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From: AEMH [secretariat@aemh.org]
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Dear all,

For your information, I attach a document "In Good Hands" received from the Association of Salaried Medical Specialists from New Zealand, which I thought might be of interest. For better understanding of the text, DHB stands for District Health Board. The report is issued by the NZ minister of health, who said in a speech:

"A strong commitment to Clinical Leadership and engaging health professionals underpins the government's health policy. Clinical leadership is about putting our clinicians at the centre of leading our health system. International evidence shows empowering clinical leadership improves service, improves patient outcomes, improves job satisfaction, and of course that in turn keeps clinicians in New Zealand."

Another quote from the British Health Minister Lord Darzi clearly enunciates:

"If clinicians are to be held to account for the quality outcomes of the care that they deliver then they can reasonably expect that they will have the powers to affect those outcomes. This means they must be empowered to set the direction for services".

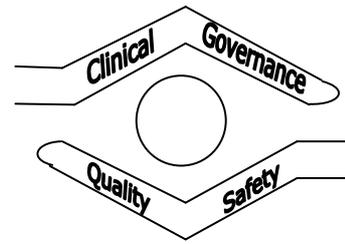
Darzi was further quoted as saying: "...where change is led by clinicians and based on evidence of improved quality of care, staff are energised by it and patients and the public more likely support it".

The Association of Salaried Medical Specialists collaborated with the minister of health on the report and made their stand clear. "The obvious has to be repeated: it is doctors, nurses, midwives, pharmacists, and other clinicians who provide the care patients need and want, not managers or boards or even Ministers. And we are working to enshrine that in the way the health system works."

I suppose that you will subscribe to this standpoint. Shouldn't the AEMH (together with other EMOs) define it's position in the same clear way on European level?

IN GOOD HANDS

Transforming Clinical Governance in New Zealand



“Healthcare that has competent, diffuse, transformational, shared leadership is safe, effective, resource efficient and economical.”

- Task Group, 2009

This report outlines transformative changes to clinical leadership that must occur, specifies some measures of that transformation, and identifies the challenge of nurturing clinical leadership.

Purpose of this Task Group Report

Throughout the New Zealand health system there has been increasing disengagement between clinicians and managers. Many clinicians have felt less and less able to influence decisions on the delivery of health care, while being held increasingly to account for the results of those decisions, or at least responsible for the outcomes. Many clinicians have decided to abrogate the responsibility for managing the health system at many levels, and just to get on with the clinical work. Many managers, left to make decisions without clinical expertise, feel less and less able to influence the clinicians who deliver the healthcare and who determine the quality and safety, and cost, of that care.

Clinical networks in primary care, developed in recent years, report effective partnerships between managers and clinicians at the network level, but poorer engagement with DHB management and governance structures.

Recognising the detrimental effects on quality and safety from increasing disengagement, all 21 DHBs and hospital specialists signed up to “Time for Quality” - an explicit commitment to a health professional partnership and principles of engagement.

This report “In Good Hands” develops that commitment to greater clinical engagement in order to improve the quality of care in our health and disability services. The Ministerial Task Group on Clinical Leadership was convened by the Minister of Health to:

- describe how we can establish strong clinical leadership and governance in the health system.
- describe and develop aspects of leadership required for good clinical governance
- develop examples of how processes for clinical governance can be established

Summary of Report

- “In Good Hands” defines clinical governance.
- It discusses components and attributes of leadership that can identify leaders, both formal and informal, and can be used to measure their performance.
- It advises transformation to structures within DHBs to achieve better quality and safety through clinical governance.
- It recommends that DHBs be required to report on outcomes of such transformation.
- It recommends action to foster and train leaders.
- It recommends sharing successes.

Definition of Clinical Governance

Clinical governance is the system through which health and disability services are accountable and responsible for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish. - Scally, Donaldson, 1998 (adapted)

Clinical governance is the system. Leadership, by clinicians and others, is a component of that system.

Introduction – the Problem

Decisions around the planning of health care now demand a balance between clinical, community and corporate governance. This balance is increasingly important as services develop population health focus (area, region, nation) as well as individual patient care, and integrate the patient journey through primary to tertiary services (and back) across specialty silos.

