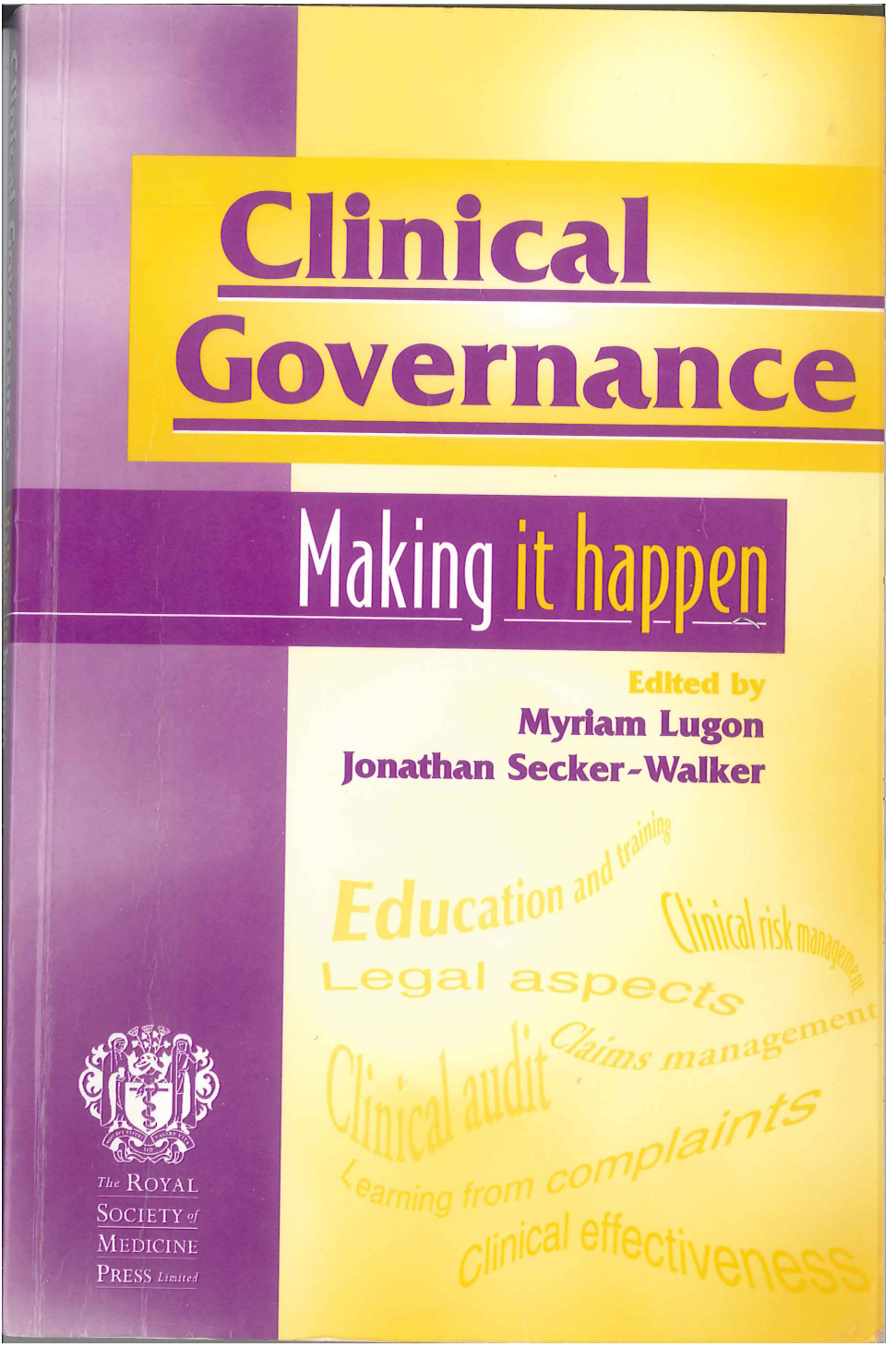
Clinical Governance
Making it happen
Edited by
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Education and training
Clinical risk management
Legal aspects
Claims management
Clinical audit
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Manager and if appropriate a separate Claims Manager; these individuals including the lead Director, should be equipped with the relevant skills and should have an understanding of the legal process. These managers will work closely with clinical teams and act as facilitators within those teams so that lessons are learnt from mistakes. To this end, these managers will need to have access to an appropriate IT system helping in the overall management of claims and clinical risk.

In order to manage claims effectively, the organisation must have a sound clinical risk management policy and procedure[7] highlighting roles and responsibilities of all staff from the Chief Executive to the grass root; this should be used as a framework to ensure translation into specialty-specific procedures. These procedures will need to be in place for all high-risk specialties, though over time these must cover comprehensively all clinical activities.

