Annex 5

Commentary on Enhancing Clinical Leadership

Contents

1	**What is clinical leadership?**	**3**
	(b) Faciliating and supporting clinical leadership	6
	(c) Everyone a leader	7
2	**Initiatives to increase elective services and reduce patient waiting times, improve access to timely primary and secondary services, and improve productivity and quality of services for patients**	**8**
3	**Ways to establish clinical networks and leadership programmes to support these goals**	**11**
	Clinical networks	11
	Why do we need another committee?	12
	Leadership programmes	14

This commentary summarises the information obtained by the MRG on clinical leadership and clinical networks both from the literature and conversations with a range of senior clinical advisors and clinical leaders. We thank those who shared information with us. The commentary provides a background to the conclusions and recommendations offered in Annex 2 and may be useful information for those clinicians and managers involved in decision-making around clinical leadership positions or considering clinical leadership as a career option. It may also be of interest to those who do not anticipate such a role for themselves but wish to support clinical leadership or participate in networks.

1 What is clinical leadership?

Health and disability system structural changes over recent decades have met with varying degrees of success in terms of their impact on relationships between clinicians. Some changes have had far-reaching consequences for clinical referral patterns and relationships. Health managers, sometimes with little understanding of health care delivery or few relationships within the sector, have been asked to implement reforms without the mandate or co-operation of the clinicians whose involvement was a pre-requisite to their success.

While this has left a legacy of distrust among clinicians in some places, reflected in some of the comments made to the MRG, we have been encouraged by the many examples of energetic and collaborative clinician-management partnerships that are able to withstand healthy debate and challenge. Respective pressures, viewpoints, and constituency expectations can be better understood and creative solutions achieved.

Clearly for this quality of leadership and decision-making to inform a realistic and durable health service a high level of conscious, informed, dedicated clinical leadership is integral. While acknowledging the past is important, it is essential that historical problems are left behind and all parties approach the future in a spirit of generosity, willing to allow colleagues the benefit of the doubt and determined to assume the best until proved otherwise. The committee has been delighted to see this spirit in action in many of those interviewed and noted that many of the most effective services we spoke with were built on this foundation.

It is always easier and more comfortable to deal with those who understand and agree. Explanations are not necessary and there is less risk of assumptions being made or misunderstandings occurring. The language is common and similar priorities and interests hold sway. Many forces draw health care professionals of all disciplines into silos as sub-specialties develop, professional scopes expand or overlap, and working pressures encourage the default to be the known and trusted. However, this can mean colleagues working in the same town or organisation have never met. We were amazed to learn, for instance, that some of the initiatives that have grown up to improve services between primary and secondary care had co-incidentally introduced clinical colleagues for the first time.

Since people already experience health services mostly within the community, touching primary care services a little over the course of their lives and more specialist services only rarely, the experience of health care for patients and many health professionals is quite different and not well served by silos. Nor is quality health care best delivered in silos. It is in this synergy of interests that the MRG found its best road map for change. As health care demands grow, the only realistic and sustainable way of ensuring the best return for most people from public health care will be to ensure that the patient becomes the centre of health service organisation and delivery.

Changing the emphasis on one health care parameter almost always results in consequences elsewhere. For example: improving health can increase costs; reducing costs can create poor outcomes, poor experience of care, or both; and patients' experience of care can improve without improving health. The quest to improve health care quality, while recognising the dynamic tension between these three factors, has been recognised by one of the leading international health care quality and improvement campaigners as the Triple Aim.[1]

The Institute for Healthcare Improvement's 'Triple Aim' concept advocates that new designs simultaneously aim to improve the health of the population, enhance the patient experience of care (including quality, access, and reliability), and reduce (or at least control) the per capita cost of care.[2]

Effective clinical and health leadership requires access to reliable information for action. Clinical leaders need access to information on clinical productivity, changes in health care practice and clinical quality standards, measures of health care quality, and health outcomes. In aggregated form, this information is invaluable for those monitoring health system performance, both in terms of providing measures of clinical performance and providing valuable contextual information for the interpretation of other performance measures.

Clinical leaders have to be aware of what can be changed and what cannot. There are both organisational and sector limits and resource constraints. Furthermore, in many examples of change there is also a factor of timing: however good an idea may appear to be, without the right constellation of circumstances, no progress is likely to be made.

