Good Governance Institute

GGI board insights paper 2: the role of the Medical Director in the NHS

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GGI board insights paper 2:
the role of the Medical Director in the NHS

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This report is part of a growing series of reports developed by the Good Governance Institute (GGI) that consider issues contributing to the better governance of healthcare organisations. GGI is an independent organisation working to improve governance through both direct work with individual boards and governing bodies, and by promoting better practice through broader, national programmes and studies. We run board development programmes, undertake governance reviews and support organisations develop towards authorisation.

Other recent GGI reports and board development tools have considered board assurance, patient safety, clinical audit, quality and safety of telehealth services for people with long-term conditions, diabetes services, better practice in treatment decision-making, productive diversity, the board assurance framework, integrated governance, governance between organisations and of course good governance.

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1 Introduction

This paper explores the role of the Medical Director in acute trusts in the NHS, and is part of an insight series produced by GGI on the key board roles within the NHS.

With the increasing significance that has been attributed to clinical leadership over recent years, the role of the Medical Director is widely seen as more important than ever. Despite this, there appears to be a lack of clarity about the role, and also significant barriers to its uptake, most pertinently the issue of career progression and succession planning.

Therefore, this paper will examine the following aspects of the role:

- background to the role: definition, importance, perception and the route to becoming a medical director
- responsibilities of the Medical Director
- what makes an effective medical director?
- accountabilities and reporting lines and the wider team
- training for the role and career progression
- barriers and challenges

The findings will inform GGI's work in this area and will be further developed in GGI's forthcoming publications.

2 Methodology

The role of the Medical Director various widely across different organisations and even trusts themselves. To inform our research, we conducted an in-depth literature review supported by benchmarking interviews with current and past Medical Directors. We approached twelve Medical Directors who had experience in the role in acute trusts across England. The interviews were carried out over the telephone with further comment provided via email. Although the trusts in our benchmarking sample varied in size, the interviews revealed similar themes regarding the challenges medical directors face. While our research specifically considered the role of the 'Executive' Medical Director as it is otherwise known, we hope it will be of relevance to other Medical Directors.

We would especially like to thank Dr Belinda Coker, Dr Nadeem Moghal, Professor Derek Bell, and Dr Andy Heeps for their feedback on various versions of this paper.

3 Background to the role

3.1 Definition, importance, and perception

3.1.1 A Medical Director is a member of the board of an NHS organisation with a clinical background. It is a role which the NHS Confederation states predates the 1983 Griffiths Report on NHS Management, and that has been growing in significance in the succeeding years. The growth in importance of the role is in line with the need to bridge the gap between management and doctors in the NHS,[1] described by Monitor, now NHS Improvement, as 'where clinical and financial governance meet,'[2] and also reflects research consistently referenced throughout the literature which suggests that organisations with engaged clinicians both deliver better care and respond to change more effectively.[3]

3.1.2 The elevation of the role is evidenced in research by the King's Fund and Birmingham University, that demonstrates that 10-20% of consultants are now involved in formal leadership roles in most trusts.[4] Further, Monitor argues that the role will gain yet more importance in the years ahead due to the need for a sustainable leadership model.[5]

3.1.3 In addition to this growth in the role, the literature notes that the role is one which is also evolving. Formerly a strictly medical role, it has now expanded to include managerial duties.[6] This was a theme also found in GGI's research with Medical Directors in NHS acute trusts, with one Medical Director at a university hospitals trust with 4,500 staff describing how the Medical Director used to be 'just a medical voice' on the board, but is now 'a fully integrated role'. These two aspects of the role, the medical and the managerial, present significant challenges for Medical Directors, including whether to maintain clinical practice and how to divide their time. This will be discussed more fully below.

3.1.4 Despite the increasing growth and importance of the role, the literature is consistent in finding that often there is an unclear perception of the role and what it entails by both other board members, and even by Medical Directors themselves. This is compounded by the fact that the role has considerable diversity, with different responsibilities and challenges, making it hard to define and generalise.

