Clinical leadership: what is it and how do we facilitate it?

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ABSTRACT

Clinical leadership has been on the New Zealand policy agenda since the launch of the 2009 *In Good Hands* report, yet performance in supporting its development has been variable. The 2016 *New Zealand Health Strategy* renews the emphasis on clinical leadership, but with few details for what this is, what the expectations are and how clinical leadership might be supported. This article backgrounds the field and provides some pointers for policymakers and the sector if New Zealand is to take the lead on clinical leadership.

Defining clinical leadership: expectations and training implications

Health professionals trained in the scientific method can struggle with clinical leadership because it is a management concept and open to different interpretations.[1] The term clinical leadership is sometimes used interchangeably with 'medical leadership'; for this article, clinical leadership could also be referred to as 'health professional leadership' and encompasses all professionals: doctors, nurses and allied care providers working in hospitals and primary care. In some cases, clinical leaders may be professionals who are no longer clinically active. As a general rule, clinical leaders should probably also be involved in delivering care.

There is evidence that leadership makes a difference in how organisations run and how services are delivered. Leadership, in itself, is an entire area of practice and academic study.[2–4] However, rather than a set of scientifically proven procedures that clinicians are trained to use in daily practice at point of care, leadership is context-dependent.[5] This means that lessons from experience or evidence of use in one location needs to be adapted for use in another, often with different results. Leadership is, by definition, about leading people. It encompasses assuming responsibility for various management activities, leading by example, and seeking as much best practice as possible to implement in organisational design and process improvements. Importantly, clinical leadership requires ability to work with professional colleagues from across an organisation and its different professional disciplines. In turn, it involves working on behalf of other clinicians and patients to improve the healthcare system. The implications for clinicians in primary care and general practice are a demand for proactively engaging in improvement activities, including helping to build mechanisms for improvement in collaboration with other primary care and hospital-based professionals.

For health professionals, their trainers and policymakers, strong clinical leadership requires all health professionals to acknowledge that they have two jobs and receive appropriate training and support for this. First, they should be well trained in their professional speciality and uphold the highest professional standards in everyday work, whether it be in general practice, nursing, pharmacy or surgery. New Zealand's health professionals, training bodies and regulators ensure this job is performed with few exceptions.[6] Second, they should be stewards of the healthcare system, working persistently to improve the system they work within. Health professionals are best placed to observe lapses in patient care and standards, and the waste in professional practice and patient time that results when the system is suboptimal. Professionals are therefore in an

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ideal position to provide leadership around the changes needed for system improvement.[7] This second job is where the goal of clinical leadership, implicit in the *New Zealand Health Strategy*, could make a real difference.[8] Presently, there is limited training for leadership in clinical practice, limited coordination of programmes offered by individual District Health Boards (DHBs), Primary Health Organisations (PHOs) or Independent Practice Associations (IPAs), and no national programme. Considerable progress and focus is needed before one could confidently say that this second job is being delivered upon. This is in contrast to the English National Health Service, for example, where there has long been a focus on leadership training.[9]

Tertiary education providers, professional colleges and regulatory authorities have a central role to play in breathing life into the second (system improvement) clinical role. If clinicians are to embrace this wholeheartedly, then students, the health professionals of the future, need to be instilled with the two-jobs responsibility and equipped with skills for both.[10,11] The skill set could be extended during postgraduate training, and requirements for meeting certain standards incorporated into professional registration and practice.

In sum, there are widespread opportunities to promote the concept of clinical leadership, which is now reinforced in the *New Zealand Health Strategy*. The two-jobs concept can be a useful method for framing what real practice should be all about. Key managers from across the health sector, such as those leading DHBs, PHOs and IPAs, have opportunities to promote and support clinical leadership and its development. This means creating mechanisms for building clinical leadership, identifying emerging leaders and investing in training. It also means that professionals see leadership as a responsibility and must have the will and capacity (previously found to be constrained[12,13]) to commit to this.