A lot of effort has gone into corporate governance, and reporting corporate outcomes, and processes are being established for community governance. However, clinical governance, and reporting on clinical outcomes, has not been the prime focus of many DHBs, especially in their hospitals. Primary care clinical networks have shown that successful clinical governance requires distributed leadership (at practice, network, and national levels), and much of primary health care governance is “in good hands”.

The challenge for the rest of the healthcare system is to transform clinical governance into an every day reality at every level of the system, to ensure the whole system is in good hands.

Principles

A process for the New Zealand healthcare system to transform towards clinical governance needs to be based on the following six principles.

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1. Quality and safety will be the goal of every clinical and administrative initiative.
 2. The most effective use of resources occurs when clinical leadership is embedded at every level of the system.
 3. Clinical decisions at the closest point of contact will be encouraged.
 4. Clinical review of administrative decisions will be enabled.
 5. Clinical governance will build on successful initiatives.
 6. Clinical governance will embed a transformative new partnership which will be an enabler for better outcomes for patients.
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Components of Clinical Leadership

Extensive expertise in other health systems explores components and attributes of effective clinical leadership. The NHS Leadership Qualities Framework lists 15 qualities or competencies. The Canadian model (CanMEDS) listing 7 domains of performance is common to, and forms the basis for, accreditation of undergraduate and postgraduate, and vocational medical education programmes, and continuing professional development programmes, throughout Australia and New Zealand, and internationally.

These competencies, outlined in the Appendix, can form both a guide to identify and develop future leaders, and a framework for measuring and reporting on clinical leadership.

Structure of Clinical Governance in the New Zealand Health System

“If clinicians are to be held to account for the quality outcomes of the care that they deliver, then they can reasonably expect that they will have the powers to affect those outcomes. This means they must be empowered to set the direction for the services they deliver, to make decisions on resources, and to make decisions on people.”

- Professor of Surgery, the Lord Darzi, Parliamentary Under Secretary of State, Department of Health UK. *NHS Next Stage Review Final Report*, 2008

The structure necessary to operationalise the Time for Quality agreement and the Quality Improvement Strategy for the best care of citizens/patients within the New Zealand health system encompasses the whole spectrum of care, from primary to tertiary and national services.

The following adjustments are imperative for the successful transformation of healthcare and effective clinical governance.

1. **DHB Boards** must establish governance structures which ensure effective partnership of clinical and corporate management. DHB Boards must be required to report on clinical outcomes and clinical effectiveness, via a nationally consistent framework. Quality and safety must be at the top of every agenda of every Board meeting and Board report.
2. **The Chief Executive** must enable strong clinical leadership and decision making throughout the organisation. Assessment of Chief Executive performance must include clinical outcomes, clinical effectiveness, and the establishment of clinical governance.
3. **DHB Governance** will promote and support clinical leadership and clinical governance at every level of the organisation. DHBs must report on clinical leadership and clinical governance through their District Annual Plans, their Statement of Intent, and scorecard reports to the Ministry. This reporting includes, but is not limited to, the functions of their Clinical Board.
4. **Clinical governance** must cover the whole patient journey, including horizontal integration across the sector and across primary and secondary/tertiary services. Tangible examples of clinical governance, which DHBs must report on, include:
 - a) Clinicians on the Executive Management Team as full active participants in all decision making
 - b) Effective partnership between clinicians and management at all levels of the organisation with shared decision making, responsibility and accountability
 - c) Decisions and trust devolved to the most appropriate clinical units or teams, which are many and varied, including clinics, offices and practices, wards and departments, hospitals and networks, regional and national bodies.
5. **Clinical leadership** must include the whole spectrum from inherent (eg surgery, clinic, bedside, theatre relationships) through peer-elect (eg practice, ward, department arrangements) to clinician-management appointment (eg clinical directors, clinical board). DHBs must report on the establishment, and effectiveness, of clinical leadership across the spectrum of their activities, aligning management to clinical activities.

6. DHBs and the health system must **identify actual and potential clinical leaders**, and foster and support the development of clinical leadership at all levels. To this end DHBs must together establish strategies to:
- a) Provide on the job training to strengthen the competencies and attributes of clinical leaders
 - b) Measure the achievement of leadership competencies in their workforce
 - c) Link with Universities, Colleges, and professional associations to coordinate funding, access to internal and external training, and support for coaching and mentoring of leadership at all levels.