The role has also changed considerably with the merging of trusts, increased managerialism, and the re-introduction of the internal market. With these new challenges, new skills are required.[7] Therefore there is a need for the role to be defined more clearly within a managerial code, so that both medical directors and other board members, and indeed clinicians, have a better understanding of the role as its significance continues to develop.

3.1.5 The lack of clarity about the role was also confirmed in GGI's interviews, with one Medical Director describing how they had to 'search for the purpose' of the role, which they found to be striving to make the organisation the safest and best it could be. Better training and induction for Medical Directors, the issue of which will be discussed below, may also be helpful in clarifying the role for both Medical Directors themselves and other members of the board.

3.2 What kind of people become Medical Directors?

3.2.1 A Medical Director needs to have a background in clinical practice. Of the Medical Directors interviewed by GGI, all were consultants in fields varying from paediatrics, to HIV and sexual health, to haematology, to intensive care and anaesthetics. Many had also held other positions in leadership

1. NHS Confederation, Future of Leadership Paper 2: Developing NHS Leadership: The Role of the Trust Medical Director, NHS Confederation, 2009, p1
2. Monitor, Supporting the role of Medical Director, 2014, p3
3. NHS Confederation, Future of Leadership Paper 2: Developing NHS Leadership: The Role of the Trust Medical Director, NHS Confederation, 2009, p1
4. Chris Ham, Medical leadership is vital for quality patients care, Health Service Journal, 2013
5. Monitor, Supporting the role of Medical Director, 2014, p28
6. Antoine Kossaify, Boris Rasputin, Jean Claude Lahaid, The Function of a Medical Director in Healthcare Institutions: A Master or a Servant, Health Service Insights, published online October 14 2013 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4089725/
7. NHS Confederation, Future of Leadership Paper 2: Developing NHS Leadership: The Role of the Trust Medical Director, NHS Confederation, 2009, p2

before coming to the role of Medical Director. This was most often Clinical Director, although one had held the role of Socio-Medical Director for large division critical care, theatres, and medical specialties, and another had undertaken the roles of both Clinical Director and Director of Quality and Safety. Most displayed a desire to lead and drive change in their organisations, and one described how she came to the management role as she had become 'bored' with the clinical world.

3.2.2 In the literature, NHS Confederation found that the route to becoming a Medical Director was generally through being a clinical director of a department of a directorate. However, it also found that there is no definite and systematic career path.[8] Interestingly, in research by Hunter Healthcare and the Faculty of Medical Leadership and Management (FMLM), many of the Medical Directors surveyed reported that they had not actually intended to become Medical Directors.[9] This reflects the gap in succession planning for Medical Directors, which will be discussed in more detail below.

8. NHS Confederation, Future of Leadership Paper 2: Developing NHS Leadership: The Role of the Trust Medical Director, NHS Confederation, p3
9. Faculty of Medical Leadership and Management and Hunter Healthcare, What Makes a Top Medical Director?, Hunter Healthcare, 2016, p4

4 Responsibilities of the Medical Director

4.1.1 The Integrated Governance Handbook states that although the Medical Director is the designated director for objectives related to care, the whole board should have collective responsibility for each objective.[10] Inevitably, the clinical aspect of leadership is often of great significance for Medical Directors, with Richard Giordano (King's Fund) finding that the top priority in his respondents' leadership agenda was improving clinical quality, safety, and patient experience in the face of reduced funding, with respondents suggesting that they see a direct link between clinical leadership and improved clinical outcomes.[11] Monitor supports this, finding that Medical Directors were most concerned about driving cultural change, leading the profession, and delivering quality governance and care despite the financial challenge.[12] Along with this being the priority of Medical Directors, Monitor argues that effective Medical Directors are 'critical to securing sustainable improvements in the quality of patient care', a pressing concern in today's NHS.[13]

4.1.2 More specifically, NHS Confederation states the following as responsibilities which should be part of the role regardless of the variation it entails:

