Journal of Nursing Management, 1998, **6**, 59–60

Editorial

Leading the team

The concept of placing responsibility for the management of resources and the performance of clinical services into the hands of staff from clinical backgrounds has been widely accepted and adopted across the UK and North America. At a time when demand for health care continues to increase, but when Government expenditure has to be limited, it has become necessary to introduce an element of control over clinical practice in order to ensure that health care is delivered with due regard for the financial and other consequences of clinical decision-making.

In the early 1980s, the *Griffiths Report* highlighted the need for pro-active management in the British National Health Service, with the intention of moving away from a culture of 'administering' the service to one based on dynamic management. The introduction of general managers was treated with suspicion by many health care professionals, and many general managers found themselves with little real power to influence the decisions of doctors. However, with the setting up of independent NHS Trusts in 1991 Chief Executives began to recognize that they could only achieve success by having a degree of co-operation from the consultants and other clinical staff within their Trusts, and as a result the model of clinical directorates began to be adopted widely across the UK.

Whilst there are several different models of clinical directorates, the themes remain the same: a clinician, a business manager and often a senior nurse take management responsibility for a service or group of services. Sometimes the business manager and nurse manager roles are combined. However, if the unit of management is to be a clinical directorate, then it must be led by a clinical director, who takes responsibility for its performance. It is generally accepted that the clinical director should have some strategic leadership skills, be a good communicator, understand management and be clinically credible. However, it is not generally accepted in the acute setting that the clinical director can be the senior nurse, no matter how well that person may fulfill those criteria. Yet there have been a number of isolated examples in medicine, surgery, obstetrics and paediatrics where the clinical director has been a nurse, but these are notable for their extreme rarity.

The introduction of clinical directorates was received with suspicion by some writers in the medical journals; for example, it was suggested that doctors who got involved would put themselves in invidious positions (Johnson 1990). Others demonstrated a cautious acceptance, for example Sang (1993), who suggested that management should be recognized as a special interest for those consultants involved and viewed as a valuable career move. Yet in many articles—with a few notable exceptions such as Capewell (1992)—there seemed to be a tacit acceptance that if a clinical director is required, then that role would be filled by a doctor.

Similarly, the early nursing literature (e.g. Hancock 1991) considered how nursing and nurses fit into a clinical directorate model without overtly suggesting that in many cases nurses might be the best individuals to lead the team. Similarly, Batehup (1992) identified some of the threats and opportunities for nurses and nursing that arise from the devolved management offered by the clinical directorate structure. She goes on to comment that the potential for nurses to acquire general management positions should be promoted, but that those that who do may on one hand criticized by their colleagues for leaving clinical nursing, and on the other by generic managers accusing them of having a crisis of identity.

Such underlying assumptions about roles should not go unchallenged; however even that challenge may be interpreted as nurses competing with other managers and professionals for power, rather than being recognized as a suggestion that the best way forward for the service might be one which has a division of labour that breaks stereotypical roles.

In 1994 Hancock argued that clinical management requires a broad range of skills, ability and experience, leading to the question 'Can we really argue that because consultants are paid more than many other health care professionals, they should automatically become team leaders?'. However the selection of a clinical director is often achieved through discussion within a team of consultants, with the Chief Executive ensuring that the individual identified at the end of the day is someone who will be constructive in their approach. The criteria for making the choice should be objective, based on the needs of the directorate and the skills of the people involved.

In reality, choices are often made based on workload, seniority in years or who's turn it is next. A senior nurse with the leadership skills and political acumen to be the clinical director should be able to influence the debate so that a nurse might be considered for the role. Equally, the nurse executive director for the trust is also in a position to float the idea to the right people at the right time.

Concerns that may be expressed about having a nurse in the role include issues of the professional oversight of consultants, authority and the ability to operate on the medical 'network'. These issues can be overcome through having a lead consultant, and through the individual having the necessary support of their colleagues. This may involve setting some ground rules at the outset, and developing allies in senior management positions.

The advantages for the directorate of making such a choice can be considerable, as by having a manager with experience of human resource, finance and quality issues, as well as a clinician's understanding of the speciality, services can be rapidly and effectively developed. It also reduces the management burden on consultants without letting them abdicate responsibility for taking part in the management process.

In the current health arena complex organizations such as hospitals need flexible, multi-disciplinary management teams that are non-hierarchical in nature (Hancock 1994). In order to make such teams work, the leader needs to be able to build trust, evolve an open and problem solving environment and develop an ownership of difficulties and objectives by team members (Neubauer 1993). The ability to be able to deliver such an agenda is currently more likely to be found among the senior nurses, than among the senior consultants.

The training for doctors in management is still extremely limited, and whilst some Trusts have run cohorts of doctors through the Diploma in Health Services Management programme, doctors seem to have generally learnt through on-the-job experience. It seems unlikely that it is accidental that the first three chapters of the new book aimed at doctors in management by Austin and Dopson (1997) are 'Working in Teams', 'Managing People' and 'Negotiating'. Whilst it is desirable for all doctors to have an understanding of these issues, these are skills that many senior nurses in directorates already have.

As well as there being potential advantages for services in considering having a nurse in the leading role in the directorate, there are also advantages for the profession and the individual. For example, there have been concerns that there are skills and knowledge deficits in nursing amongst those who are the potential future leaders of the profession (King's Fund 1995). As a clinical director, the senior nurse sits on the operational management board of the trust, and has the opportunity to develop higher management skills. Such developments are not without risks. However, it can provide a relatively safe progression if, for whatever reason, the role has to be relinquished, then the individual can return to the senior nurse role.

There has been a great deal written about doctors in management since the advent of clinical directorates, yet the great potential for maximizing service development by nurses taking the leadership position in some of those teams has yet to be fully realized.

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