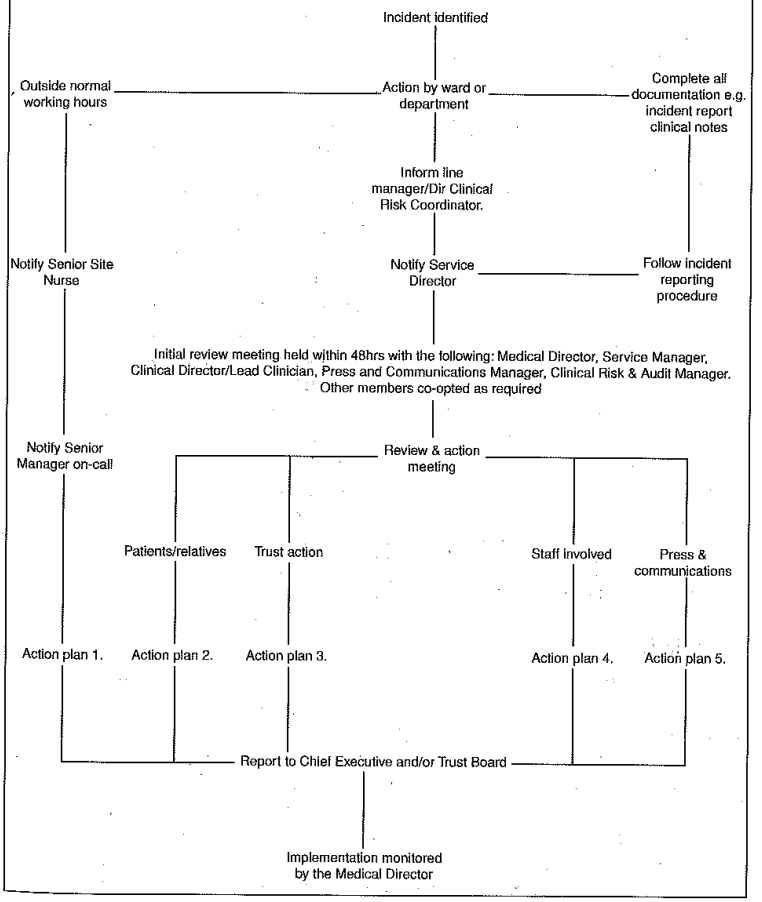
Each specialty needs to identify an individual taking responsibility for monitoring the implementation of the procedure and who will ensure that untoward events, incidents and near misses are reported speedily, investigated and action taken if appropriate. This individual should have a clear line of accountability and be appropriately trained. Close working relationship with all members of the clinical team, the Trust Clinical Risk Manager and/or the Claims Manager if they are different individuals, must be developed; clear line of communication will also need to be established to ensure advice is readily available. This approach rigorously implemented will allow the identification of potential claims at an early stage.

Serious clinical incidents

At times serious clinical incidents may occur; these would include any event resulting in, or with the potential to develop into, serious damage/injury or death of a patient, as an unexpected consequence of clinical care; death or serious injury where foul play is suspected; a number of unexpected/unexplained deaths; a suspicion of a serious error or errors by a member of staff which would give rise to public or professional concerns. This list, however, is by no means exhaustive. Here is a practical example: the diagnosis of acute pancreatitis in a young man in the accident and emergency is missed, the patient is discharged and dies. Such serious clinical incidents often attract media attention. It is therefore important that action is taken early and relatives/patients seen by a senior manager. These should not be left to the common sense of the manager present at the time but enshrined in a clear and explicit process, a serious clinical incident procedure. The procedure should include flow charts defining the role of the staff involved and the action to be taken whatever time of the day or night it is. Box 8.1 describes the process in outline. These incidents are likely to result in relatives seeking compensation from the Trust.

Serious clinical incidents and potential claims identified through the adverse event reporting system must be investigated early when the events surrounding the incidents are still fresh in the mind of the staff involved; and the sequence of events clearly remembered. The Claims Manager will need to be notified immediately so that a copy of the documentation can be secured and a file created identifying the patient's administrative details, the list of staff involved, a chronological summary of the clinical events, worksheets and relevant legal information.[8] Staff must be interviewed and statements

Box 8.1. Serious clinical incident process



taken; in case of potential litigation this is best done by the Claims Manager. It is important that they are made aware of the potential for litigation even though the Trust may not have received a letter before action and may not receive one for many months. Up to now statements taken on behalf of legal advisers, are considered privileged information,[9] providing their purpose is to inform solicitors about the case with potential litigation. This may be challenged and in the event, the information gathered will have to be disclosed. Statements must therefore consist of factual information only. The

actions of the organisation must be transparent and if negligence is identified during the investigation, this should not be hidden as it will serve no purpose and undoubtedly these facts will come to light during the legal process.

The Claims Manager

Claims must be processed speedily and records of progress monitored and logged. The Claim file as mentioned earlier must be kept up to date and relevant clinical staff kept informed of the different stages the claim is at. This must be the responsibility of the Claims Manager.

The Claims Manager has therefore a pivotal role to play; liaising with the relevant clinical team, the Medical Director, the solicitors, the NHSLA and CNST as appropriate. In England, the majority of trusts have become members of the Clinical Negligence Scheme for Trust, created specifically to protect the Trust against the effect of large claims;[10] this will be discussed in more detail later in this chapter. When joining the scheme, trusts choose their excess and are therefore responsible for the payment in full of claims below the excess. It is therefore beneficial to the organisation if the Claims Manager is able to advise on the organisation's liability and the settlement of small claims in terms of quantum and process; thus ensuring that where negligence and trust liability is established, a quick settlement is achieved to minimise legal costs.