Given this, it is particularly important for all involved to find a way to align their goals and ambitions. Focusing on the stewardship of resources to deliver the best value and quality holistic services which are centered on patients may well provide the platform for all parties to embrace a new culture.

Clinical and resource accountabilities are inextricably linked, but leadership legitimacy for clinicians and managers derives from very different sources. Managers must lead, respect, and protect corporate governance, while in a professional bureaucracy, the ability to influence or lead change is fluid and dependent on the opinions of others or the appropriateness of one's actions. This in turn can be subject to many different interests and competing pressures, making the tension for those clinical leaders who find themselves bridging the divide particularly difficult at times.

The MRG heard from many that those who take on clinical leadership roles are seen by their colleagues as having "joined the dark side". While this is far from new,[3] if clinical leadership is to be effective, then clinicians in general must be willing to reach some reconciliation of this tension and to support and work alongside clinical leaders and their management partners to share both decision-making and responsibility for the consequences.

Fundamentally, this requires a deep cultural change, which needs to be led by building an appreciation of, and enthusiasm for, the opportunities. A sea change is needed to release the collaborative energy for leadership responsibilities across the whole system. To be meaningful and sustained, cultural change such as this cannot be dictated by timetables or performance frameworks, but can be affected and enhanced by consistent and

[1] http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm accessed 29 May 2009.

[2] http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm.

[3] Ham C. (2003). 'Improving the Performance of Health Services: The Role of Clinical Leadership'. ***Lancet*** 361(9373): 1978-80.

convincing communications (celebrating past successes and successful clinical-managerial partnerships and describing a future where leaders have the tools to work across professional, geographical, and political boundaries to improve the nation's health), developing, strengthening and recognising appropriate skills, dealing with barriers, and ensuring leadership teams can achieve some meaningful successes and rewards.

While each DHB has its own set of values, they all share some in common such as integrity, collaboration, excellence, finding a way, and stewardship. They also share change principles such as: working across the system, and with patients, in order to design and implement change; decision-making taken as close to the patient as possible; clinical ownership and leadership; and bringing all parts of the system to work around the same goals.

One way of recognising and celebrating leadership as a valued contributor to the health care system could be to introduce a formal awards programme, similar to the Health Innovation Awards[4] and the quality awards offered by many individual DHBs, but on an individual level similar to the Leadership Award Programme in the UK. Annual awards judged by a senior independent panel of health care leaders could consider the efforts of those nominated by their peers in any part of the public health service – including nurses, ward staff, community workers, mental health staff, as well as doctors and strategic level leaders. A range of individual award categories could be included, each with their own specific criteria.[5]

The evidence shows that health care leadership, particularly in hospitals, proceeds more effectively in teams rather than by particular individuals, however charismatic.[6] The expectations placed on leaders from their respective constituencies may be incompletely compatible, so that leadership groups often exhibit a cyclical pattern, both in membership and in their ability to effect change. Leadership teams are thus formed, develop working relationships that foster daily decision-making and longer-term planning, and may then grow in achievements and influence. Other factors can affect this course, including resource limitations and an appreciation of the human factors and their consequences inherent in successful change management. Leadership team relationships and effectiveness can be powerfully affected by changes in membership and the environment over which they may themselves have little or no influence. This can result in individual frustration and the team's harmony being diminished. Not only must clinicians be ready to help colleagues accommodate these tensions, but they must themselves appreciate their environment, what can be achieved or changed, and also understand the imperatives of policy-makers.[7] At the same time, managers will benefit from development to better appreciate this environment themselves, as well as the clinical perspectives and priorities of their clinical leadership partners.

[4] UK Leadership Awards http://www.nhsleadershipawards.nhs.uk/.