Policy on clinical leadership in New Zealand

For some time now, political and bureaucratic leaders have emphasised clinical leadership in the New Zealand health system, with good reason.[14,15] The concept of 'clinical leadership' was central to the 2009 report of the Ministerial Task Group on Clinical Leadership, *In Good Hands*.[16] This report was endorsed by then Minister of Health, Tony Ryall, with an expectation that all DHBs and, by proxy PHOs, would implement its recommendations.[17] A subsequent assessment focused on DHBs showed variable performances in developing leadership mechanisms, with a demand for considerable improvement.[12,13] Some DHBs appeared to invest more in leadership activities than others. In better performing DHBs, the board and executive teams demonstrated considerably more commitment to supporting professional leadership; and some DHBs benefited from the drive and contribution of several key professional leaders. This emphasis on clinical leadership, of course, contrasts with the era of the 1990s 'health reforms' when health professionals were considered to have little to contribute to governance of the healthcare system.[18,19]

The present Minister of Health, Dr Jonathan Coleman, has consistently expressed the view that clinical leadership is central to the government's health policy and to DHB organisation.[20] Clinical leadership is also inherent to the 2016 *New Zealand Health Strategy,* which charts key policy directions for the health system. An example is in the concept of working as 'one team'. Central to this is '*developing leadership, talent and workforce skills throughout the system*' and a goal of creating a '*system leadership and talent management programme*'.[8] Details for this were yet to be announced at the time this article was written and, as noted, progress is required on various fronts for a health system characterised by robust clinical leadership. The remainder of this article highlights approaches for policymakers, DHBs, PHOs, IPAs and training institutes to consider for delivering on the promise of clinical leadership.

Building structures for clinical leadership

Different structures for health system governance and organisation exist. New Zealand has experience with many, including structures that promoted competition between providers, and

democratic governance that tends to be hierarchical and managerial in nature.[19] In practical terms, this means orders come down through the system with effects on professionals who often feel they have not been included in decision-making. DHB boards are accountable first to government and, in turn, place often strong expectations on the executive team around financial performance and other policy areas.[19,21]

Clinically led structures may look very different from management-led structures.[22] A perhaps useful analogy for structure is that of universities. Here, almost without exception, academics (the professionals) hold all key leadership positions. They have worked their way up through the organisation, with an expectation from the outset that they will contribute to administration, so they intimately understand the business. Importantly, they work in partnership with administrators on whom they rely for analytical and other support. Ideally, once in the highest leadership positions, they maintain some research and teaching, meaning they are professionally active but, along with colleagues throughout the system, are also involved in leading system improvement, thereby achieving the two-jobs concept. Many academics bemoan involvement in what are often seen to be trivial decisions, but would not want the alternative of being led by, and answerable to, generic managers.[23]

There are several options for health organisations to fulfil the goal of a clinically led structure. First is committing to the university model to ensure that all key leadership staff are professionally qualified, including the Chief Executive. Many DHBs and PHOs have this model or something close to it in place. Few, however, require that their leaders are also clinically active, although general practitioners and practice nurses tend to be closely engaged in PHO and IPA leadership. Requiring leaders to be clinically active sends an important message to professionals throughout the organisation that the leaders understand the working environment; it provides leaders with the first-hand experience that underscores the concerns of front-line professionals, especially around how the system might be improved; and it means that leaders also demonstrate a commitment, through action, to the two-jobs concept.

Second, most if not all DHBs have created a 'clinical council' or similarly titled entity. While these tend to vary in purpose and composition, a common aim is to provide clinical oversight of organisational decision-making and clinical services delivery. Clinical councils often feature a spectrum of professional representatives, including primary care clinicians such as general practitioners, along with the executive leadership and, ideally, community representation. Council work may range from oversight of clinical services building projects, of care quality and standards, and of organisational performance. The more successful and productive clinical councils are given the capacity to veto DHB board and executive decisions, should these be considered by council to be unsound. In other words, like universities, professionals have the final say. This means there is considerably more scope for dialogue between professionals, managers and the board. It means that plans and decisions are subject to sufficient consultation, and that the different professional, patient and other interests have been incorporated in the process.

Conclusion

Clinical leadership is an important foundation for good quality, well-run healthcare services and systems, and for improvement. New Zealand is in a strong position to be an international leader in building a clinically led system, with considerable progress made on this in recent years. Policymakers are again emphasising clinical leadership, including in the 2016 *New Zealand Health Strategy*. However, as this article has implied, in order to realise the vision, there is work to be done. This includes engaging in a process of defining clinical leadership and the expectations for this, as well as considering the structural adjustments required to propel clinical leadership development. The responsibility for this falls on all points in our healthcare system: our policymakers in Wellington, our DHBs, PHOs, IPAs and other providers, our tertiary trainers, professional colleges and regulatory authorities, and, of course, our healthcare professionals. This distributed base naturally indicates a need for coordination and, indeed, leadership for clinical leadership. Let us hope that a next step in the policy debate includes creation of a mechanism for this.

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COMPETING INTERESTS
None.