Indeed it is not uncommon for quantum of £5000 to be accompanied by a bill for legal fees of >£25,000; this disparity between costs and damages in medical negligence cases has been highlighted in the Woolf report.[11] A practical guide advising claims managers on the legal process and on good practice for claims management has already been published,[12] the reader should therefore refer to these sources for details that are beyond the scope of this chapter.

Using in house clinical expertise

When claims are being made or when potential claims are identified, it is helpful to have an early view on the appropriateness to settle or defend the claims. In some instances, the decision to settle is easy. Here is such an example: a youngish man undergoes a cataract extraction with lens implant; a month later he develops pain and blurred vision in the eye and presents himself to the A&E Department on a Saturday night and is seen by the on call SHO in ophthalmology; he is examined and referred to the ophthalmic clinic the following Monday; by the Monday morning the wound has broken down and the eye is frankly infected; it is the plaintiff's case that he should have been referred to the specialist hospital on the Saturday. In such cases liability and causation are clear; the costs and damages in such a case could reach £60,000 which could exceed the limit the hospital has agreed with the CNST; the case would therefore need to be referred to the CNST and approval to proceed sought. In many cases, the decision to settle is not so clear cut; expert advice is therefore required.

The Trust has through the staff it employs, access to extensive specialist advice which needs to be harnessed as a cost-effective way of getting expert opinion. By setting up an Incidents and Claims Review Committee (ICRC),[13] the Trust will create a mechanism for taking an early view of the degree to which a plaintiff is correct or

incorrect in the assertion of sub-optimal standard of care. Claims will fall into three main categories; those where the standard of care fell short of what is considered acceptable, those where care was of the highest standard and those where there is some degree of uncertainty as to the quality of care delivered.

The ICRC will deal specifically with cases where there is uncertainty about the quality of care and the defensibility of the claims thus providing support to the Trust's lawyers; it will also assist in the Trust's risk management programme in assessing the quality of care provided to patients and making recommendations for changes in clinical or organisational practice. Such a committee needs to be chaired by the Medical Director and consists of senior clinicians respected by their colleagues for their experience and impartiality. Other members should include the Director of Nursing, the Trust Solicitor, the Claims Manager or Legal Affairs Managers and should be serviced by the Clinical Risk Manager. The presence of the Trust's solicitor on the committee is extremely beneficial; it gives him/her the opportunity to gain valuable information on the clinical claims under consideration but also develop the legal knowledge of the clinicians on the committee. The Committee's role is:

1. To review all cases where disclosure of notes has been sought by a plaintiff, particularly difficult cases.
2. To review all cases where the Clinical Risk Management process has identified the potential for litigation.
3. To monitor progress of litigation underway.
4. To make recommendations where changes in practice are required.

The Clinical Risk Manager and Claims Manager meet with the Medical Director to decide on the claims to be considered by the committee. A couple of relevant clinicians are asked to review the appropriate case in depth and present their views at the meeting. The clinicians charged to undertake the review would receive a comprehensive set of information, the other members a summary of the case only. It may be appropriate for the legal adviser to receive more comprehensive information. Each case will be debated in detail before a decision is made.

The decision agreed by the committee will depend on the type of cases presented to them. In circumstances where standards of care are deemed to be poor, consent to an early settlement will be given; the reasons behind the decision must be explicit. The committee should also make explicit recommendations for the changes required in the care process to avoid repetition of the event. In other circumstances, the committee may not be able to reach a decision but requires further information or an external expert opinion. Finally the committee may agree that the care given was of the highest standard and that the case should be defended. Again the reasons behind the decision must be explicit to provide the Clinical Risk Manager and lawyers the opportunity to analyse the committee's rationale and help them prepare a defence. It is important in such cases that the plaintiff's lawyers are notified quickly that having obtained clinical advice, the Trust will not settle. This approach may result in the termination of a dubious claim.

It must, however, be recognised that in some cases the cost of mounting a defence will far outweigh the damages. In such an event, the Trust Medical Director should report the outcome to a panel consisting of the Chief Executive, the Director of

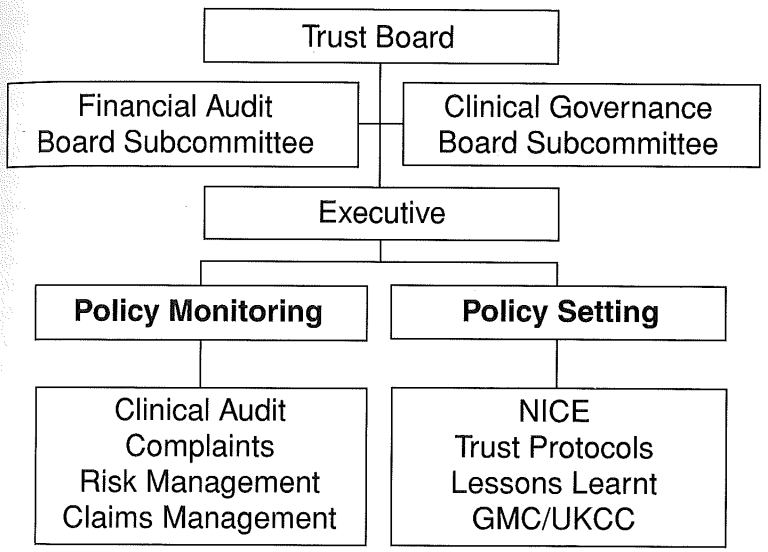


Fig. 3.1. Example of reporting infrastructure.

