "No training as a director!"

Strategy and finance:

- "Challenge is moving from operations to strategy – much more concerned with operational delivery in previous roles compared to this one"
- "But, all too easily drawn in to the operational too, especially on medical performance and human resources – It felt like I had to have all the answers; I was pulled into a lot of operational issues"
- "Need to maintain a strategic view and have far more strategy and financial awareness – the main challenge was the financial reporting rules, which even as a clinical director are not something one needs to worry about".

Relationships with the general body of clinicians:

- "Need to educate medical staff that the medical director is not their representative"
- "As clinical director you are usually in your area of expertise – as medical director you have to exercise judgement in areas where you are not expert; you need to gain the confidence of the board and the consultant body"
- "Hostility from medical staff"

- “Patient safety and quality not for compromise – I have completely changed medical culture and medical leadership and have now got [an amazing medical team]”.

Volume of work and time management:

- “The job is huge and endless – the balancing of clinical and executive responsibilities, meetings and a home life is difficult – we never see the medical director”…
- “Public expectations on quality and safety are now massive”
- “24/7 responsibility, so maintaining a clinical commitment is difficult – I had to cease clinical practice which was a huge step psychologically”
- “A wide range of responsibilities with no set team – particularly in a community trust”
- “Responding to external bodies – national and regional regulators and commissioners, overview and scrutiny committee, LA [local authority] committees”
- “The sheer number of meetings”.

Resilience:

- “The stress of the job and working with new local organisations”
- “I had senior positions in a range of organisations but nothing compares with this”
- “External scrutiny”
- “Can be lonely”
- “Left quite isolated from peers, who are normally a strength/support. Who can you turn to for support as medical director? I will be in the Trust for many years to come and will still have to work with my clinical colleagues who are impacted by every decision I make, come what may, whereas my Director colleagues will move on. What is the exit strategy?”

The environment of the last 12 months is completely different from that at the time of my appointment. Over the last year I have had to deal with the winter pressures of 2012/13, the impact of the introduction of NHS 111, the fallout from Francis with the emphasis on developing openness, transparency and candour, dealing with the process of a Keogh review and its consequent actions. The big difference is the scale and breadth of responsibility with inadequate support at the outset. I now have a team of clinical leaders in the organisation who will continue the work when I retire.

Board dynamics

Where medical directors had held the role in more than one trust, we were keen to know the differences in style, and what characteristics they thought best supported success in the role. Capturing these observations gives us valuable general lessons for other medical directors and for developing well led boards. Three main themes emerged and are outlined below.

The role of the chair and chief executive

Medical directors felt that a clear strategic vision and strong leadership from the chief executive made a huge difference alongside commitment to clinical engagement with leadership in the organisation. Many of them also cited the style, personality and ambition of the chair and chief executive.

The role of non executive directors

When done well, medical directors saw the role of non executive director as very important in the development and high performance of the medical director contributing:

- constructive challenge
- supportive culture (without being collusive or undermining the holding of executives to account)
- acting as a critical friend
- trust and confidence
- rating medical expertise
- Not ‘them and us’.

Common ambition

Medical directors valued a board that supported:

- team working
- openness and honesty
- a focus on quality, patient care, clinical information and data
- stability
- being reflective and learning
- a unified vision.

Succession planning

Given the importance of the role and its raised profile, we were keen to know about trusts' plans to identify and develop potential future medical directors, to inform what might be done nationally alongside the local.

Starting out

35 respondents had no plans, or were in the early stages of planning how to go about identifying and developing successors. Responses included:

- "Unfunded (but worked up plans)"
- "None, despite my best efforts!"
- "I'm afraid that at the moment there are practically none. I was appointed to the MD role after 9 months as a clinical director [CD]. There is not much in the way of formal training for either the CD or MD role within this organisation and it is something I am passionate about and I am ensuring that a process of identifying and training of potential future leaders is developed here"
- "Emerging clinical leadership strategy with board support"
- "Restructuring to facilitate this".

