To investigate how highly performing organisations support clinician involvement in decision-making and leading change.

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Signed: Dated:
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- My husband for his attention to detail in planning the schedule, and my boys for helping me to enjoy the sights along the way.
EXECUTIVE SUMMARY

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AIM: To investigate how highly performing organisations support clinician involvement in decision-making and leading change

METHOD: Thirty-five interviews were conducted of over 60 people in healthcare organisations across the United Kingdom, Denmark, Sweden and the USA. I visited three hospitals and participated on a tour of the Sidney R. Garfield Innovation Centre in Oakland, California and attended a two day conference on Clinical Commissioning in Manchester, UK.

The following questions provided the basis for the interviews conducted.

1. If clinician involvement in decision-making is important, how can it be embedded in national, state and local health strategy?
2. What knowledge, skills and behaviours do clinicians need to play an effective part along with patients, communities and government in decision-making?
3. For clinicians currently involved at a senior level, what were the barriers and enablers to success in their personal journey?

RESULTS: Three major themes, and multiple sub-themes, emerged from the responses to these questions.

1. The value of clinician involvement
2. Embedding clinician involvement
3. The knowledge, skills and behaviours required for clinician involvement in decision-making

RECOMMENDATIONS:

1. That all clinical education and training contain a component that addresses leadership and management knowledge, skills and behaviours. All clinicians must have the foundation competencies, with more advanced training for those in more senior roles. Interprofessional and interdisciplinary learning should be an underlying principle.

2. That there is a requirement for government, Local Health Districts/Networks, hospitals and community services to include active clinicians, from the outset, in the teams involved in strategic planning, priority setting, resource allocation, consultation processes and implementation of health care services.

3. That opportunities are created for clinicians, and in particular, junior clinicians, for experiential learning in leadership and management, based on international
examples, such as attachments to senior leaders, involvement in major redesign and reform projects and programs, and interprofessional learning with managers.

4. That health care organisations support clinicians to share responsibility and accountability for health outcomes, quality and cost with managers through

- Appropriate recruitment
- Education and training
- Access to content experts eg business managers, data and IT
- Clear delineation of responsibilities and accountabilities

IMPLEMENTATION AND DISSEMINATION

Since returning from my Fellowship trip I have presented or will be presenting in a number of forums including:

Hunter New England Local Health District
- Clinical Leadership Program Graduation Ceremony
- Innovation Support Advisory Committee
- District Managers’ Forum

Australian and New Zealand College of Anaesthetists
- WA Summer Scientific Meeting Plenary Speaker
- Annual Scientific Meeting, Perth – Invited speaker

This study has value for:

- NSW Ministry of Health, in particular, the Agency for Clinical Innovation, the Clinical Excellence Commission, the Health Education and Training Institute and Local Health Districts

- Health Workforce Australia

- Postgraduate training bodies – nursing, allied health and prevocational and vocational medical bodies

- University Clinical Schools
PROGRAM

November 30 – December 1, 2011
Manchester
NHS Alliance Conference

December, 2011
London
Alistair Henderson  Chief Executive, Academy of Medical Royal Colleges
John Clark  Senior Fellow, King’s Fund
Dr Emma Stanton  Senior Institute Associate, Harvard Business School
CEO, Beacon Health Strategies UK
Harkness Fellow in Health Care Policy
Kirsten Armit  Faculty Manager, Faculty of Medical Leadership and Management
Marijka Trickett  Faculty Co-ordinator, Faculty of Medical Leadership and Management
Dr Anna Moore  Clinical Fellow to Department of Health and Faculty of Medical Leadership and Management, NHS Medical Director’s Clinical Fellow Scheme
Dr Yasmin Ahmed-Little  Co-Chair, The Network
Dr Bob Klaber  Consultant Paediatrician, Imperial College Healthcare, St Mary’s Hospital
Prof Bernard Crump  Visiting Professor, University of Leicester
Honorary Professor, University of Warwick
Past CE, NHS Institute For Innovation And Improvement
Dr Ashley McKimm  Head of Quality, BMJ Group