Delegated responsibilities

The Chief Executive is the officer accountable for the delivery of high standards of care. He/she, however, will need to identify the clinical lead to take the process forward within the organisation; this must be a Board level post – either the Medical Director or the Nursing Director. The lead will need to work very closely with his/her opposite number and with the Human Resources Director to ensure that clinical governance is included in an overall organisational development plan.

The lead will not only need to ensure that the reporting arrangements are clear and satisfy the Board that the appropriate processes are in place, but also investigate areas of concern and challenge clinical practice whenever necessary. The partnership between the Nursing Director and the Medical Director is critical if the delivery of this agenda is to succeed. The nursing profession has long accepted the concepts of working in teams according to clear guidelines and followed programmes of continuous professional development tailored to their individual and service needs; doctors (consultants) on the whole have been less formal about their practice and their personal and professional development – which has been largely left to an individual's decision.

We believe, therefore, that the Medical Director should be given the overall lead for the clinical governance initiative and that he/she should work closely with the Director of Nursing to ensure that explicit standards are set for clinical teams. We do not believe that organisations should consider giving joint lead to the two clinical members of the Board; this is likely to give confusing message to the organisation and may fragment the implementation process. The role of the Medical Director is described in detail in Chapter 12. Chief Executives should make clear to their organisation, however, that delivering high quality of care is everybody's responsibility both at an individual and team level and that performance management will include monitoring not only national performance indicators but also issues of clinical practice; this will be described later on in this chapter. The Chief Executive also needs to create the right environment for clinical quality to flourish; involving clinicians in management is one way to achieve this, as is the support of a team approach to reflective learning, currently adopted by nursing.

Role of the individual

Clinicians individually are responsible and accountable for their clinical practice; to this end they must ensure that they have the appropriate skills to deliver care safely and therefore ensure that their continuous professional development programme is aimed at the maintenance or acquisition of new skills if these are required. The trust will therefore need to establish a robust performance appraisal for all its staff (including the consultants) which will help identify the needs of individuals and services as far as continuous professional development is concerned. Individual clinicians must now monitor their own practice by taking part in clinical audit and by adhering to the policies and procedures of their organisations. They should also ensure that new techniques are introduced safely and by agreement. A framework for the introduction of new techniques is described in Chapter 8. Clinicians will also need to ensure that they fulfil the requirements for clinical supervision of junior members of staff.

Role of the clinical team

Care today is delivered in clinical teams usually centred on clinical directorates. In their document *Maintaining Good Medical Practice* published in July 1998, the General Medical Council acknowledges that care is delivered in a clinical team and that team members must demonstrate a commitment to effective clinical practice and good quality care and a willingness to learn.[1] The clinical team at a service level must ensure that clinical policies agreed at an organisational level are implemented; this may require the development of care pathways or guidelines. Where appropriate these should address the whole continuum of care from the GP practice, through the accident and emergency department or the outpatient clinic, to the inpatient stay and back to primary care. Services may therefore need to identify how they secure the advice and support of primary care for such development and thus address clinical governance issues across the interface. It may be appropriate for some conditions to include the steps taken in tertiary care and clarify the interface between primary, secondary and

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The Role of the Medical Director

Jenny Simpson

'The Medical Director is the guardian of clinical probity' – Dr Alastair Scotland, October 1993, Medical Directors Group, the British Association of Medical Managers.

The complex and constantly evolving role of the Medical Director provides a fascinating perspective from which to view the development of clinical governance. The Medical Director in any NHS organisation is so closely involved in the development of clinical governance, it could perhaps be said that the principles of clinical governance more or less define the job of the Medical Director.

This chapter sets out to examine the role of the Medical Director – perhaps the most challenging in today's NHS. First, the context is set, by exploring the development of the role from the beginning, then moving on to discuss the nature of the job and the practical realities that face the Medical Director. The chapter concludes with a discussion of the skills and knowledge Medical Directors need to be able to do the job. The underlying thesis of the chapter is that in most organisations the Medical Director is the key player in clinical governance and that it is crucial for the long term health of the NHS that Medical Directors are educated and developed so that they can deliver these complex and challenging roles effectively and with confidence.

The early days

When trusts were first created, following the 1991 White Paper, *Working for patients*, the single uniting feature of the job was a singular lack of clarity. The White Paper had positioned the Medical Director as a statutory role, but the nature of the job was neither described nor defined. The ethos of the day was very much to let Trusts find their own way of developing the role and thus the job very much reflected the culture of the Trust itself.

Job descriptions and indeed contracts were either vague or entirely absent and for the first two years or so, each Medical Director's job was peculiar to the individual organisation. Medical Directors largely assumed that the role was representative, providing the medical staff view at the Trust board. At board meetings in the early days of Trusts, Medical Directors functioned very much as the former chairmen of medical staff committees and adopted much the same behaviour.