- Leading the formation and implementation of clinical strategy
- Taking a lead on clinical standards
- Providing clinical advice to the board
- Providing professional leadership and being a bridge between medical staff and the board
- Providing translation, assessing the mood and creating alignment between the organisation and doctors (which can be difficult, for example when challenging clinical colleagues)
- Outward facing work with external organisations

Other responsibilities which are sometimes delegated but often seen as belonging to the Medical Director include:

- Clinical governance
- Acting as Responsible Officer for revalidation
- Education
- Medical staffing planning
- Disciplinary issues concerning doctors[14]

4.1.3 The findings in the literature about the responsibilities of the Medical Director are largely consistent with those reported by Medical Directors in GGI's research. Several of our respondents told us that their responsibilities included clinical strategy, quality and safety, management and development of the clinical body, and nurturing and training new medical leadership. The responsibility of creating and promoting a patient focused culture was also mentioned, which was also an aspect of the role expounded in the literature.[15] Several of the respondents had also spent time changing the committee structure of their organisations. However, although the NHS Confederation states that the responsibilities of the Medical Director should include outward facing work, our research found a notable variation in the level of outward facing work reported. While several reported working closely with the local Clinical Commissioning Group (CCG), and some also with local social care and public health services, one Medical Director told us that she does not work with any local organisations, complaining that these organisations are very slow in integrating with the NHS. Even those that did report working closely with local organisations thought this interaction was limited. However, as one of our respondents pointed out, outward facing work with local organisations will become increasingly important as progress is made with Sustainability and Transformation Plans (STPs).

10. John Bullivant & Michael Deighan, Integrated Governance Handbook: A handbook for executives and non-executives in healthcare organisations, Department of Health, 2006, p47
11. Richard Giordano, Leadership Needs of Medical Directors and Clinical Directors, The King's Fund, 2010, p3
12. Monitor, Supporting the role of Medical Director, 2014, p4
13. Ibid p3
14. NHS Confederation, Future of Leadership Paper 2: Developing NHS Leadership: The Role of the Trust Medical Director, NHS Confederation, 2009, p2
15. Antoine Kossaify, Boris Rasputin, Jean Claude Lahaid, The Function of a Medical Director in Healthcare Institutions: A Master or a Servant, Health Service Insights, published online October 14 2013 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4089725/

4.1.4 Further to these responsibilities, the literature addresses the question of whether or not a Medical Director should retain some clinical practice, and how they should divide their time between clinical and managerial duties. The Faculty of Medical Leadership and Management (FMLM) states that the role 'inevitably means having a foot in both camps,'[16] and, although views vary, the literature seems to agree that most Medical Directors prefer to retain at least some clinical practice. The benefits of this include maintaining credibility, providing a link to clinical realities, and allowing a route back to clinical practice.[17] This includes keeping up to date with and maintaining first-hand experience of patient care and perspectives, and the fact that, as they are fundamentally clinicians, Medical Directors enjoy clinical work and believe it keeps them balanced.[18] However, the literature also states disadvantages, with the NHS Confederation finding that there was a danger that maintaining clinical practice risked sending a message that the role of Medical Director is not important enough to be doing full time.[19] Furthermore, FMLM also found that retaining clinical practice could result in a fragmented working experience, with one Medical Director, describing 'being pulled in different directions'.[20] In larger trusts, maintaining clinical practice could be seen as an 'overcommitment'.[21] Despite these problems FMLM concludes that 'the benefits are clear', a view stated throughout the literature and in our own interviews.[22] Multiple respondents told us that maintaining practice helps them 'keep their feet on the ground' and maintain an important link with the clinical aspect of the work.