Manchester
Prof Rajan Madhok  Medical Director, Manchester Primary Care Trust

December 6 – 19, 2011
Denmark
S1 Leadership Network  10 senior clinicians and managers
Glostrup Hospital
Dr Per Jorgensen  Vice-Director
Dr Lars Jacobsen  Clinical Director, Dept of Anesthesiology
Lone Piening  Nursing Co-Director, Dept of Anesthesiology
Dorte Jeppesen  Head, Department of Development and Education
Marianne Lunde Knudsen  Program Director, Leadership programmes developed by The Danish Medical Association
Bispebjerg Hospital
Dr Steen Hansen Werner  Vice-Director
Dr Benn Duus  Clinical Director, Department of Orthopaedics
Dr Anne Frolich  Team Leader, Department of Integrated Care
Dr Carsten Hendriksen
Sweden
Göran Henriks Director, Qulturum, Jönköping
County Council
Marie Bergeling Improvement Leader
Berit Axelsson Patient Safety Improvement Leader
Rolf Bardon Communications Manager
Malin Skedring Hallgren Patient Involvement Leader
Dr Peter Nordlund Deputy Head Intensive Care, Ryhov County Hospital
Dr Werner Puskar Head, Radiology Department
Britt-Mari Banck Nurse Manager, Self-Dialysis Unit

January 8-12, 2012
Boston
Centre for Medical Simulation
Dr Jenny Rudolph Assistant Clinical Professor of Anaesthesia
Harvard Medical School and Massachusetts General Hospital
Director, Institute for Medical Simulation Graduate Programs
Dr Dan Raemer Director, Research and Development
Dr Robert Simon Education Director
Dr Roxanne Gardner Assistant Professor of Obstetrics, Gynecology and Reproductive Biology Harvard Medical School
Faculty member

Institute for Healthcare Improvement (IHI)
Trina Lorch Manager, Program and Business Development
Dr Karen Boudreau Senior Vice President, Medical Director for the IHI Continuum Portfolio
Dr Kathy Luther Vice President, Hospital Portfolio Planning and Administration
Carly Strang Director, Open School
Michael Briddon, Managing Editor of the Open School
Dr Donald Goldmann Senior Vice President, Institute for Healthcare Improvement
Martha Rome Director of the Triple Aim Initiative.

Dr Adam Elshaug Sidney Sax Fellow
School of Population Health and Clinical Practice, University of Adelaide
Harvard Medical School

January 17-18, 2012
San Francisco
Molly Porter Director, Kaiser Permanente International
Dr Amy Compton-Phillips Associate Executive Director, Quality, The Permanente Federation

February 15, 2012
Sydney
Jillian Skinner Minister for Health, Minister for Health Research
NSW Parliament
INTRODUCTION

One of the major findings of the 2009/2010 National Health and Hospital Reform (NHHR) process was the need for increased involvement of clinicians in decision-making in health care and in leading change toward improving the health of Australians, their experience of health care and in gaining the most health for our dollar. However, this level of involvement requires a set of skills that is not part of a clinician’s undergraduate training. In addition, clinicians must be given real responsibility, authority and accountability which must be embedded in healthcare structures. Leading healthcare organisations across the world are addressing this gap as a priority and in innovative ways.

Clinicians are at the ‘pointy end’ of the system, where the final decisions regarding health care are made with patients. Choices available and choices made at this moment in time are the outputs of an extraordinarily complex system that requires the skills of a wide range of people. The NHHR process suggested that there is currently an imbalance in this skill set with a lack of clinician involvement informing priority setting and resource allocation. Worthy plans by governments require clinical input along with that of patients, carers, managers, local government and non-government organisations to ensure that evidence-based policy can be fully implemented. It is at the point of delivery of care that failures of policy-making, resourcing and implementation are most acutely felt, and feedback by clinicians of failure at the coal-face is essential. Embedding high quality clinician involvement at all levels of policy making will increase the opportunities for clinicians to advocate effectively for the health of all Australians.

The word ‘clinician’ is used throughout this study to include doctors, nurses and the allied health professions. In many organisations, however, there is a noticeable gap between the degree to which nurses and doctors, in particular, are involved in high level decision making, In these places, especial effort is being directed at improving doctor involvement.

The word ‘involvement’ is used throughout this study to indicate a practical, visible participation in decision-making processes. The word ‘engagement’ is used where the interviewee or a document uses this word and should be interpreted in the context of its origin. In some cases it implies ‘involvement’ but in others it refers to ‘gaining the interest of’ or ‘convinging to participate’, for example.

THE VALUE OF CLINICIAN INVOLVEMENT

“policy makers can prod and poke healthcare systems as much as they like, but their ability to make things happen is mediated by the autonomy afforded to healthcare professionals delivering care to patients at the frontline”
Spurgeon, Clark and Ham, 2010
In his 2008 review *High Quality Care for All*, Lord Darzi, the then UK Parliamentary Under-Secretary of State in the Department of Health, stated that **clinical leadership is central to the success of healthcare reform**. Multiple qualitative studies and reviews support this assertion but making it happen in a consistent, high quality way continues to be a challenge. In particular, many groups have singled out doctors as having a crucial role because they lead at the coal-face where final decisions about care are made.