Early on, there were Medical Directors in post with no specific time allocated and no reward whatsoever. In reality, these individuals were regarded as mere figureheads with no real managerial influence to speak of. Over the first few months, many Medical Directors fell by the wayside, as it became clear that not only was the role extremely complex, but also that it demanded a great deal from the busy clinician.

As the months went by, it became very clear that the role had a number of different aspects. A striking phenomenon in the early days was the variation between Medical Director jobs – one Medical Director spent most of his management time finding beds for acute emergency admissions, whilst another was solely concerned with sorting out contracting arrangements with the then newly introduced fundholding general practitioners. With the passage of time, however, this new breed of professionals began to share their experiences somewhat and the role became more clearly defined, with discrete functions beginning to emerge.

Developing clear managerial relationships

Amongst the newly appointed Medical Directors, who on the whole were somewhat bewildered with their new positions, emerged a group of individuals who had a much clearer vision of what the role could and should be. By 1993–94, this group of doctors had taken on the role pro-actively and were determined to play a major role in the strategic direction of their Trusts. They set about developing clear managerial relationships, both with the Chief Executive and with Clinical Directors. This cadre of individuals which had been meeting under the auspices of the Medical Directors Group of the British Association of Medical Managers, transformed itself in April 1994 into the Association of Trust Medical Directors (ATMD) which sits within the BAMM organisation.

By the summer of 1996, the ATMD was in a position to produce a document entitled *The Roles and Responsibilities of the Medical Director*, based on an extensive survey of UK Medical Directors, which drew together the key common elements of the job. The circulation of this document also served to enlighten the NHS as to quite how broad and demanding the role of the Medical Director had become. On the other hand, it clearly also engendered some considerable anxiety in those Trusts where the Medical Director was not performing these duties or was trying to deliver the role with inadequate time, resources or skill.

Alongside the production of this document, Medical Directors had been developing their skills and knowledge at an impressive pace. Many had undertaken some form of management development, others had gained their skills by hard-earned experience. By the time *Roles and Responsibilities* was published, a major change had taken place. Medical Directors had begun to emerge as key strategic players in Trusts and it was generally agreed that the job simply could not be done on much less than a half-time commitment. Also, there was a distinct change in the type of person appointed to the post. Initially, the role seemed to be the domain of the pre-retirement consultant, the elder statesman, and the well-respected clinician getting towards the end of his or her career. These individuals were characterised by a determination not to rock the boat, to keep things on an even keel, and had largely acquired their positions by means of a tap on the shoulder from the Chief Executive, or as many described it, 'by not jumping back quickly enough when the chief executive was looking for volunteers'.

Broaden horizons

The newer breed of Medical Directors was most certainly younger. They also saw the opportunity of being a Medical Director as a strategic career step, as a chance to spread

wings, broaden horizons and gain valuable experience. Many of this new breed had previously been involved in some form of management development, either through involvement in management projects or as a result of a personal commitment to understanding more about management. The new breed took the role very seriously, despite the fact that the drawbacks – the constant battle between managerial and clinical demands, the lack of any career progression for those taking on these roles and a lack of a reward system that would make the post attractive – were by now, only too clearly appreciated. These issues, which are still largely unresolved today, were fully recognised at this stage as being of critical, if the role were to attract the brightest and best clinicians.

That said, doctors were and remain, increasingly attracted to take on the job. Why should this be so? Given the ever increasing pressure and need to get the quality of clinical care right, the stress of balancing a clinical and a managerial career, with less than excellent rewards, why then should doctors take on these posts?

The answer lies in the satisfaction clinicians found in using the insight and skill gained over years and years of operational clinical practice, to improve services for patients. Many doctors have been utterly frustrated for years by working in a system that simply does not support the delivery of excellent health care to patients. This does not, on any account, reflect ill-will or idleness on anyone's part, but is the inevitable consequence of a structure in which those making the policy and managerial decisions do not have the insight and knowledge of those working at the coal face, on a day to day basis. Many Medical Directors have commented that though they may earn less and have much more in the way of hassle, they nevertheless prefer to work in a medical management role than in a pure clinical job. It is both intellectually demanding and constantly changing. The ever present need to develop a creative solution to complex and high level problems is challenging. However, many Medical Directors describe the sense of achievement when the apparently impossible is made to happen through smart thinking, effective persuasion and leadership, as being by far the most satisfying part of the job.

The last ten years has seen a major change in attitude on the part of medical professionals, from one in which management is a 'dirty word', its sole purpose being to thwart the effort of clinical professionals, to one in which every doctor has management as part of his or her job and the choice is whether to do that part well and with the appropriate knowledge and skill – or not. These changes, however, have not taken place at the same pace everywhere, nor has the environment of the NHS remained stable.

To-day's medical management environment

The last few years has seen major changes in the public's perception and indeed expectations of healthcare. In the past, the public had been happy to believe that 'doctor knows best' and was comfortable in accepting the doctor's superior knowledge base. The public was also largely unaware of major differences in either quality of, or access to, healthcare.