[5] Based on the UK Leadership Awards http://www.nhsleadershipawards.nhs.uk/. Possible categories include Health Care Leader of the Year (an inspirational, innovative, and highly effective leader of change), Health Care Mentor of the Year (highly committed to the development of less experienced clinical leaders), Health Care Partner of the Year (leadership of integration across traditional boundaries such as DHB/primary or new inter-disciplinary or novel workforce models), Health Care Quality Champion of the Year (any staff member who lives patient service quality and service improvement), Health Care Change Leader of the Year (an individual who has led successful change over an extended period resulting in sustained health care improvement for a population i.e. not an individual project), Health Care Innovator of the Year (anyone who has consistently supported and delivered improvements in care delivery through better use of resources), and Health Care Award for Inspiration (a clinical leader who has demonstrated outstanding consistent attention to improving patients' experience of health care, who consistently supports and develops colleagues in a nurturing respectful way, and who has a reputation for personal courage and responsibility in stewardship of their role).

[6] Denis J-L, Lamonthe L, Langley A. (2001). 'The Dynamics of Collective Leadership and Strategic Change in Pluralistic Organisations'. ***Acad Manage Journal*** (44): 809-37.

[7] Ham C .(2003). 'Improving the performance of health services: the role of clinical leadership' ***Lancet 361***(9373):1978-80.

Development programmes therefore need to have a deliberate focus on shared leadership learning and development within the local environment. The MRG heard about several such successful initiatives,[8] but noted that while these clearly fitted the local environment well, it was important these were not expected to function as 'off-the-shelf' answers for others.

(b) Faciliating and supporting clinical leadership

Clinical autonomy has long been a treasured preserve of the medical profession.[9] Some 26 years ago, however, an editorial in the BMJ argued:

"Clinical freedom is dead, and no one need regret its passing. Clinical freedom was the right – some seemed to believe the divine right – of doctors to do whatever in their opinion was best for their patients. In the days when investigation was non-existent and treatment as harmless as it was ineffective the doctor's opinion was all that there was, but now opinion is not good enough. If we do not have the resources to do all that is technically possible then medical care must be limited to what is of proved value, and the medical profession will have to set opinion aside.[10]

The editorial went on to point out that small incremental advances in care, the commonest result of painstaking research, are still frequently ignored in favour of hopeful, but untested, promises of much bigger improvements because clinicians rarely see from research the dramatic enhancements in treatments both patients and the profession so long for. The tension between aspirations for rapid advances and the reality of painstaking, research-based progress may partly explain why even treatments with strong evidence of benefit are slow to be adopted and may help explain why clinical accountability for financial management can be seen as jeopardising better patient care, since accountability seeks evidence, or at least sound reasoning for decisions. Clinical leaders find themselves caught between their constituencies' expectations and the need to consider the wider implications.

Clarity about responsibilities, aims, and expectations are especially important for clinicians working in partnerships. While there has been discussion about the different responsibilities and position descriptions assigned to chief medical officers and directors of nursing, in particular, there is also some value in fitting the role to the organisation. Many tasks will be similar (e.g. clinical governance, professional leadership and providing clinical advice to the board), others will be localised, simply because of size and organisational structural differences.

Views are mixed about the advantages and disadvantages of part-time compared with full-time clinical leadership roles, particularly at more senior levels. Credibility with peers is often said to require current clinical practice and this also ensures a route back to full-time clinical practice. However, membership of a specific service risks perceptions of bias and exposure to clinical responsibilities can become too limited and there are other ways of maintaining currency while deriving credibility from their leadership role. Undertaking a senior leadership role in a part-time capacity sends a message about its importance and value. Increasing demands from the leadership role can lead to the inability to meet expectations and frustration unless leadership time can be ring-fenced in some way.

[8] For example, Xcelr8 Programme in Canterbury DHB; Midland Leadership Programme; CMDHB Institute of Leadership.

[9] Wright L, Malcolm L and Barnett P. (2001). ***Clinical Leadership and Clinical Governance: A Review of Developments in NZ and Internationally***. Report commissioned by CLANZ for MoH.

[10] Hampton JR. (1983). 'The End of Clinical Freedom'. ***BMJ*** (287): 1237.

For these reasons, the MRG believes local responsiveness to organisational needs is of greater value than a common, national position description for different levels of clinical leader and that a prescriptive formula will be less helpful than a clear expectation of effective clinical managerial partnership. Clinical-managerial partnerships should be meaningful and visible at every level.