16. Faculty of Medical Leadership and Management and Hunter, What Makes a Top Medical Director?, Hunter Healthcare, 2016, p5
17. NHS Confederation, Future of Leadership Paper 2: Developing NHS Leadership: The Role of the Trust Medical Director, NHS Confederation, 2009, p4
18. Faculty of Medical Leadership and Management and Hunter, What Makes a Top Medical Director?, Hunter Healthcare, 2016, p6-7
19. NHS Confederation, Future of Leadership Paper 2: Developing NHS Leadership: The Role of the Trust Medical Director, NHS Confederation, 2009, p4
20. Faculty of Medical Leadership and Management and Hunter, What Makes a Top Medical Director?, Hunter Healthcare, 2016, p5
21. Ibid p8
22. Ibid

5 What makes an effective Medical Director?

5.1.0 FMLM found that Medical Directors believed that the most important qualities and behaviours needed to carry out the role successfully were personal resilience, integrity, honesty and openness, communication skills, and compassion.[23] In terms of the most important management approaches, respondents listed the following:

- Not being afraid to have difficult conversations and honest dialogue (64%)
- Holding colleagues to account (59%)
- Spending time networking and influencing colleagues to drive change (59%)
- Being able to identify the most important factor when faced with multiple (54%)[24]

Reinforcing this research, Giordano's surveying of Medical Directors found that they have high levels of confidence in their skills in influencing, negotiation and communication, and furthermore, in their ability to use resources to maintain quality of care.[25] This final point seems particularly relevant considering the responsibility of Medical Directors to be the driving force behind high quality care despite the financial pressures on the NHS.

5.1.2 Giordano also reports a point of variation among Medical Directors about whether they need to master the tools often used by managers, with some believing they should understand and use them, some arguing that they are simply needed to appreciate and be able to work with those who do, and finally some suggesting that they should simply know enough to ensure the work is being done properly. Giordano concludes that Medical Directors do not necessarily have to have these skills, but need the ability to move from clinical work to engagement with the board.[26] However, the tension Medical Directors feel between their work in the clinical body and the governing body is something apparent both in the literature and in GGI's own research. In line with the literature, our interviewees held widely varying views on the need to obtain managerial qualifications based on their individual experience.

5.1.3 In addition to being highlighted in the literature as an important quality for a Medical Director, nearly all of the Medical Directors we spoke to felt that resilience was required to become a successful Medical Director. This often came alongside communication skills, because, as several of the respondents pointed out, it is not always easy to build consensus in reconciling the clinical with the managerial. Other qualities mentioned were confidence, humility, empathy, and professional knowledge and experience. Finally, several Medical Directors noted the importance of being, in the words of one respondent, 'available, approachable, and visible', especially to senior clinicians. This included being on the front line and meeting staff. In this regard, maintaining clinical practice is conducive to developing this visibility and building relationships with the clinical staff.

23. Faculty of Medical Leadership and Management and Hunter, What Makes a Top Medical Director?, Hunter Healthcare, 2016, p10-12
24. Ibid p11
25. Richard Giordano, Leadership Needs of Medical Directors and Clinical Directors, The King's Fund, 2010, p1
26. Ibid p7-8

6 The Medical Director and others

6.1 Accountabilities and reporting lines

6.1.1 As a member of the executive team, the Medical Director reports to the Chief Executive. The Medical Director along with the Director of Nursing are usually the only clinicians on the Executive Board of acute trusts.

6.2 Working with others on the board

6.2.1 The nature of the working relationship between the Medical Director and other board members will be vital in determining the quality of governance. Giordano found that Medical Directors were keen to work with managerial colleagues as equal partners, arguing it is important that Medical Directors get the support they need to do this effectively.[27] He also found that currently this support largely comes through discussions with the Chief Executive, which 71% of respondents reported. One respondent described how these high level discussions allow a common understanding to develop between clinicians and managers.[28] Monitor expanded upon Giordano's research by reviewing the relationships with individual positions in the board, with that of the Non-Executive Director (NED) being of particular significance. As introduced earlier, there seems to be a tendency for NEDs to view the role of Medical Director as primarily operational and a link with the consultant body, thus undervaluing the strategic contribution of the role.[29] However, when developed and maintained, this relationship is regarded as important in delivering high performance through the following:

- Constructive challenge
- Supportive culture
- Acting as a 'critical friend'
- Trust and confidence
- Rating medical expertise
- Not a 'them and us' attitude[30]