Identifying the next generation

There were a range of approaches to identifying the next generation and often there was a multi-pronged approach. Common initiatives are outlined below with the number of people mentioning them in brackets:

- learning and development programmes for deputy, associates or clinical directors (42 mentions)
- using management structures/career pathways to develop capability (34)
- talent mapping (15)
- project experience (6)
- mentoring (2).

Responses included:

- “Leadership development and mentoring”
- “System of devolved project leads”
- “Deputies all on the NHS Leadership Academy leadership programme”
- “Development programmes for clinical leads”
- “Coaching and mentoring for senior medical managers”
- “Associate medical directors and clinical directors gaining experience”
- “Talent Review programme being run with HR department”
- “Bespoke medical leadership course for the trust”
- “Giving clinicians exposure to new roles and deputising responsibilities”
- “Active leadership faculty at the hospital”
- “Medical management structures are developmental”
- “Talent mapping and management based on appraisal”
- “Developing an in-house system for clinical engagement, leadership, training and succession”
- “Just created a new layer of medical leaders, sitting above the traditional clinical director (multi-specialty) roles”
- “We have a long established Trust Clinical Leadership Development programme - 14 years - and there are a range of capable and experienced clinical managers who could take on this role.”

Career trajectory – what comes after the medical director role?

The future attractiveness of MD roles needs greater clarity about what comes afterwards, assuming it doesn’t always tie in with the last few years before retirement – this was frequently flagged up in the survey. A range of opportunities/responses were mentioned but they are mostly ideas to explore rather than concrete plans. The number of mentions is listed in brackets:

- retirement (25 mentions)
- too early/unclear/no plans (19)
- chief executive (10)
- regional or national role (10)
- return to clinical consultant practice (3)

- medical director at another (bigger) trust, then chief executive
- medical director outside UK or NHS
- Health Education England role
- unclear what comes next if not in position to retire
- teaching and training
- Care Quality Commission inspections
- director in a charity
- non executive director in medical technology firm, industry, or education and training
- (undetermined) wider professional role
- management consultancy
- National Clinical Advisory Service or General Medical Council role.

5. Motivations, challenges and making the role more attractive

We asked ‘what made you want to be a medical director?’ and received a range of multiple reasons. Common responses are outlined below with the number of mentions in brackets:

- making improvements to services and patient care on a larger scale (42)
- engaging with trust strategy, management and clinical leadership – committed to the organisation (37)
- challenge, learning, professional development (22)
- approached by colleagues/chief executive (10).

> I gradually became more involved in medical management over a decade or so and really enjoyed the wider, strategic thinking, problem solving and networking. It provided me with an intellectual stimulation which clinical work, unfortunately, no longer did. Becoming an MD was an evolutionary process; it was not something I set out to do.

A selection of motivations giving a richer picture than the thematic headlines, were:

- “Influence the trust strategy”
- “Started as interim”
- “Trusts need doctors to be involved in management”
- “To lead change and culture change”
- “More responsibility”
- “The poor job done by my predecessor”
- “Intellectual stimulation from strategic discussions and a personal belief that well managed organisations bring out the best in clinicians”
- “To build a learning organisation”
- “Natural progression”
- “To ensure clinical leadership of management decisions”
- “Bridging obvious gap between clinical and business/management in the NHS”
- “The challenge of influencing whole health economies”
- “Sense of duty”
- “Financial reward”
- “To develop the next generation of clinical leaders”
- “To influence service development and design”.

A burning ambition to take on the role and responsibilities. It seemed the logical step towards the end of my clinical, educational and managerial career. It has proved most challenging and stimulating and is the best thing I have done. It has been a suitable climax to my professional life. I have learnt more about myself in the last 6 months than during any similar period in the past. It has been rewarding to see changes in the culture of the whole organisation with a marked improvement in the quality of care provided by employees of the Trust.

A common narrative emerged around the **potential barriers** to taking on medical director roles:

- giving up clinical work, clinical de-skilling, the exit strategy and difficulty of returning to clinical practice
- the effect on relationships with peers, sometimes irreversibly, and general reputational risk, professional isolation and insecurity
- lack of recognition for the time and effort given to the role – often under-resourced with unrealistic demands and expectations
- giving up private practice or work for the commercial sector (which is much better remunerated)
- perceived to have less respect and support than academic roles such as professor, or work for the Colleges and specialty associations
- lack of development and career structure – why do it early in a career?