Valid career choices for clinicians may range from taking on progressively more senior leadership roles from clinical director through to chief medical officer or director of nursing appointments, to undertaking a leadership role for a limited term only. The transition between leadership roles and clinical practice needs to be managed organisationally, professionally, and educationally. For those doctors wishing to take on more senior roles, opportunities for career planning and development are presently ad hoc, unless one chooses to follow an action learning development programme. These more comprehensive options will suit some doctors but many others need the practical skills and tools to lead and effect change in daily practice, and successful local programmes already exist in some DHBs tailored to suit specific needs and environments.

Valuing clinical leadership must be visible and meaningful. In many organisations, clinical leaders have received a small salary allowance or a nominal sessional payment. Formal allocation of working week-day sessional time for leadership responsibilities with back-filling support for clinical practice responsibilities that have been relinquished sends a clear message that clinical leadership and clinical responsibilities are of exactly equal value to the organisation's core business.

(c) Everyone a leader

"If I have seen farther than others, it is because I was standing on the shoulders of giants." Isaac Newton

Active member participation is essential to the success of a team and every bit as important as being a good leader. Indeed, it could be argued that it is the limited understanding and appreciation of the role and responsibilities of team members that is a significant barrier to clinicians considering leadership roles.

Paradoxically, practising the skills needed to be a good team player is an excellent preparation for higher leadership,[11] since all leaders are also simultaneously members of other teams. There are tensions between individual benefit and the collective good, and between the necessity at times of choosing between conflicting good options, which means that leadership inevitably brings hard choices. An understanding of this can help participants accept decisions they may not personally prefer or like. When this happens, actions such as not undermining a leader who has made the unpopular decision, discussing differences directly and privately with a leader, making decisions but keeping the leader informed, and fixing problems as they arise without worrying about who gets the credit are all qualities and behaviours that build the team. They engender respect and a positive working atmosphere.

[11]Meilinger Col PS. ***The Ten Rules of Good Followership: Concepts for Air Force Leadership***. pp99-101.

Furthermore, only by reflecting on what it has been like to be a participant will a leader understand and ensure (s)he meets the team's needs. Effective and frequent communication, for example, is key to focusing teams on the common goal and to allay unfounded fears or rumours, while care for the team's well-being ensures steps can be taken quickly to deal with problems. Understanding the aims and objectives of the team empowers individual team members to solve problems as and when they arise – making decision-making closest to the patient an everyday reality.

Those in the front-line are those with most experience and understanding of the needs of the patient and must be able to influence leaders' thinking about the direction of services and of the organisation as a whole. Participants' relationships with their respective leaders are therefore crucial and both must actively maintain open, courageous, honest, and authentic communication.

The MRG believes that these matters deserve more attention and discussion, both academically and as part of health care leadership development and education. Health care has learned fresh approaches from other industries in several areas – lean thinking from manufacturing and safety from aviation are good examples. Other professions or services may have useful insights into what it means to be a team member that would help health care develop better relationships throughout organisations and help address this particular barrier.

Realistically however building a new leadership culture in which complementary clinical and management skills collaborate to achieve the best outcomes will take time and individual personal effort. It is also important to acknowledge that establishing a new culture of this sort is most likely to achieve early wins where resources are (relatively) plentiful and decisions are likely to be about investments. The present environment means ongoing investment at previous levels cannot be expected, and clinical leaders are going to be involved in prioritisation decisions from the beginning.

2 Initiatives to increase elective services and reduce patient waiting times, improve access to timely primary and secondary services, and improve productivity and quality of services for patients

Clinical leadership is a means to improved quality, design, affordability, and delivery of services. The Government's focus on increasing elective services – encompassing both elective surgery and access to non-interventional specialist advice through formal outpatient appointments or via individual discussion (virtual consultation) – offers an ideal opportunity to apply the concepts and principles of clinical leadership practically to this important priority, while ensuring other clinical imperatives are also protected.

Elective and emergency surgical service provision is inextricably linked in most settings, simply because the same resources – both human and physical – provide both. Furthermore, a small number of elective cases may subsequently require urgent intervention and intensive post-operative support. As the population ages and the legacies of obesity and smoking mean patients present with significant co-morbidities, much elective work will require comprehensive clinical back up both pre- and post-operatively.

Only clinical involvement and leadership will enable this tension between elective and emergency service provision to be well managed. Similarly, reviewing the appropriate locations for service provision across the whole health system should enable better role delineation and ensure the right services are being delivered in the right place (moving appropriate services back into the community for instance and relieving pressure on hospital services to in turn support primary care by increasing access for advice and assessments).