Clinical engagement is about more than simply appointing people to particular positions or forming committees. It is about recognising the diffuse nature of leadership in healthcare organisations and the importance of influence as well as authority. Within health professions a range of leaders also exist who may not be official leaders in the eyes of the organisation; however they may be influential for other reasons amongst their peers, for example academic appointments, positions in professional organisations such as Colleges and Societies, or elected representation.

"Leadership is emphasised as a mechanism for effecting change and enhancing quality - with opportunities for this more likely to arise ... at a local than a national level. [It] requires a new obligation to step up, work with other leaders, both clinical and managerial, and change the system where it would benefit patients."

- Darzi, High Quality Care For All, 2008

Empowerment of clinicians is the best means of realising this obligation, and will be accompanied by a willingness to accept responsibility and accountability, including for best use of resources.

Reporting on the Transformation

Quality and safety will improve when DHBs, and their Chief Executives, are required to report clinical outcomes, and the establishment of clinical governance within their healthcare organisations, as part of their routine "bottom line" and their own performance measures.

The Task Group recommends that, at a minimum, DHBs must::

1. Report on clinical outcomes and clinical effectiveness, in a nationally consistent manner.
2. Ensure that quality and safety are at the top of every agenda of every Board meeting and Board report.
3. Assess their own and Chief Executive performance on measures that include clinical outcomes and the establishment of clinical governance.
4. Report on clinical leadership and clinical governance through their District Annual Plans and scorecard reports to the Ministry.
5. Demonstrate clinician involvement at all levels of the organisation including the Executive Management team.**
6. Demonstrate devolvement of decision making and responsibility to the most appropriate clinical unit or team.**

**The mechanisms for reporting on 5. and 6. must include clinicians themselves.

**An example is existing Joint Consultative Committees.

7. Identify actual and potential clinical leaders, and foster and support the development of clinical leadership at all levels.
8. Coordinate funding, access to internal and external training, and support for coaching and mentoring of leadership at all levels.

Nationally Consistent Reporting

The health safety and quality literature clearly states that measurement is a very effective tool for driving change. The existing well established and validated international leadership metrics should be applied to the New Zealand healthcare industry.

The Task Group recommends that a small group be tasked with developing an initial national framework for reporting on clinical outcomes, clinical effectiveness, and clinical leadership within DHBs. This evidence-based framework should be part of existing reporting mechanisms such as “balanced scorecards” to the Ministry, and should be validated for accuracy by clinician groups within DHBs.

The initial framework should be reviewed and updated regularly as part of a national process to improve the quality and safety of health and disability services.

“...where change is led by clinicians and based on evidence of improved quality of care, staff are energised by it and patients and the public more likely to support it.”
- Darzi, High Quality Care For All, 2008

Sharing Successes

DHBs, through clinical networks and other networks, should share the successes of effective clinical governance. Some current examples of these successes include:

- Quality Improvement processes eg Cornerstone in primary care
- PHO accreditation - Te Wana programme for Healthcare Aotearoa
- Regional quality and education programmes through primary care networks
- Hospital medical department credentialing in MidCentral and Counties Manukau
- Regional cancer networks
- Joint Consultation Committees – local DHB and national
- Newborn Life Support Course – nationally consistent training in resuscitation
- TelePaediatrics – videoconference network linking child health professionals
- New Zealand Incident Management System – training and standards

The Task Group is aware that many other examples of clinical leadership have led to major improvements in quality and safety. Supporting and sharing these successes requires transforming leadership throughout the entire system, including not just DHBs but also at Ministry level and national advisory groups.

“Starting from isolated pockets of excellence and innovation, clinical leadership still has a long road to travel. But it is an essential road for both clinicians and their patients. A deep commitment to patient care and to traditional clinical skills will always remain the core of a clinician’s identity. To achieve the best and most sustainable quality of care, however, a commitment to building high-performing organisations must complement these traditional values. All the evidence suggests that patients will see the benefit.”