Other issues included:

- potentially limited and boring portfolio
- some prefer operational roles to strategic/management work
- lack of interest from the board
- an enormous challenge with internal/external stakeholders unwilling to consider the necessary service changes
- less defined management pathway than professions such as nursing
- lack of role models.

There was a reasonable consensus on what might make the role more attractive. Some areas are outlined below with the number of mentions in brackets:

- supportive **organisational structures**, board and medical leadership team (including clinical backfill support), HR and administration (34)
- **improved training and career structure**, exit strategy, exposure to management early on

I think there are two things [to make the role more attractive]. One is the appeal as perceived from an external perspective, and that is about communicating what one does and the system within which one does it. Secondly, it is in the role itself, and for me it has become more attractive as the board's expectations have changed over time from a culture of command and control where I was frequently asked for assurance on local issues which I felt needed to be influenced by local clinicians before coming to board; to a place now where we are working toward a more devolved autonomy for services. This allows for more strategy within board meetings, and makes my role less a policing role.

(medical student onwards) and dedicated qualifications and college support (31)

- peer support and better understanding of the role in the wider medical profession (7)
- time to do the job well (7)
- improved pay and reward (7)
- a more defined role (6) and role models (3)
- more job security on a par with clinical work – possibly time-limited appointments
- reductions in bureaucracy
- training in corporate processes.

6. Learning and development

Support provided to date

We asked "What learning programmes have you done and what would you recommend?"

Table 6: Most popular learning programmes

Rank	Freq	Course provider / programme / qualification
1	24	King's Fund Programmes including: i) Action learning set ii) Medical director programme iii) Senior clinical leaders iv) Workshop in Seattle
2	13	British Association of Medical Management and Faculty of Medical Leadership and Management (FMLM)
3	13	NHS Leadership Academy Top Leaders
4	10	Regional Leadership Academy
5	10	Action Learning Sets
6	8	Masters / Master of Business Administration (MBA) including: i) Open University ii) Manchester

A wide and diverse range of other learning programmes were also mentioned:

Ashridge Leadership Development Programme
Aspiring Chief Executive programme
Aspiring Directors programme
Board development with personal profiling
Caldicott training
CASS Exec Directors Devt Programme
CEO Leadership Development Course (Windsor)
Executive Coaching
Faculty of Medical Leadership and Management
Foundation Trust Network
Good Governance Institute
Harvard
Hay Top Leaders Programme
Health Foundation Generation Q
Health Foundation Leadership Fellows
Healthcare Finance Managers Association training
Institute for Health Improvement
internal trust leadership programme
international visits - e.g. Jonkoping
Kaiser Permanente new chiefs orientation
Leadership (Bradford)
Leadership (Keele) - advanced medical leadership
McKinsey/Monitor SLM programme
MD network
Mentor
Monitor
National Clinical Advisory Service
Next Generation CE Programme
NHS Elect
NHS England
NHS London Aspiring CEO programme
NHS mentorship scheme
peer group of MDs
PGD in medical admin
private mentoring/PDP
Regional leadership development programme
Regional MD network
Res consortium
Responsible Officer training
Secondment in DH
SHA programmes
UCLP Staff College
Warwick MD programme
whole board development with AQUA
work with industry execs
York University management course for new doctors

The programmes most often recommended, in order of frequency, were: Kings Fund, action learning sets, coaching, networks, mentor and MBA.

We asked what life experience best prepared people for medical director roles. Common and/or interesting responses included:-

- family, child and caring responsibilities (several)
- experiences as emergency consultants, psychotherapists and GPs (several)
- leadership training for the army (1)
- governor of a charity (1)
- board director of a premier league football club (1)
- academic careers (1).

Being told by the mother of a 9-year-old child in a karate class that I was helping in that I was "11 out of 10" when his mother asked him how it went. Apparently he never gives anything more than 8. Taught me the importance of feedback; positive spirit; that critics do not have to be your peers or seniors; that experience of the end user does not depend on your rank but on 'human factors'; that we all have a life outside of work; that we can all be good at something if we are helped to find this.