Increasing elective service delivery includes:

(a) Ensuring that the need for elective services is assessed correctly, promptly, and efficiently and needs are properly prioritised, and

(b) Once assessed, ensuring that more elective service needs are met more quickly to a high quality standard, within the resources available.

In increasing elective throughput, complementary considerations should not be overlooked, particularly:

(c) Ensuring primary care providers are appropriately supported to deal with those patients who cannot be treated within available resources, and

(d) In the medium and longer term, continuing to contain elective service demand by reducing the chronic disease burden and limiting the long-term sequelae of poor lifestyle choices.

Closer primary/secondary links and understanding at local level will facilitate more effective referrals and streamline assessment of elective cases. The introduction of GP Liaison Officers has undoubtedly done much to build links and understanding, but other aspects of elective service management would benefit from additional clinical champions and senior clinical endorsement. For example, the MRG has been told that the work on prioritisation tools, despite being clinically led, has not been comprehensively understood in primary, nor universally applied in secondary, services. Yet better appreciation of these tools may help primary care refer suitable cases and secondary services ensure their resources are reliably targeted to those most in need.

Increasing primary care access to appropriate diagnostics has also been shown to improve the quality and appropriateness of referrals. Recent pilots have achieved some success in this area and should be further developed, publicised and evaluated, recognising that local differences in availability of resources may mean tailoring solutions locally.

The Government's initiative in increasing elective theatre stock notwithstanding, for many communities, increasing elective services is essentially about ensuring maximal use of current capacity. This in turn will necessitate clinical leadership to develop more efficient models of care. Recognising that workforce pressures across the sector mean new scopes of practice and novel clinical roles are inevitable, clinical leaders must accept the challenge to design and develop an appropriate workforce that recognises the unique characteristics of existing professional disciplines and builds capability in their support.

The MRG agrees with the views of the SMO commission[12] that, to date, even the trialling of other approaches, such as nurse anaesthetists, physician assistants and different models to support patients with chronic health conditions have been relatively rare. While this is by no means the sole solution to workforce concerns, these do appear to offer some support in other jurisdictions.

The additional workforce being trained to meet the additional theatre capacity needed will require adequate exposure to clinical material during their courses and then to be supervised and developed during their post-graduate training. This will require thoughtful clinical leaders who can balance current clinical care demands with these additional training and supervision needs.

The MRG is very aware that present elective service provision does not meet existing clinical need. This is true for most, if not all, countries worldwide whatever their economic situation. However somewhat unusually internationally, New Zealand has for a long time been open with its population and explained when specialist interventional needs cannot be met within existing capacity. This does however increase the responsibilities of primary care practitioners, who must support those patients who do not meet local access criteria. This is a further opportunity for closer secondary/primary linkages in developing good supportive information and care pathways for these patients in primary care. Initiatives already exist in this regard, but should now be accelerated.

[12] Director General of Health's Commission on Competitive and Sustainable Terms and Conditions of Employment for Senior Medical and Dental Officers Employed by District Health Boards (June 2009).

3 Ways to establish clinical networks and leadership programmes to support these goals

CLINICAL NETWORKS

Clinical networks[13] are in essence a way of "...enabling traditional professional and organisational boundaries to be crossed within an environment of professional generosity, to improve patient care."[14] Although the term "clinical network" is sometimes attributed to the Scottish Health Service, which began introducing a formalised version, known as managed clinical networks in 1999,[15] the New Zealand National Renal Advisory Board, a different style of network, had already begun work two years previously, itself pre-dated by a policy vision for NHS cancer services linking expertise from primary care through secondary and tertiary services.[16]

Other jurisdictions have since adopted the term, though the focus, functions, structures, accountabilities and even the impetus to create a network varies considerably. Networks may be informal or directed towards sharing information, co-ordinating care, collective service planning, or may be mandated to deliver all of these functions.