6.2.2 Monitor also examined the relationship between the Medical Director and the Chief Executive, with many Medical Directors holding the view that a clear strategic vision and effective leadership from the Chief Executive is important in developing clinical engagement. That said, Kossaify et al. noted that despite the relationship between the Medical Director and the Chief Executive being crucial, it is important for the Medical Director to maintain a high degree of visibility with both clinical and non-clinical staff.[31] Regarding the board more generally, the research found that Medical Directors valued a board that supported:

- Team working
- Openness and honesty
- A focus on quality, patient care, clinical information and data
- Stability
- Reflective learning
- A unified vision[32]

6.2.3 In our research, respondents reported that they rely on both the Chief Executive and Deputy Chief Executive in enabling strategy implementation. Executive colleagues in general were also mentioned, however, echoing Giordano's research above, none of the Medical Directors reported working closely with individual NEDs. This could be due to a lack of understanding of each other's roles or lack of appropriate induction processes to obtain this information. Other figures mentioned were the Director of Planning, Director of Strategy, Chair, and Director of Nursing.

27. Richard Giordano, Leadership Needs of Medical Directors and Clinical Directors, The King's Fund, 2010, p1
28. Ibid p4-5
29. Monitor, Supporting the role of Medical Director, 2014, p10
30. Ibid p16
31. Antoine Kossaify, Boris Rasputin, Jean Claude Lahaid, The Function of a Medical Director in Healthcare Institutions: A Master or a Servant, Health Service Insights, published online October 14 2013 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4089725/
32. Monitor, Supporting the role of Medical Director, 2014, p16

6.3 The Medical Director and the Clinical Body

6.3.1 Tensions can arise between the Medical Director and the Clinical body. There exists a perception among clinicians that by moving into a management role, a Medical Director has 'gone over to the dark side'.[33] This seems indicative of a tension between management and frontline staff which perhaps could be relieved by promoting further clinical engagement in the governing body of an NHS organisation. Furthermore, FMLM found that some doctors perceive the role of Medical Director as that of a 'trade union style representative', something echoed elsewhere \ in the literature. Medical Directors are not intended to undertake this role, but at the same time FMLM noted that without the respect of the medical body a Medical Director will be unable to succeed in the role. One Medical Director in the research suggested that this was symptomatic of a failure to clearly define the role within the system, rather than the misconceptions of doctors themselves.[34]

33. Health Service Journal (HSJ), The Making of a Medical Director, 1 March 2016
34. Faculty of Medical Leadership and Management and Hunter, What Makes a Top Medical Director?, Hunter Healthcare, 2016, p6

7 Training for the role and career progression

7.1 Training and qualifications

7.1.1 A significant issue with the role of Medical Director is that there is no clear and systematic career path. In terms of preparation and training for the role, the NHS Confederation argues that although there is some value in formal management courses, more advantageous are courses which deal with actual issues encountered on the job rather than simply management theory. Practical opportunities are also mentioned, including mentorship, coaching, and shadowing and secondment to other organisations.[35] In addition to these, Medical Directors in Giordano's research reported receiving support in the form of budgeting workshops, stakeholder planning and contingency planning.[36] Monitor found that a number of their respondents reported undertaking training programmes with the King's Fund, which were also the most often recommended.[37] In terms of additional support and resources, newly established Medical Directors demonstrated an 'overwhelming support' for mentoring and coaching, echoing NHS Confederation, while those who were more established in their post sought support from the board, Chief Executive and medical team, experience in other industries, action learning sets, peer networks and coaching, and career planning.[38]

7.1.2 The training of the Medical Directors we interviewed varied widely and hence their take on what constitutes the best career path. Most had completed at least a few courses or received certificates in leadership or corporate governance. Experiences ranged from a Strategic Medical Director course at the King's Fund to secondments at organisations such as the NHS Institute for Innovation and Improvement. Although most spoke positively of their experiences, there was also a perception that additional courses are not always very practical in attaining the day to day skills needed to be a Medical Director. In the words of one of our respondents: 'No courses can prepare you to be a leader. You have to learn by example, be encouraged, and have the desire to lead.'

