ADVICE

ASMS
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SENIOR DOCTORS IN FORMAL CLINICAL LEADERSHIP POSITIONS

The need for formal leadership positions

Patients and their families need senior doctors leading their health system at all levels. While distributive clinical leadership is essential to deliver the highest quality care at every encounter and at every planning meeting, formal leadership positions anchor the role of senior doctors at the helm of the system.

These formal positions should attract the highest calibre of clinicians, should be sought after, supported, rewarded, and resourced to function at the front of high performing teams.

Formal leadership positions have been integral to health systems and components of those systems for generations. Many eminent doctors have served in these positions. Some have struggled to make a difference and resigned to return to clinical practice.

A role as a formal clinical leader can be immensely fulfilling, an opportunity to shape health services on a large scale, and by doing so improve the health of the population as well as the individual. It will often be senior doctors in formal leadership positions who change

culture and challenge managers, politicians - and their colleagues - to provide better patient-centred care.

'In Good Hands' (2009) opened with "Healthcare that has competent, diffuse, transformational, shared leadership is safe, effective, resource efficient and economical". It outlined the principles of clinical governance required to transform the New Zealand health system away from an administrative focus on financial outcomes:

- quality and safety will be the goal of every clinical and administrative initiative
- the most effective use of resources occurs when clinical leadership is embedded at every level of the system
- clinical decisions at the closest point of contact will be encouraged
- clinical review of administrative decisions will be enabled
- clinical governance will build on successful initiatives such as the Time for Quality agreement between DHBs and senior doctors and dentists
- clinical governance will embed a transformative new partnership which will be an enabler for better outcomes for patients.

The Ministerial Task Group paper discussed qualities and competencies of clinical leaders, observing that there are different styles of leadership in different industries but there are qualities, particularly in health care, which research has found to be common to effective leadership, qualities which cumulatively form a leadership style: specific technical skills, charismatic inspiration, cooperation, optimism, a sense of purpose or mission, empathy, an ability to delegate and to nurture, a dedication that consumes much of a leaders' life.

Clinical leadership includes the whole spectrum from inherent (surgery, clinic, bedside, theatre) through peer-elect (practice, ward, department) to clinician-management appointment (clinical directors, clinical board). Formal positions in District Health Boards (DHBs), either elected or appointed, are the focus of this paper. Senior doctors have often found themselves in these positions rather than striving to achieve them. *'In Good Hands'* identified that to achieve the highest quality of clinical leadership, 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:

- provide on-the-job training to strengthen the competencies and attributes of clinical leaders
- measure the achievement of leadership competencies in their workforce and
- 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 leadership should be an integral part of the training and role of a senior medical officer, ideally starting at undergraduate level, and should be essential in postgraduate workforce deployment and development.

A clinical leader has the responsibility to not just advocate for high quality and safe patient care but also represent the workforce and create a work environment where clinicians and non-clinicians alike can fully enjoy their useful and rewarding work.

Clinical leaders deserve support from management and from their colleagues, enough time, and sufficient resources to fill their crucial role. It is also reasonable to expect remuneration that reflects the value placed on this work by all within the institution and within the health system.

This paper outlines some of the issues facing senior doctors in these positions and offers advice to help doctors thinking of taking up such a position, as well as those currently in formal clinical leadership roles. Any SMO thinking of taking up a formal clinical leadership position should consider the issues set out in the advice section below and seek the advice of their colleagues and ASMS industrial staff.

"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."

Darzi, NHS Next Stage Review Final Report

Advice on taking up a formal clinical leadership position

- The provisions of the MECA (Clause 52), dealing with appointments, expressly apply to the filling of all formal clinical leadership positions and require participation by SMOs at the DHB/service, both in developing the job description and in the appointment process. This should ensure that anyone achieving a formal clinical leadership position has the support of their colleagues.
- You will need a clear job or position description with goals and objectives that are both reasonable and achievable. Under the MECA, job descriptions must be mutually agreed. (As a guide use Clause 48 in the MECA).
- A critical ingredient if you are to enjoy your clinical leadership position will be assessing at this stage

whether you will be able to make a difference.

- The MECA (Clause 48(e)) provides for a separate allocation of time for formal clinical leadership duties. As well, senior doctors should have the normal allocation of non-clinical time that follows from clinical duties at the DHB. See the *ASMS Standpoint on hours of work and job size:* http://www.asms.org.nz/wp-content/uploads/2014/08/ASMS-Standpoint-Hours-of-work-and-job-size.pdf).
- The most common issue that the ASMS deals with is inadequate or no FTE allocated for formal clinical leadership responsibilities. An inadequate allocation of paid hours for clinical leadership positions within DHBs will undermine and devalue clinical leadership. SMOs thinking of taking up these roles are advised to look carefully at the job description to see if the position responsibilities can be fulfilled in the time allocated and not sign up unless they can.
- You are entitled to administrative and other support from your DHB including legal, human resources support, accommodation, accounting, business analysis and other data appropriate to the position as well as leadership training. Ideally the level of support should be canvassed before you definitively accept the position.
- Reasonable extra remuneration that reflects the value placed on this work by your DHB should be agreed before you take up the position.
- The Parachute clause. You should make sure you have an explicit agreement from your employer that you can revert to (or in the case of an outside appointee, take up) a clinical role if you leave your position or are displaced from your position.
- ASMS Industrial Officers are happy to advise members on a confidential basis about their terms and conditions of employment when they take up a role as a formal clinical leader.

A wide variety of positions

There is a wide range of clinical leadership roles within DHBs, and many DHBs use different terms to describe each role. There is no standard or generic position description for most of these roles.