- Mountford and Webb, 2009

**Ministerial Task Group on Clinical Leadership
In Good Hands – Transforming Clinical Governance in New Zealand
February 2009**

APPENDIX

Components of Clinical Leadership

The NHS Leadership Qualities Framework was the result of consultation including feedback from hundreds of clinicians and managers in the NHS.

A brief overview of the 15 qualities of the NHS Leadership Qualities Framework is.

Cluster One: Personal Qualities

1. Self Belief – The inner confidence that you will succeed and can overcome obstacles to achieve the best outcomes for service improvement
2. Self Awareness – Knowing your own strengths and limitations and understanding your own emotions and the impact of your behaviour on others in diverse situations
3. Self Management – Being able to manage your own emotions and be resilient in a range of complex and demanding situations
4. Drive for Improvement – A deep motivation to improve performance in the health service and thereby to make a real difference to others' health and quality of life
5. Personal Integrity – A strongly held sense of commitment to openness, honesty, inclusiveness and high standards in undertaking the leadership role.

Cluster Two: Setting Direction

1. Seizing the Future – Being prepared to take action now and implement a vision for the future development of services
2. Intellectual Flexibility – The facility to embrace and cut through ambiguity and complexity and to be open to creativity in leading and developing services
3. Broad Scanning – Taking the time to gather information from a wide range of sources
4. Political Astuteness – Showing commitment and ability to understand diverse groups and power bases within organisations and the wider community, and the dynamic between them, so as to lead health services more effectively
5. Drive for Results – A strong commitment to making service performance improvements and a determination to achieve positive service outcomes for users.

Cluster Three: Delivering the Service

1. Leading Change Through People – Communicating the vision and rationale for change and modernisation, and engaging and facilitating others to work collaboratively to achieve real change
2. Holding to Account – The strength of resolve to hold others to account for agreed targets and to be held accountable for delivering a high level of service
3. Empowering Others – Striving to facilitate others' contribution and to share leadership nurturing capability and long-term development of others
4. Effective and Strategic Influencing – Being able and prepared to adopt a number of ways to gain support and influence diverse parties with the aim of securing health improvements
5. Collaborative Working – Being committed to working and engaging constructively with internal and external stakeholders.

Each of these competencies may exist or develop to variable strengths in an individual, and not all individuals will necessarily be equally strong in all attributes. Individuals will complement each other to achieve overall clinical governance by shared leadership.

Other countries have developed frameworks which share the common theme that clinical leadership in health is essential, and must be developed throughout the system.

NHS Leadership Qualities Framework



CanMEDS roles framework

- Medical Expert (the central role)
- Communicator
- Collaborator
- Health Advocate
- Manager
- Scholar
- Professional

The Canadian model of the domains of performance (CanMEDS) is common to,

and forms the basis for, accreditation of undergraduate and postgraduate and vocational medical education programmes, and continuing professional development programmes (eg MCNZ guidelines), throughout Australia and New Zealand, and internationally.

For other clinicians this model can be adapted, with the central or principle domain (for doctors - medical expertise) changed to nursing, or physiotherapy, or other allied health expertise, surrounded by the same six roles (communicator, collaborator, etc). The same six domains are applicable to associated professional groups within the healthcare industry, surrounding a central or principle domain specific to their profession eg managers requiring expertise in management of the health industry. Similarly for human resource practitioners, information technology practitioners, and even financial advisors, accountants, and lawyers.

The Canadian Health Leadership Framework (see appendix) is essentially similar to the NHS Leadership framework. New Zealand needs to adopt, not invent, its own.

“Leadership is not advanced management ... most ... corporations today are over managed and under led ... they need to develop their capacity to exercise leadership.”

- John Kotter, Professor of Leadership, Harvard Business School.

In fact, leadership is required within all professional groups in healthcare. There are different styles of leadership in different industries but there are qualities, particularly in healthcare, which research has found to be common to effective leadership.

Qualities which cumulatively form a leadership style:

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|---|---|
| - specific technical skills | - credibility |
| - charismatic inspiration | - optimism |
| - cooperation | - a sense of purpose or mission |
| - networking | - ability to generate trust |
| - empathy | - an ability to delegate and to nurture |
| - a dedication that consumes much of a leaders' life. | |

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