There is some evidence however that networks do best when their functions are precise and clearly defined. In Queensland, clinical networks have grown from clinical practice improvement initiatives and are allowed to set their own agenda and operate quite independently, though with some central support. In New South Wales, networks are concerned with the dissemination of evidence-based practice, while in South Australia, the impetus has been on ensuring better equity in service provision across rural and metropolitan services. Even within New Zealand, the MRG has found several different models in existence, from the organic coalescence of like-minded clinicians drawn to collaborate by a common concern (of which the National Renal Advisory Board is a good example), to regional networks, such as those implemented through the NZ Cancer Control Strategy Action Plan and the Ministry-mandated, national model such as the proposed national cardiothoracic surgical network.

Whatever the genesis and form, networks typically do some or most of the following:

- Provide advice on the development and adoption of evidence-based policy,
- Inform strategic and operational planning for health and health service delivery, including the appropriate distribution of clinical services spanning low volume/high cost interventions through to high volume care within a defined geographical area,
- Provide opportunities to develop systems and work practices that improve clinical expertise and encourage best use of both physical and intellectual resources,
- Enable and support collaboration on teaching and research,

[13] Also called 'health networks' in Western Australia.

[14] Metropolitan Health and Aged Care Services Division, Victorian Government Department of Human Services. (2008). ***Clinical Networks: A Framework for Victoria.***

[15] MEL. (10): 1999.

[16] Calman K and Hine D. (1995). ***A Policy Framework for Commissioning Cancer Services***. Departments of Health of England and Wales.

- Develop performance indicators in key areas of activity to ensure the indicators are clinically relevant and robust and encourage audits for benchmarking and to establish national standards and support peer review,
- Promote a stable workforce and planning,
- Enable inequalities of access to be addressed, and
- Align activities with the Government's strategic plan for health services, focusing on the promotion of health and well-being and building sustainable models of care.

On the other hand, clinical networks are not alternative management structures or fund holders. They are not responsible for monitoring compliance. Importantly, they are not a way of devolving responsibility for finding solutions to otherwise 'impossible' problems.

Why do we need another committee?

Conceptually, clinical networks offer a different approach to addressing long-standing problems in health care, such as the separation between primary and hospital care, local ownership of standards and practice quality, professional boundaries and the involvement of consumers. Professionals work best when invited to apply their specialist skills and knowledge and flourish when their own clinical interests and concerns are at the heart of the activity.[17]

The effectiveness of this concept has not been widely evaluated. When Scotland's Tayside Diabetes Managed Clinical Network was reviewed,[18] researchers found a blend of two forms: firstly, an egalitarian cooperative of clinicians linked by personal relationships and charismatic leadership, where quality improvement was delivered through the soft governance of persuasion and collegiality, and secondly, a hierarchical format of committees that defined network strategy, enabled consumer participation and linked the network across the NHS. Early results suggested the policy-driven, hierarchical form struggled to implement quality improvement without the strong professional enclave, but the enclave itself was at risk if significant individuals lost interest.

More recent work showed networks are often dynamic groups that develop and mature in stages, suggesting their establishment may be complex, iterative and should not be rushed.[19] Some network activities (such as co-ordinating care and enhancing effectiveness, efficiency and consistency of care) increased in importance with time, while others (such as the importance of specific individual members) declined. Two factors initially declined, but subsequently rose in importance again:

- Engagement based on trust that networks can achieve results, and
- Momentum and enthusiasm is easy.

A comparison of voluntary with mandated clinical networks in the same jurisdiction[20] highlights some important distinctions: voluntary networks emphasised the clinical condition of primary interest and achieved broad consensus on the aims and purpose of the network (an 'us' mentality), whereas the mandated network focused on organisational issues and found the aims and purpose of the network continued to be contested (a 'them' approach).

[17] Braithwaite J, Runciman WB and Merry AF. (2009). 'Towards Safer, Better Healthcare: Harnessing the Natural Properties of Complex Sociotechnical Systems'. ***Quality and Safety in Health Care*** (18): 37-41.

[18] Pagliari C, Morris A and Evans J et al. (2005). 'Lessons for "clinical network" implementation'. ***Fam. Pract.*** (22): 49.

[19] Rushmer R. (2004). ***A National Survey of Clinical Leads and Managers of Scotland's Diabetes and CHD Networks***. Presented at a National Workshop to share and discuss research findings into clinical networks hosted by the universities of Dundee and St Andrews on 4 February 2009. http://www.sdhi.ac.uk/documents/National%20Survey%20A.ppt#1 accessed 10 June 2009.