Patrol leader in the Boy Scouts - and I really mean that... Experience in the organisation, motivation and direction of a bunch of rowdy 11 to 15 year olds on 8-mile walks in the Lake District in the rain was just what was needed to manage stroppy consultants who all think they know what is best for everyone else...

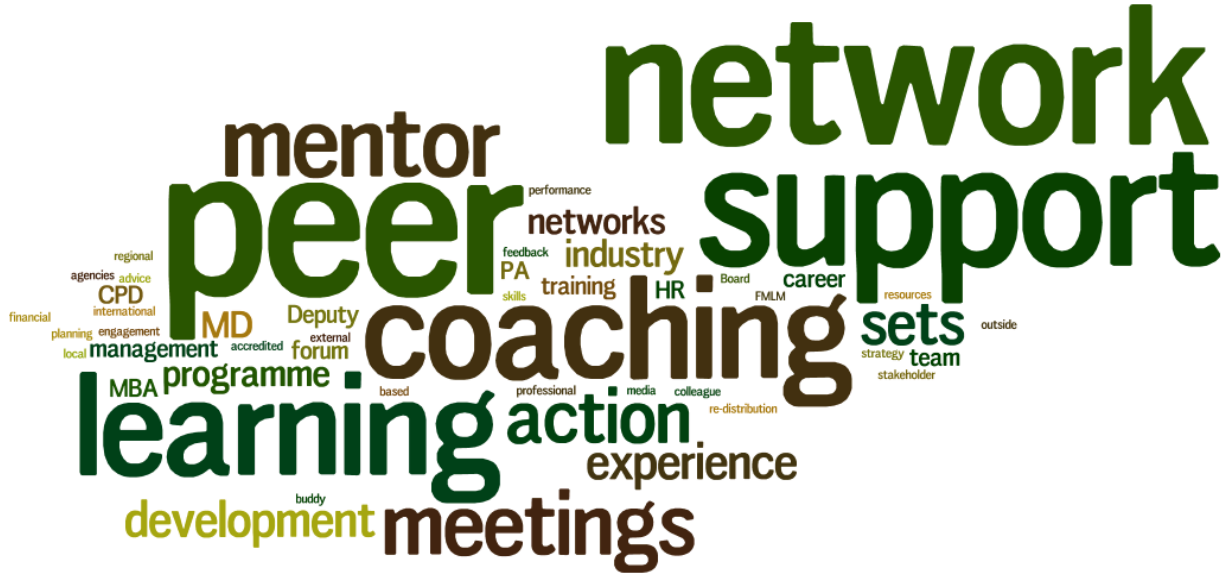
We asked what additional support or resources would be useful for in-post medical directors – both newly appointed and experienced.

Newly appointed medical directors expressed overwhelming support for mentoring and coaching, delivered by experienced medical directors or externally. Others highlighted the importance of induction, buddying and having clarity about the role and the expectations of the job. Networking and formal/informal development programmes also commonly featured.

They mentioned:

- “Formal but personalised development programme”
- “Structured development particularly in governance, finance and planning”
- “Mentor. And a generous induction period”
- “Senior, non organisational mentor”
- “Support from experienced MD”
- “To insist on knowing the scope/clarity of their role and the expectation”
- “Very structured mentoring and shadowing in another trust”
- “Appropriate admin support. Clearly defined roles for AMDs”
- “Support to deal with difficult senior medical colleagues”.

More established medical directors focused on support from the board, chief executive and medical team; experience in other industries; action learning sets; peer networks and coaching; and career planning.



They mentioned:

- “Coaching and learning sets, top up personal development”
- “A supportive executive and a supportive MD team”
- “A deputy to share the work”
- “MD network (which we do have in my region) and development through those meetings”
- “Update program with accredited training resources”
- “Network opportunities including online events”.