The rate of technological advance has been dramatic over the last decade and has radically altered what can be provided – and therefore what can be demanded and

expected of the NHS. Alongside this, exposure on television documentaries of numerous service failures and the frank depiction of the medical world in television drama, 'soaps' and other media forms, have all contributed to a growing public awareness that doctors are indeed fallible human beings. Uncomfortable as this notion might be, the public has realised that health care standards in all parts of the country are by no means identical. The ease of access to resources of medical knowledge through the information superhighway has further empowered members of the public, who are not only becoming aware of the possibilities that healthcare could deliver but are also far less accepting of the concept of clinical freedom. All of this has led to a far less stable environment, a situation which has been further fuelled by a number of very public failures in the systems safeguarding the clinical probity of NHS organisations.

Most prominent in the public eye has been the Bristol heart surgery case in 1998, in which paediatric cardiac surgeons continued to operate despite clear evidence that they should no longer do so, given the mortality of the procedures in their hands. This case along with the failures of cancer screening services which hit the headlines throughout 1998 have served as a catalyst to the current thinking on clinical governance. Indeed, performance of clinical practitioners, along with a growing preoccupation with quality management systems and the added impetus of the failures have, between them, contributed in large measure to the quality management aspects of the Government's White Paper of December 1997, *The New NHS. Modern. Dependable.*

It is within this context that today's Medical Director works and lives. It is a fascinating and demanding role, which should not, on any account, be taken lightly. Above all, the role of Medical Director should not be undertaken by individuals without the appropriate aptitude, knowledge and skills. It is essential that the trust board ensures that the right individual with the right support, training, development and resources is appointed to this role which is so critical to the Trust's future health.

Clinical Governance and the Medical Director

In the new world of clinical governance, the Medical Director and his or her counterpart in nursing management are the key players in the Trust. The case study below outlines some of the issues involved.

• Case study. The issues

Dr Wellman, Medical Director at Heartwood Hospital was having a trying day. The chief cause of his concern was Andrew Thompson, the senior surgeon in the hospital. Although Andrew had no formal managerial role in the Trust he was nevertheless extremely influential as the 'elder statesman' surgeon. Gordon Wellman had become increasingly concerned about the infection rate from Andrew's team, particularly in his cholecystectomy patients. An audit had been undertaken 18 months previously and the audit team had felt that, as a whole, the surgical infection rates were high. The directorate team had drawn up a set of guidelines, and all the surgeons had agreed to change their practice. Now, 18 months on, although the infection rate across the directorate had improved, Andrew's rates were as high, if not higher than they were before.

Now Gordon had been acutely embarrassed by a conversation with Becky Morris, Nurse Manager in the Surgical Directorate. Becky had been concerned for some time about Mr Thompson's behaviour in theatre. He was rude and aggressive on many occasions and frequently late for lists. Furthermore, as she tartly observed, 'It's a waste of time drawing up guidelines – the good ones take them on board anyway, but Andrew won't listen to anyone but himself. He always does his own thing'.

Four miles across the city, at the Royal Hospital, Dr John Burton, Medical Director was frowning over the list of consultants applying for management training courses. He had masterminded the implementation of an appraisal system for all consultant staff two years previously. The initial first year had been extremely hard work, not only in terms of getting through the appraisal session with each of the 108 consultants, and the subsequent follow up personal development meetings, but also in terms of training the clinical directors in conducting the appraisals themselves. This year, however, the process had been somewhat less stressful with the Clinical Directors taking on much more of the load.

Dr Burton is keen to be as accommodating as possible to the consultants. However, each consultant has his or her clinical CME accredits to achieve, and time and resources are limited. The dilemma John Burton now faces is how to allocate the meagre management development budget fairly amongst the consultant staff, whilst at the same time ensuring that the skills and knowledge most needed by the Trust broadly matches those of the individuals. 'I have to say that what I think is needed and what they think they need are sometimes entirely different things' he mused, 'but I'm still really pleased that the colleagues are showing such enthusiasm.'

The management philosophy at the Royal, developed over the last five years between John Burton and Mark Winston, Chief Executive, was one of ensuring that effective systems are in place to monitor the quality of clinical practice. Thus, clinical audit, risk management, patient feedback, outcome measures and process improvement systems had been developed over the years in a structured programme, alongside an active approach to developing strong clinical leadership. These systems, however, are only ever as good as the individuals concerned, and the ability of these individuals to influence their clinical colleagues. The trust's executive team, having placed considerable emphasis on the systems development side over the last 5 years, is now fairly confident that quality failures will be picked up swiftly. The predominant emphasis now at the Royal is on developing individuals and encouraging them to adopt a more proactive approach – preventing disasters before they have a chance to happen.

The first duty of any Medical Director in delivering clinical governance must be to ensure that systems to pick up quality failures are in place. It is, however, all too easy to make the assumption that once the basic systems are in place, no more need be done, the box is checked and everyone can relax. Indeed it is crucial that Medical Directors fight against the inherent tendency to focus on systems, technology and committee structures as being the 'answer' to clinical governance.