7.1.3 One of the Medical Directors we interviewed had undertaken a large variety of different courses, including an MBA, secondments, and work at the Harvard Kennedy School of Governance. He believed that this education had greatly helped him but conceded that he had been lucky in his opportunities. A few of our respondents said that they would be keen to undertake an MBA, but did not feel they would be able to balance it with existing work and family commitments. It may therefore be necessary to offer more support to Medical Directors seeking training opportunities.

7.1.4 Finally, there is also the question of where to go next. There is not a strong tradition of Medical Directors moving between organisations, and there is feeling that a return to clinical practice will be difficult, something that could potentially put off budding Medical Directors.[39] Just as there is no defined career path to becoming a Medical Director, what those in the role choose to do after varies widely.

7.2 Succession Planning

7.2.1 Succession planning, or rather the lack of it, has also been identified as a key issue, and one which, we understand, is putting off junior doctors from seeking leadership roles. Monitor found that a significant number of its respondents either had no plans for succession planning, or were in the early stages of planning how to go about identifying and developing successors. Common methods for identification included learning and development programmes for deputy, associate, or clinical directors.[40] Despite this, FMLM found that often Medical Directors are creating opportunities to engage clinicians with the role and prepare them for it. Methods employed by respondents in this research included sending clinical directors on King's Fund training programmes, setting up a medical leadership programme with Warwick Business School, and offering training courses to staff.[41]

35. NHS Confederation, Future of Leadership Paper 2: Developing NHS Leadership: The Role of the Trust Medical Director, NHS Confederation, 2009, p3
36. Richard Giordano, Leadership Needs of Medical Directors and Clinical Directors, The King's Fund, 2010, p5
37. Monitor, Supporting the role of Medical Director, 2014, p22-3
38. Ibid p24-5
39. NHS Confederation, Future of Leadership Paper 2: Developing NHS Leadership: The Role of the Trust Medical Director, NHS Confederation, 2009, p5
40. Monitor, Supporting the role of Medical Director, 2014, p22-3
41. Faculty of Medical Leadership and Management and Hunter, What Makes a Top Medical Director?, Hunter Healthcare, 2016, p20-21

7.2.3 One of the Medical Directors we spoke to said that when she was first considering taking on the role, she felt unprepared and was concerned that she would not have 'what it takes'. This sentiment is shared by many Medical Directors who, before taking on the job, have no exposure to the board and little understanding of what is required of them.[42] However, as in the literature, several of our respondents were taking steps to improve succession planning in their organisation by identifying clinicians with leadership capabilities and nurturing and training them internally, and combining this with external courses. 'Leading by example' and implementing a more 'clinical-led' structure were both identified as being conducive to achieving this. One of the Medical Directors believed that having more clinicians on the board is one way to ensure that in 50 years' time the NHS is thriving, and believed succession planning and continuity of leadership was key to this.

42. HSJ, The Making of a Medical Director, 1 April 2016

8 Barriers and challenges of the role

8.1.1 Along with the issue of succession planning, Monitor identifies a 'common narrative' among Medical Directors about potential barriers to taking up the role:

- Lack of recognition for time an effort, often under-resourced, with unrealistic demands and expectations
- Giving up private practice and the commercial sector (which can offer better remuneration)
- Perceived to have less respect and support than academic roles
- Lack of development and career structure: why do it early on in a career?