[20] Greig G. (2009). ***The Story of Four Managed Clinical Networks in Scotland.*** http://www.sdhi.ac.uk/documents/The%20Story%20of%204%20MCNs.ppt#1 accessed June 10 2009.

An abiding challenge in health care is how to spread good practice and achieve a reduction in variations from accepted standards of care. One of the main limitations to the rapid spread of innovation and quality standards appears to be a need for local testing and ownership and a reluctance to accept others' experience. Indeed, one of the factors to which the success of the Canterbury Initiative[21] is attributed, is the very involvement of local clinicians in developing a local solution.

Practical hurdles experienced in establishing and maintaining clinical networks both within New Zealand and overseas include finding passionate people able to make time to do the work (usually pro bono), limitations of supporting resource, burn out and disengagement of participants when success is delayed, disagreement about standards and the place (mandate) of professional bodies (should the network include elected members, for instance?). Some balance must also be found between a network's autonomy and the competing priorities and demands of the organisations delivering health care, and between responsibility and authority.

Clarity around decision-making is necessary to avoid misunderstandings. There is also an obvious balance to be found between a clear statement of the group's governance, including an inclusive membership, and effective supporting arrangements and the ability to be flexible and responsive to specific needs.

Clinical leadership is a given for these networks, and the leadership style should respect the values of all members. Commitment is most likely to be maintained where participants can see meaningful consequences of the network's activities and believe the group is addressing important aspects of patient care.

The size of the network is important, as the range of professional groups involved in the particular discipline or health specialty, primary care practitioners and patients or their representatives, should be included. However, overly extensive networks may become unwieldy and slow and involvement may be difficult to maintain. Local examples have dealt with this differently, for example by creating individual working parties to address particular questions that report back to an executive or steering group.[22]

Regular and effective communication both within the network and between members and other interested parties is essential. Building bridges, often across multiple boundaries, is a key activity of all networks.

Opinion is divided on the value of specific 'team-building' exercises, since the very activity of working collaboratively on a particular task often acts as the stimulus for building relationships. However, while technology may allow well-established networks to meet more efficiently, networks are likely to be most effective when people have already met in person and share some mutual confidence and trust.

Expectations of what a new network may achieve and by when should be realistic. Clinicians may express frustration with a perceived slowness of decision-making and with overall progress, and sometimes this may be due to lack of appreciation of the real boundaries of influence. Conversely, we are concerned that overly high expectations may force unrealistic timeframes on what are in effect consensus-based relationships.

[21] A PHO/DHB network aiming to improve primary/secondary integration across all specialties, rather than within a single hospital discipline.
[22] For example, northern regional cancer network.

Some suitable means of monitoring and measuring progress may reassure members that progress is being made and demonstrate the network's value to observers. The time and effort contributed by individual members needs to be recognised, both in dedicated and protected time for the network leader(s), including appropriate back-filling support for their home organisation(s), and management/administrative support for co-ordination, intra-network communication, and development of draft proposals etc.

Potential risks include too many networks, reinforcing discipline, specialty or service level silos and paradoxically making integrated, holistic care for the patient more difficult.

Evaluation of the success and achievements of networks can be complicated: potential outcomes can be both tangible (such as service change, agreed clinical protocols) and intangible (including increasing professional cohesiveness, handling conflict and enhancing patient involvement and self-care). Importantly, the intangible outcomes, which are strongly attributed to clinical networks, are those that emerge first and on which any tangible results are predicated. This means it takes time for tangible outcomes to emerge. What has not yet been explored in the literature to any depth is to what extent clinical networks affect patients' experience of health care services.

The MRG has had the opportunity to consider both mandated and organic models in New Zealand, and have been particularly impressed with the commitment, passion, and frank enjoyment that exists alongside specific achievements, where a network has evolved naturally. The NRAB, for example, produces detailed standards and audits all centres against these, providing valuable information for clinicians' own use in improving their services. We noted too that networks that coalesce naturally – or at least have the ability to develop along semi-autonomous lines – appear to align much better with delivering a quality health service.