Although all DHBs have a Chief Medical Officer (or similar) role, and some have deputy or assistant CMO roles, not all CMO roles share the same responsibilities, authority or delegations. Some are designated Advisor, some have DHB-wide responsibilities, others are more hospital focused. Other roles or positions with clinical leadership duties and responsibilities have different titles, such as Clinical Leader, Clinical Director, Chief of Surgery/Medicine/Psychiatry, Executive/Medical Director, Medical Head, or Head of Department. Clinical heads of department may be responsible for just their colleagues' performance, others in combined directorates with many departments are responsible for senior doctors in specialties quite different from their own. Some DHBs have senior doctors in roles with 'single point of accountability' where they operate as clinical and business managers. Other DHBs have SMO clinical leaders in partnerships with managers and nursing leaders. Roles therefore vary from accountability for only their colleagues, to joint accountability for all members of the department as well as budgets, targets, performance, quality.

Some of these clinical leadership positions are formal appointments that include a clinical practice component, and may have been advertised outside the DHB. Others may be advertised within DHBs and include or exclude a clinical practice component. Some of these will be full time, but nearly all doctors continue to practice some clinical FTE in order to retain their APC.

Terms of office vary across the country and even within DHBs. Some are for fixed terms, such as Canterbury DHB with a fixed term of three years. Rotating these roles among all the senior doctors in a department is less common, with most rotations applied for, and many having formal interview processes.

The head of department is the most common formal clinical leadership position. Even in DHBs where there has been a conscious effort to do away with these positions, they have re-emerged in an organic way. There is nearly always a 'go to person' among the SMOs within departments. These will be the crucial positions in any DHB that make sure that information, concerns and initiatives flow both ways through a DHB's structure and that all SMOs contribute to the strategic direction of their service. They are essential to regional collaboration and for integration with primary care.

What you need to function as a clinical leader

When you consider taking up a position as a formal clinical leader, consider the issues set out in the advice section above, and make sure that you seek the advice of an ASMS Industrial Officer. Some of the issues that you will need to canvass are dealt with in detail in the box. They include making sure that you have sufficient time to do the job, that the job is properly supported by the DHB, that it is properly rewarded and that you have a "parachute clause" with the right to return to a clinical position if and when you leave the formal clinical leadership position.

The most contested issue is time to properly perform in the role and balancing leadership duties with an understandable desire to remain active clinically. It is important both for your colleagues and for you that your clinical position is backfilled or this tension may make the position untenable.

Support for a clinical leader

This can include administrative (such as EA/PA dedicated to and of a quality reflecting the importance of the role), legal, human resources support, and appropriate accommodation. Formal clinical leaders should also make sure they understand their obligations under health and safety and other legislation and ensure that they have appropriate support from the DHB to effectively discharge these obligations. Financial and accounting, business analysis, data and outcomes information, quality improvement processes (such as rapid cycle PDSA), performance management, and IT/IS expertise are fundamental supports necessary for clinical leaders to perform at the peak of their licence.

Clinical leadership training

Training in formal clinical leadership can be crucial to making a success of this role and should be part of the package offered when you take up this role. At a minimum your DHB should train you in its own management and budgeting processes and provide you with the necessary business data, patient flow data, and health needs analysis data to enable you to do your job. You should also receive generic training in clinical leadership. Though there is national consensus that this training is necessary, there is no consensus on a single training programme. One training path is to become a fellow of the Royal Australasian College of Medical Administrators (RACMA). A number of CMOs (as well as some other doctors) are fellows of the College. This offers the advantage of not requiring separate clinical practice to maintain an APC, but it may not be the appropriate training for all doctors in formal leadership positions, such as someone with a small FTE appointment as a clinical head of department.

Clause 36.6 of the MECA envisages leave approved by the employer to participate in programmes, courses, conferences and activities related to the development of professional leadership. This is a discretionary clause but is a discretion which has a good fit with DHB and senior doctor desires to produce the very best clinical leaders. Medically focused leadership training may generate MOPS points and may be suitable for CME.

Some formal programmes and resources are accessible through the websites of organisations such as: *Ko Awatea, RACP SPPP* and *RACMA.*

Walking the tightrope: tensions and challenges for formal clinical leaders

There will be tensions as formal clinical leaders embrace and negotiate distributive clinical leadership for their colleagues with managers. In some DHBs, formal clinical leaders who hold a position that is responsible beyond their own specialty may be regarded by administration, and clinicians, as simply managers with a clinical background.

Formal clinical leaders may find themselves drawn into dealing with complaints about their peers or disciplinary issues involving SMOs. In this role it is imperative that they have the right expertise and support made available to them from the DHB. The expertise clinical leaders bring to the process should be as guardians of patient safety and quality of care. Questions surrounding quality of care should be adjudicated through evidence, professional standards and recourse to appropriate expert advice. Investigations of clinical practice are covered in Clause 42 of the MECA.

"Leadership is tough, can be painful and certainly requires resilience."

Collegiality

There is a natural tension between 'collegiality' which clinicians value highly, and a single colleague expected to lead and command. Ideally formal clinical leaders embed a culture of mutual respect that favours conversations and consensus decision-making, in contrast to some approaches of 'managerialism' with its hierarchy and bureaucracy, risk aversion, and conflict avoidance. There are delicate boundaries between clinical, corporate, and community expectations. Clinical leaders must straddle these boundaries whilst retaining the respect of their clinical colleagues, managers, and patients.

Formal clinical leaders and distributive clinical leadership

Formal clinical leaders should ensure they regularly report up and down. SMOs and clinical staff in their department should have both a sense of being listened to and being heard. Ideally formal leadership positions can be an opportunity to be the voice of distributive clinical leadership in management deliberations, and the guardians of patient safety and quality of care.

Relevant reading

ASMS Standpoint on hours of work and job size

ASMS DHB MECA 1 July 2013 – 30 June 2016