Other issues included a lack of interest from the board and both internal and external stakeholders being unwilling to consider the necessary changes.[43] This 'common narrative' of issues exists throughout the literature. Points raised elsewhere include the regulatory burden and workload being too high (raised by 67% and 62% of respondents respectively in FMLM's research)[44], and the presence of 'tribalism' in the NHS which makes it difficult for Medical Directors to bridge two cultures.[45] Another problem facing Medical Directors is the growth of managerialism, with successive governments relying on general managers to implement healthcare reform, resulting in substantial investment to support the leadership development of general managers, whilst not replicating this to support doctors to become leaders.[46]

8.1.2 The transition itself from purely clinical work to leadership brings with it challenges, as shown by Monitor:

- Understanding how the board works and the breadth of individual and corporate responsibility
- Strategy and finance
- Relationships with the general body of clinicians (see above)
- Volume of work and time management
- Resilience needed to cope with scrutiny and isolation[47]

8.1.3 The problem of relationships with peers, particularly clinicians, was also discussed by our respondents. One Medical Director had even been referred by consultants to the General Medical Council (GMC) for investigations, which were unfounded but resulted from poor relationships. On the other hand, other Medical Directors commented that maintaining relationships with under-performing clinicians was difficult, with investigations being difficult and time consuming. One believed that the key to developing positive relationships was to demonstrate that as a leader, you are doing good for the whole organisation, not just the management.

8.1.4 Practical issues such as workload, too many meetings, and financial barriers to investing in quality and safety were also cited as major challenges, as was a lack of support and feeling isolated, and needing to be 'all things to all people'.

43. Monitor, Supporting the role of Medical Director, 2014, p1
44. Faculty of Medical Leadership and Management and Hunter, What Makes a Top Medical Director?, Hunter Healthcare, 2016, p9
45. Chris Ham and Helen Dickinson, Engaging Doctors in Leadership: What can we learn from international experience and research evidence?, NHS Institute for Innovation and Improvement, 2008, p16
46. HSJ, Medical leadership is vital for quality patients care, 30 April 2013
47. Monitor, Supporting the role of Medical Director, 2014, p14

9 Conclusions and recommendations

9.1.1 Despite the variations in the role across organisations, some common themes can be identified around responsibilities and challenges faced by Medical Directors. More in depth understanding of the role by members of the board, as well as clinicians themselves, can go a long way in making the role more effective. The NHS has not yet produced an up-to-date code distinctly outlining the role and its expectations which would clarify the role for Medical Directors and others. We recommend that each trust develop and disseminate its own set of induction materials where the role of the Medical Director is explored and clearly outlined within the context of the organisation. This would be conducive to improving some of the challenges faced by Medical Directors described in this paper and to developing good working relationships.

When it comes to the future of the role more generally, we recommend:

- Developing clearer training and career pathways for both potential and current Medical Directors and succession planning. This should go hand in hand with a wider policy of increasing clinician recruitment for leadership roles.
- Giving Medical Directors more freedom to retain clinical practice, and having the opportunity to return to it, particularly in the same organisation. Clinicians should not have to make a choice between clinical practice and managerialism. Striving to find a middle ground would contribute to more effective clinical leadership.
- Better understanding of the role by other board members, particularly its strategic aspects. Our research found that NEDs especially often lack an understanding about the role and may benefit significantly from better induction processes. Both NEDs and MDs stand to gain from developing a stronger working relationship on the board.
- Developing an enhanced understanding of the leadership elements of the role by the clinical body. Understanding the role within everyday realities of the organisation may help an MD win the support of the clinical body. Clearer guidelines on the role disseminated by the trust can help increase understanding and encourage young doctors to become interested in the role early on in their careers.

10 Acknowledgements and references

10.1.1 GGI would like to thank those Medical Directors who freely gave their time and input to this paper.

10.1.2 Blackburn, S. et al., Integrated Governance Handbook: A handbook for executives and non-executives in healthcare organisations, Department of Health, 2006

Bohmer, R. *The instrumental value of medical leadership*, The King's Fund, 2012

Bullivant, J. et al., Good Governance Handbook, GGI/HQIP, 2015

Faculty of Medical Leadership and Management and Hunter Healthcare, *What Makes a Top Medical Director?* Hunter Healthcare, 2016-07-29

Giordano, R. *Leadership Needs of Medical Directors and Clinical Directors*, The King's Fund, 2010

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