Leadership programmes

The *McKinsey Quarterly* acknowledges the contribution of highly visible, formal leadership roles, and describes the USA hospital model, where at least three distinct types of medical leaders (institutional, service, and front-line) leader exist and are inter-dependent.

Institutional leaders are the "...sophisticated clinical leaders who often occupy formal, executive-level roles ... [who] …communicate a powerful, clinically based vision and have deep, broad skills in both leadership and administration …such as negotiation and influence." Support for change is frequently built by showing how proposals can improve quality of care.

Service leaders, on the other hand, are "...passionate advocates of their own units or teams …[and] are also aware of the context and requirements of the whole organization." Basing their activities on clinical evidence of benefit, this group takes accountability for the clinical and financial performance of their service.

Thirdly, front-line leaders are the clinicians who concentrate on the direct delivery of patient care and also contribute to continuous quality improvement as opportunities present during their daily work. This group should be competent in common systems and quality improvement techniques and must also know the "...basics of leadership, such as an awareness of their personal style and how to work well in teams."[23]

[23] Mountford J and Webb C. (2009). 'When Clinicians Lead'. ***McKinsey Quarterly*** (Feb).

While the McKinsey model concentrates on medical leadership in an institutional setting, there are obvious parallels with other clinical disciplines. Clinical leadership models in primary care demonstrate similar qualities and need similar skills.

The MRG has heard from a number of groups of various factors that are perceived to limit clinicians' willingness to participate as leaders at whatever level. These include:

(a) Recognition that influencing and leading change, however minor, often calls for considerable effort, persistence and at times a willingness to accept colleagues' sometimes harsh criticism,

(b) Professional bureaucracies function quite differently from business command and control models, and leadership frequently depends on tacit permission from the group conditional on representing the group's views. Where leaders face competing demands – commonly nowadays to balance the budget while advancing the cause of delivering more and better health outcomes – peer support may be withdrawn. Unlike the more traditional career development pathways for senior clinicians, where reducing front-line clinical practice to take on research, teaching or collegiate leadership can bring considerable professional recognition and satisfaction, reducing clinical practice to take on leadership roles can result in personal and professional isolation, and

(c) Misunderstandings about the broader pressures and demands of health care services within a national context and assumptions about the skills and tools used in leading change can leave clinicians feeling mislead and confused about what is expected of a leadership role and what can realistically be achieved.

Leadership development will require appreciation of the operational environment in some depth, as well as personal skills and competencies and a knowledge of available tools that can help in certain situations. As *In Good Hands* has highlighted, various frameworks for leadership skills and abilities exist, which all to a greater or lesser extent reflect personal leadership qualities as categorised by CanMEDS. These are now widely included in professional education programmes – both at undergraduate and post-graduate levels – and should serve future generations of senior staff well.

However, while these are all important leadership qualities to be nurtured and developed, there is also a knowledge base, including appreciation of particular techniques and tools (for example in change management, evidence analysis and quality improvement measures and tools) that are not yet widely taught as part of professional undergraduate or post-graduate education. Some of the requisite knowledge base could be taught through formalised programmes, and academic recognition of such will be important in raising the profession's recognition of and respect for those in leadership roles. Seed funding to establish academic departments of clinical leadership could be considered at the university level to support research in the area and promote the formalisation of academic achievement. This would enhance the status of clinical leadership and management beside the more traditionally-based academic streams, enable clinicians to plan, assess, and monitor their own learning and development in leadership, and offer objective measures for selection for formal leadership appointments.

At the same time, however, the MRG recognises that adults learn best when able to integrate their own rich experience and existing knowledge with new learning. Adults are typically problem-oriented and practical and look for the relevance of any learning to current needs.[24] Formalised leadership programmes should therefore include more personalised, self-directed learning opportunities, involving guided individual reflection and evaluation. This aspect of leadership development should continue beyond any formalised academic course, through appropriate networks (similar perhaps to the national CMOs' network) and regionally-based action learning groups.

In undertaking this task, the MRG is aware that there are many clinicians in leadership roles already who may benefit from continuing development. There are also those showing potential for the future, and finally, there are opportunities to teach leadership skills and approaches throughout professional education that will serve clinicians of the future and the health service in general well.

[24] Knowles M. (1978). ***The Adult Learner: A Neglected Species***. Gulf Publishing Co, Houston, USA.