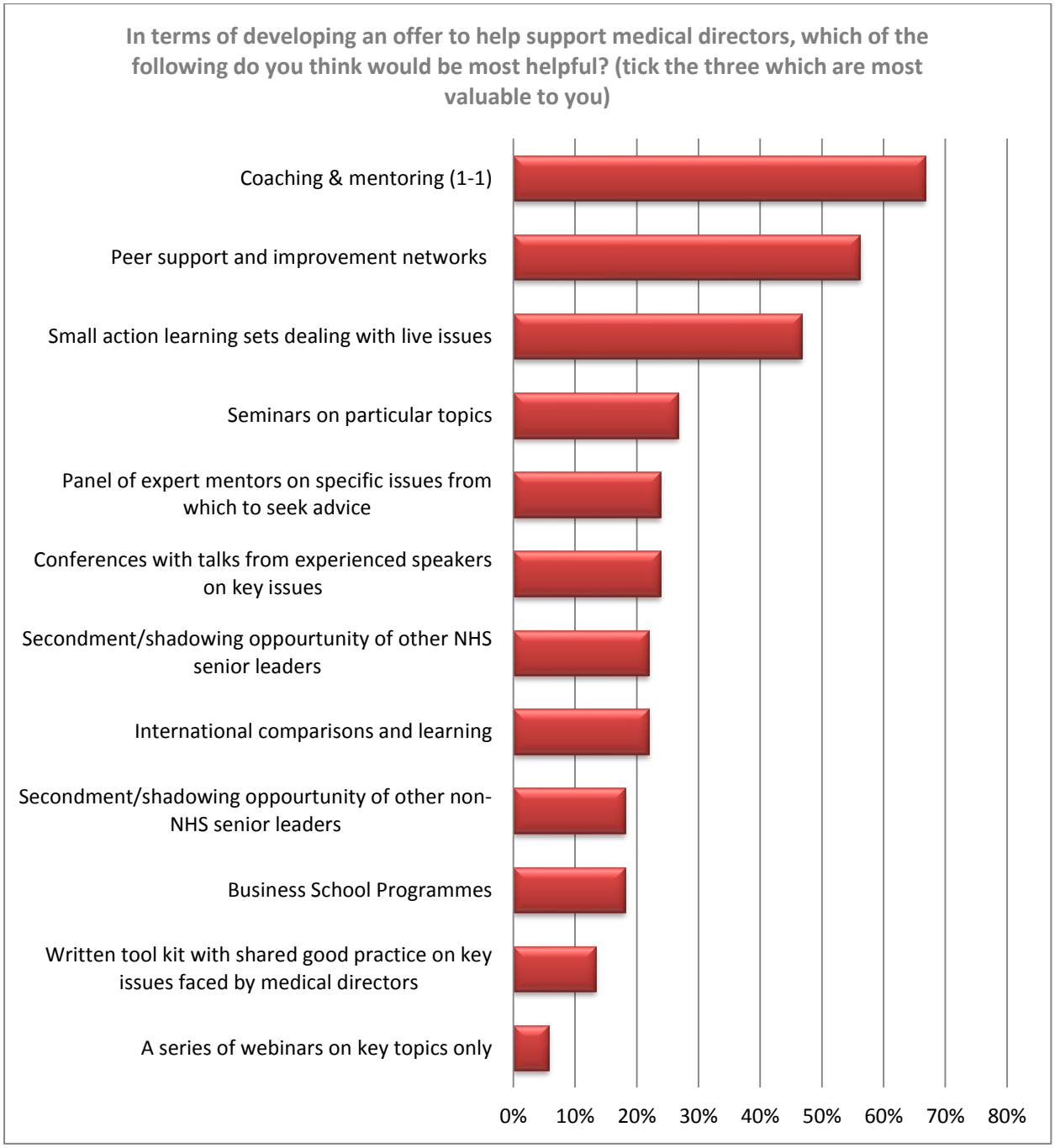
Peer support and system networking

We asked about links with other medical directors (eg bi-laterals) and which forums were most useful and why. Responses ranged from those with no network, through those who lamented the demise of earlier regional networks, those who had healthy engagement through active regional networks, bi-laterals monthly or every 2-3 months, a mental health medical directors group, responsible officer networks and mention of the UCL Partners MD Forum and FMLM.