It is fundamental that medical managers understand that the key to managing clinical performance, to achieving clinical governance, is mastering the art of influencing colleagues, peers with whom the individual has probably worked for many years and persuading them, at the very minimum, to improve their clinical performance, should it not be of an acceptable standard. At best, clinical governance is about creating an environment in which all clinical professionals are motivated and inspired to improve their clinical and professional performance, even though it is already of a high standard. Clearly the challenges that face the Medical Director vary greatly depending on the nature of the Trust and the type of management systems that are in place to monitor quality.

Developing the right culture

The basic management challenge, however, faces every Medical Director and is common to every Trust – that of developing the right culture to allow quality improvement to take place. The fact that has to be faced is that no one can change the individual's clinical practice, other than themselves. Information can be produced, mission statements can be issued, policies and guidelines can be circulated, persuasion, exhortation and peer pressure can be brought to bear – but unless the clinician has made a conscious decision to change or improve the way he or she performs, nothing will happen. Changing clinical behaviour is notoriously difficult. As the Nurse Manager in the case quite rightly observed, the 'good', conscientious clinicians, who indeed, are by far in the majority, are keen to improve their practice anyway – after all, no clinician sets off to do the job poorly in the first place. However, there is a small number of doctors who are simply unwilling to change their practice and indeed do not see any need so to do.

Clinical governance aims to develop and enhance clinical practice amongst the good, whilst simultaneously providing a set of systems to ensure that poor practice is identified, the lessons learnt implemented into clinical practice and the effect of these lessons monitored.

The two Trusts described in the case have very different approaches and have very different perspectives on the introduction of clinical governance. However, the huge difference between the organisations is only really appreciated by the small number of clinical staff who hold sessions in both Trusts.

• **Case study.** Three months later

Back at Heartwood hospital, things are not going at all well. Andrew Thompson lost his temper with a senior theatre nurse last week, swore at her and was both threatening and abusive to her. The scene was witnessed by Dr Malcolm Neil, a newly appointed Consultant Anaesthetist. Dr Neil works mainly at the Royal but also covers two lists each week at Heartwood and had recently taken on Andrew Thompson's list. Dr Neil is hoping to take over as clinical director of anaesthesia at the Royal and has a keen interest in quality management models.

'I am just appalled by this man's behaviour,' he mused to himself 'but what is the right thing to do? The management lot at Heartwood don't seem to be interested and yet this man is going to do some real damage before too long – if he's not already done so? We have ways of picking all this up at the Royal, but nothing here at Heartwood so I'm now left with the question of whether I should report him. If I do, it's not going to win me any friends – but if I don't, maybe *I'm* in the wrong. I'm sure the latest guidance from the GMC makes that clear.' Finally Dr Neil decides to have an informal chat with John Burton at the Royal who whilst busy, as always, is happy to spend half an hour chewing over the matter.

Meanwhile at Heartwood, Gordon Wellman had just received a formal complaint about Andrew Thompson from Becky Morris. He was at his desk, considering the next steps when the telephone rang. 'The Chairman and I wondered if you could pop over for a few minutes?' the Trust's chief executive Paul Johnson said, 'We've got some pretty serious complaints we need to discuss with you.' Dr Wellman made his way over to the Executive Offices with a heavy heart.

Over at the Royal, Dr Neil was feeling somewhat more optimistic. He had had the chance to talk things through with John Burton and had decided to confront both Gordon Wellman and Paul Johnson at Heartwood the next day.

The nuts and bolts of clinical governance must be in place at directorate or service level. The Medical Director cannot and should not personally oversee every consultant or process. With the development of clinical governance, the Medical Director's role becomes quite clear. As the guardian of clinical probity, the Medical Director must be confident that effective systems and effective clinical leadership are in place for each and every clinical service within the Trust. That said, the Medical Director must also know how to deal effectively, appropriately and skilfully with the clinician whose performance is falling below the expected standard.

This is often a complex business, with multiple aspects. The colleague may be ill, may be stressed, may be behaving in an unacceptable manner or may be incompetent. However, most problems with colleagues do not present with a single convenient label on them. Most are multifaceted, with information presenting from every direction and sporadically. The Medical Director must constantly be on the alert for patterns of unusual behavior amongst clinical colleagues. The Medical Director must be close enough to the action to know when things are going wrong and to be closely connected to the internal, informal networks of the Trust. At the same time, however, he or she must also stand back sufficiently to view the organisation as a whole and set the issues within the right context.

It is the Medical Director's responsibility to make sure that the culture and environment is one in which poor performance and clinical risk are managed with skill and sensitivity. Consultants and particularly clinical directors must be made fully aware of how much of the monitoring and indeed investigation of effective performance should be undertaken and at what stage the matter should be reported to the Medical Director. There must, of course, be a full and open relationship between the Medical Director, Clinical Director and consultant colleagues. Without this, the Medical Director can not hope to be successful in clinical governance.

Develop the informal network

Consider the Trusts outlined in the case. At the Royal, considerable effort has been put into developing a system. The philosophy of the Trust is clearly articulated, at every step of the management process. The process, which provides a useful vehicle for discussing performance and the needs for further professional development, also provides a mechanism for managing staff morale and health. An important by-product, however, is the opportunity the process provides to develop the informal network, to gain the soft information of who is doing what – and which areas of the Trust the Medical Director might wish to focus on most clearly. The appraisal process makes staff feel valued. It is unfortunate to note that an approach like this remains somewhat unusual in today's NHS. As one consultant remarked, rather sadly, 'this is the first time anyone has ever asked or cared about what I do next'.

In contrast, at Heartwood, each and every problem in the service will come as an unpleasant surprise, simply because the ethos of proactively seeking out the problems is not there and Gordon Wellman does not have the 'inside knowledge' he needs to be effective. The Trust management is therefore set on the back foot and is constantly reacting to issues that could and should have been prevented.

There are many and varied calls upon the Medical Director's time. As most Medical Directors are still working clinically, time is indeed under pressure. However, of all the many things a Medical Director must do, this determination to create the right culture and the right networks is top priority. Without it, the role as a Medical Director is totally reactive and as such is not really manageable. At the Royal, John Burton has created a culture which will support him in his job, by means of an appraisal system. There are in fact many other ways and other systems that can be used as a mechanism to change the culture of an organisation and the true art is identifying the mechanism most likely to bring about change, given the nature of the Trust.

• Case study. The next day

Malcolm Neil arrived early for his list at Heartwood hospital. He had arranged to have a word with Gordon Wellman and Paul Johnson before he went to theatre, although now he was beginning to question the wisdom of his actions. His confidence of the previous evening had evaporated on his arrival at Heartwood, and now he desperately wished he had kept quiet. As he began to explain his concerns to the Medical Director and Chief Executive he sensed that Gordon Wellman was already somewhat stressed and irritated at his remarks. Paul Johnson on the other hand listened calmly and encouraged Malcolm to expand on his anxieties about Andrew Thompson's performance. 'It's no use avoiding the issue any more. Something's just got to be done!' Gordon Wellman was almost shouting, 'Why is this sort of thing always happening here? Can't we have some sort of quality policy in this place to stop all this nonsense?' Malcolm Neil was not terribly sure what to say about all this but began anyway to describe some of the processes in place at the Royal. Again Paul Johnson listened carefully and Malcolm left for his list feeling that at least no harm had been done.

Two days later John Burton at the Royal was slightly surprised to hear from Paul Johnson at Heartwood. Paul had spoken to Mark Winston and had asked if both Chief Executives and Medical Directors could get together one evening for a drink to explore the possibility of sharing the Royal's approach to performance management with colleagues at Heartwood.

It is not easy to be a Medical Director. In many ways the introduction of clinical governance has clarified many of the issues, but at the same time has given the role considerable breadth and complexity, along with accountability for the fundamental in healthcare – the quality of clinical practice. It is essential that Medical Directors do the job well – a poorly performing Medical Director does no-one any service and can cause considerable damage.

So what makes a good Medical Director?

- First and foremost must come judgement. Just as in the clinical world, the facts and figures may be there, the why's and wherefore's evident. The real skill, however, lies in the Medical Director's judgement, timing, sensitivity and knowledge of how both the individuals and the organisation itself will react – and his or her ability to use this skill to make things happen.

- Second there is a menu of skills without which the Medical Director simply cannot survive. In terms of the clinical governance agenda, these must include risk and crisis management – and dealing with the poorly performing colleagues. Medical Directors must also know enough about the systems that should be in place to spot when they are not functioning properly. Medical Directors must above all know when the limits of their own knowledge have been reached – and they must certainly not be too proud to ask for help when they know they are in trouble.

- Finally – and perhaps this should come first, Medical Directors should know how to communicate effectively – not only with patients but also with colleagues, at board level, with the public, with the other clinical disciplines and with the media. All the knowledge and skill is useless if the ideas are not communicated effectively. If the key to buying a new business property is location, location, location, then the key to effective Medical Directoring must be communicate, communicate, communicate.

This may all seem a daunting prospect – and yet the real opportunity afforded by clinical governance must not be ignored by Medical Directors. Clinical governance provides not only a framework for the task of the Medical Director, but also provides the legitimacy and the power to demand demonstrable standards of quality in clinical care. For years clinicians – even those in medical management positions – have struggled with improving service quality, without the benefit of a nationally driven framework. Clinical governance provides that framework. It is now time for clinicians and medical managers in particular to demonstrate their determination to make clinical governance a reality and to make a real difference to the quality of care the NHS provides.

Case study. Clinical governance and the Medical Director

- Clinical governance happens at directorate or service level – the Medical Director's job is to create the right environment to liberate and empower Clinical Directors to deliver clinical governance, through leadership and management systems.
- The Medical Director, along with management and clinical colleagues, should regard the development of a proactive, energetic approach to managing the quality of clinical performance as his or her topmost priority.
- The Medical Director must take every step to ensure that each clinical service or specialty
  (a) has effective and efficient clinical leadership
  (b) has high quality management and information systems.
- The Medical Director must be able to demonstrate with confidence that, for each service or specialty, the quality of clinical care is monitored, and when lacking that lessons are learnt and implemented.
- The Medical Director must develop robust informal networks with the Clinical Directors, other clinicians and managers which will allow a detailed knowledge and 'feel' for the organisation whilst simultaneously keeping an organisation–wide perspective.
- Communication, time management, investigation and influencing skills are key requirements.

References

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