Preferred learning, support and development approaches for the future

We offered a list of options that might be useful in delivery of support and asked respondents to select 3. This table reflects the most popular in order of priority.

Figure 9: Popular approaches to support



Current concerns

We asked what concerns medical directors had that they might particularly like to share with experts and peers. Again, respondents could choose 3 issues.

Figure 10: Sharing learning with experts and peers

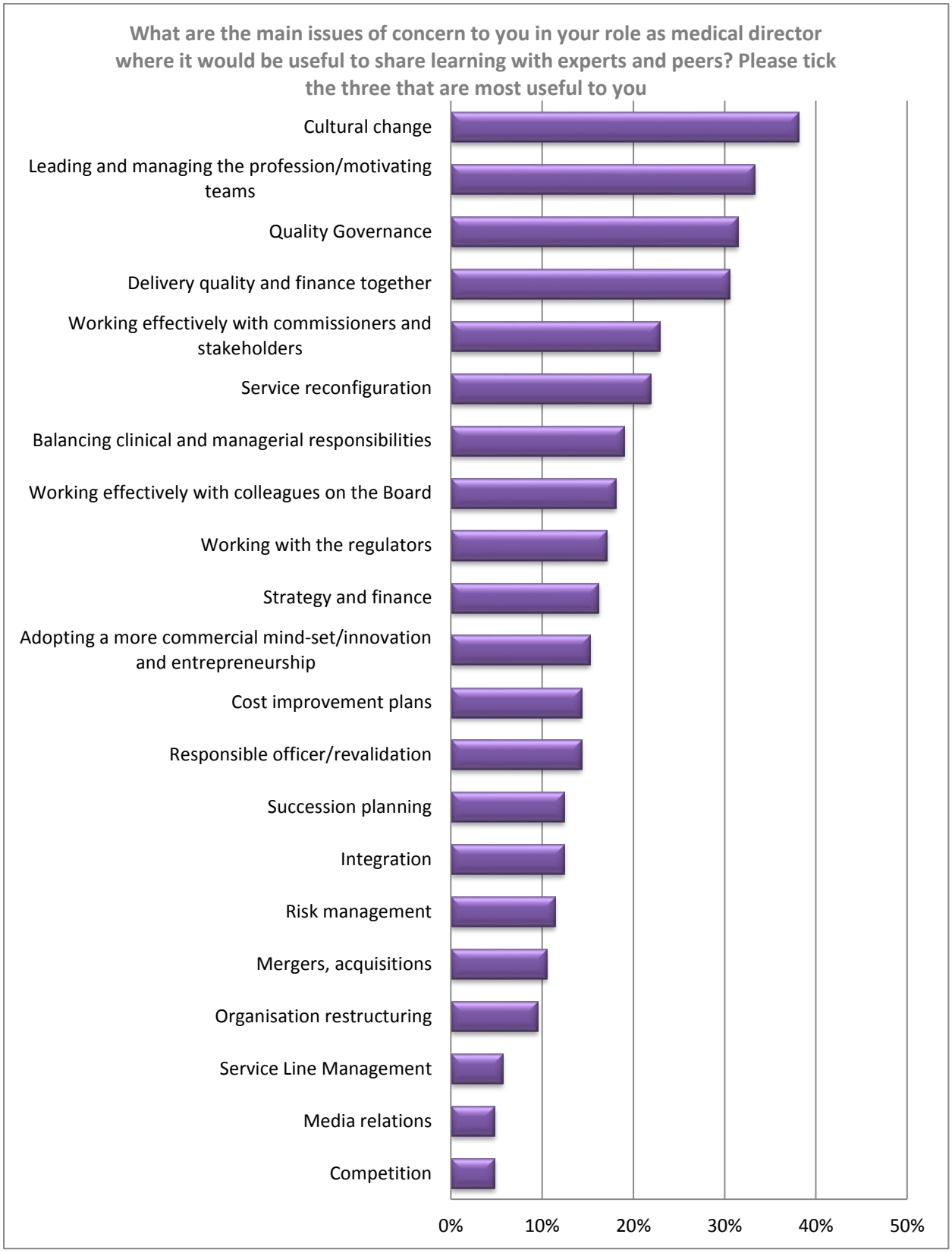
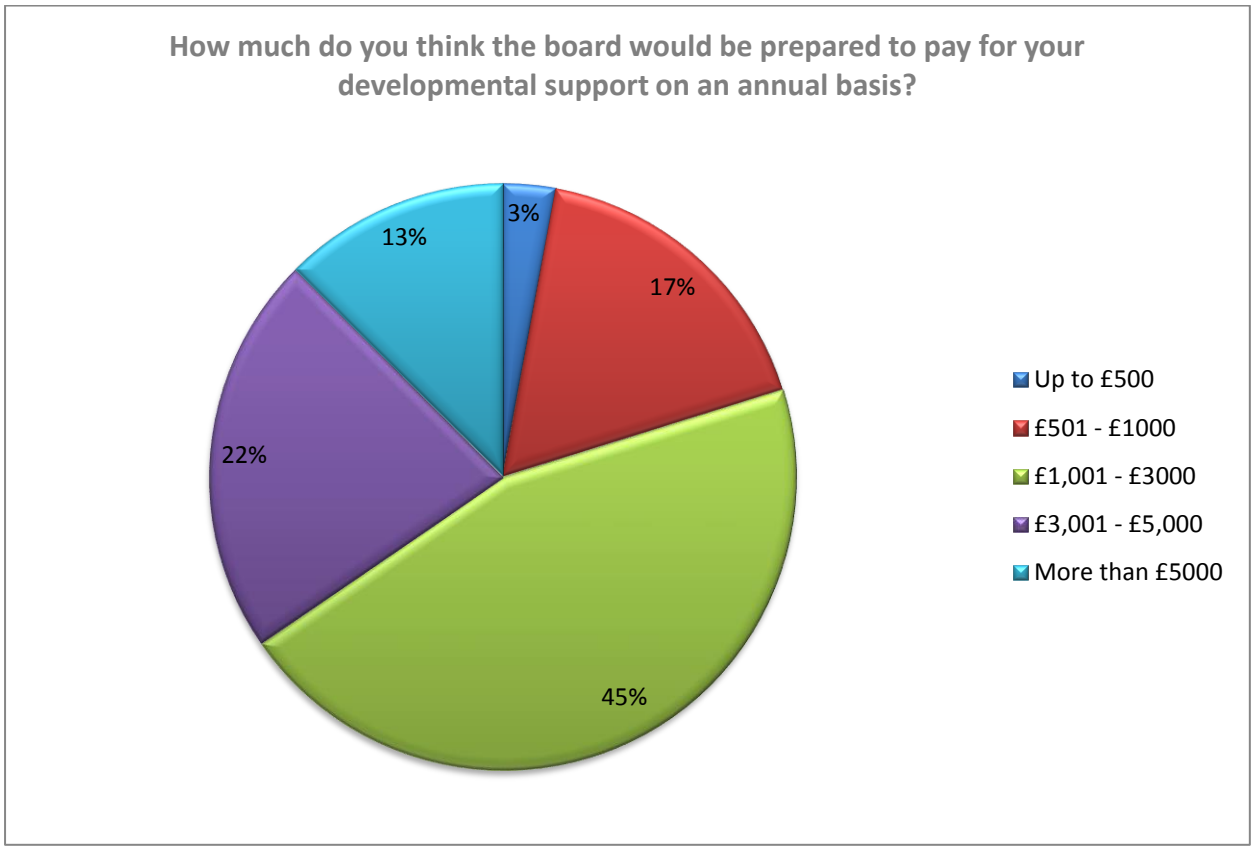


Figure 11: Likely board annual spend on medical director learning and development



7. General observations on the role of medical director in 2014

There are frustrations with the role but several reasons why it is still seen as worthwhile.

It is essential

- “A vital role. Unique and challenging. No one else commands the same respect or authority with medical colleagues and maybe even other senior clinicians.”
- “The MD role will gain more importance in the years ahead and those entering these roles will need increasing support and development as the role continues to change. The one important quality required of an MD is to be able to adapt to change.”
- “This is critical to delivery of revamped, effective and responsive healthcare.”
- “An essential role at board level.”
- “It’s a massive role that continues to grow and the importance of leading medical culture is undervalued.”

It is enjoyable

- “It's hard; it’s challenging; it's very exciting. It's the best job I have ever had.”
- “Thank you for taking the time to ask - these roles can be very stressful and people need to acknowledge this - they can equally be exciting, satisfying and make a real difference to patients and staff.”
- “Really fulfilling role, but need resilience and a positive mind set!”
- “Fantastic job!”
- “Every day has been different, challenging and rewarding. Best job I've done (most of the time) and worst (some of the time).”
- “10 years on, I have really enjoyed my job. Really hard at first but certainly the last 2 years have been great with an opportunity to see the results of changes which I led.”

It is varied and demanding

- “The number of roles and responsibilities continues to grow and the range of external bodies with whom a relationship should be maintained is becoming increasingly complex. Maintaining clinical skills and credibility is important but risks compromise in the present environment.”
- “The role will not suit everybody and is challenging - the people who apply are self selected and should above all be resilient - they do need ‘safe friends’ to be able to contact and discuss issues with as it can be a very lonely place at times. The support of the executive team and board are critical to being able to sustain the considerable burden of responsibility that goes with the territory.”
- “It needs to be better defined and made more attractive and appear less of a career risk. It is also seen as a pre-retirement role but if you are young, the post MD role is very murky.”
- “The posts are very different in different organisations with a limited and basic set of responsibilities but much broader for experienced MDs whose portfolios develop around their skill set. Help for the next steps is necessary.”
- “The role is many and varied, and probably reflects individuals and the needs of the trusts. I think more thought should be given by trusts as to what they want from the MD, as it would be a pity if the unique skills are not used to their maximum and in my view should be focused on quality/safety/clinical leadership, etc.”

Messages for future medical directors and the wider NHS

- “I believe that boards and chief execs need to view their MDs as being at the centre of their organisations rather than a bolt-on provider to the board. In the same way that previously financial targets were the measure of success, the reality now is that quality and patient safety should be the motivator for change. The medical director should be the engineer of that change, and help in facilitating them in that role is essential.”

- “I would always recommend taking this role in another trust rather than carrying baggage. You bring a lot of different ideas and ways of doing things which establish your reputation.”

- The relationship between the MD and the Chief Nurse and HR Director is crucial and multi-professional development may be helpful.”

- “Useful supports have been NCAS and the recently appointed GMC relationship manager which has been incredibly useful and supportive in these difficult HR areas.”

- “The post is highly stressful and many clinicians ill prepared for it. A business manager support as well as deputies, induction and coaching would be useful.”

- “It is a difficult role for which medical training does not adequately prepare one. A good supportive personal assistant with lots of discretion is vitally important.”

- “For me it wasn't until I was in the post that I realised quite how demanding a role it is and how totally unprepared for it I was. I think if all doctors had some training in medical management from an early stage in their careers, then they would hopefully have a better appreciation of the demands that the MD role has. I am certain that I want to maintain a clinical role since I think it is necessary to maintain credibility with my clinical colleagues, but it is very difficult to balance the demands of the MD and clinical consultant role.”

- “Medical directors of ambulance services face some different challenges to other organisations. Currently one of these is a dearth of suitably qualified or experienced candidates. Most of my colleagues are part time and therefore have more limited opportunities for networking or providing mutual support.”

- “I still think the majority of MDs do it because they have a genuine desire to ‘give something back’ to their organisation or they relish the challenge. Only a few see it as a career move planned over many years, and as such, in the majority of cases returning to being ‘just a consultant’ after completing the role can (and possibly will) be difficult.”

- “Need to combine the unique approach of an experienced clinician with outstanding leadership and managerial skills. Important to define career pathway and role for ex-medical directors.”

Monitor

Making the health sector work for patients

Contact us

Monitor, Wellington House,
133-155 Waterloo Road,
London, SE1 8UG

Telephone: 020 3747 0000
Email: enquiries@monitor.gov.uk
Website: www.monitor.gov.uk

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