In his plenary address to the Clinical Commissioning Conference in Manchester in November 2011, the Secretary of State for Health, **Andrew Lansley**, spoke about the handing back of leadership to clinicians to improve the quality and efficiency of healthcare in the NHS.

“...power is really now being handed over in the NHS........to empower patients and empower clinicians, I have to disempower the Department of Health, the Secretary of State.”

“I think it would be rather sensible if we have a million qualified, exceptional people across the National Health Service to trust them to deliver.”

Andrew Lansley

**Why does it matter?**

“Doctors may be reluctant enablers but they can be powerful disablers.”

Professor Rajan Madhok

Intuitively, clinical staff who feel that they are part of a team and who feel that their contribution is valued are more likely to be involved in quality and service improvement. Quantitative evidence for the link between the level of medical engagement and hospital performance has been demonstrated Spurgeon et al (2011), using the **Medical Engagement Scale** (Spurgeon et al 2008). This scale was developed and validated by the same team using a database of over 23 000 healthcare professionals.

In particular, they found a strong positive correlation between medical engagement and improved patient mortality and between engagement and measures of levels of service. Statistically significant associations were found between engagement and quality measures, financial performance and achievement of performance targets. Another group who have learnt the value of frontline clinician involvement is the team at the Sidney R. Garfield Innovation Center in Oakland, California, home to the Kaiser Permanente innovation team. This warehouse in the airport and freight district, houses several spaces
that simulate healthcare environments – an operating theatre, a ward, a clinic, a person’s home. Here, teams can test out new devices, technologies or work practices. When asked what lessons they had learnt over time, the tour leader said that, in the beginning, the innovation team would run with the idea, developing it up to implementation phase. After a number of failures at this point, the team identified what they now call the ‘O Gap’, or operationalization gap. Without the frontline clinicians on the team, important mistakes were made, resulting in a failure to implement. All teams now include the end-users from the beginning. This correlates well with the way in which policy is often developed at a long arm’s length from the coal-face, failing to take into account the barriers that may exist to implementation.

What are the barriers?

A number of the interviewees in the study made reference to the Griffiths Report (Griffiths 1983) which was commissioned in 1983 to review the NHS. The recommendations from the report were centred on the establishment of a clear management and reporting structure including the employment of managers at every level of the NHS. The report called for strong clinician involvement at hospital level in resource allocation decisions. There was a backlash from doctors, in particular, however, who felt that budget decisions were the role of managers, not clinicians. Some interviewees postulated that this was the point, at least in the UK, at which clinicians and managers began to diverge, with clinicians becoming less and less involved and less and less skilled in the management of health services. Others pointed out that the performance of managers is measured by the indicators determined by government, and that they may not wish to relinquish control over issues that will reflect on them personally.

Over time, then, in the UK as in Australia, senior management positions have increasingly been filled by non-clinical applicants. Nurses appear to have maintained a stronger managerial presence than doctors, however. Senior nurses and senior managers interviewed postulated that there were a number of reasons for this difference:

1. Nurses have a clear career path to management
2. Nurses have role models who have chosen management
3. Medical specialists spend around fifteen years full-time to reach even junior status in their chosen field. To ‘dilute’ this with other roles or to pursue another career pathway is often characterised as a ‘waste’, or a dereliction of collegial values – “going to the dark side”.
4. Doctors may feel uncomfortable in a role for which they have no training – few wish to be move from ‘expert’ to ‘novice’.

Where is clinician involvement valued and how can you tell?

While the UK appears to have begun its journey to increased clinician involvement 5 or 6 years ago, interviewees in Denmark and Sweden describe the role of clinicians as an integral part of a team or system that delivers care for a community. The clinicians themselves were somewhat puzzled that their input would be considered anything other than essential.
In both Scandinavian countries, regional bodies hold funding and responsibility for buying care for their population from primary, community and acute sectors.
In Denmark, the hospitals I visited have a Nursing and a Medical Vice-Director under a Director. There is a clear framework for clinician involvement in strategic and operational planning with regular meetings with clinical heads of departments as a group and as individual departments. These occurred as often as fortnightly. Planning for the next year, within the limitations of the budget and priorities for the community, is a shared task between the hospital vice-directors and their department heads. Regular review of these plans is scheduled throughout the year. Department heads saw themselves as responsible and accountable for health outcomes, quality and costs within their department.
Another way in which the value of clinician involvement is demonstrated is in organisations that recruit clinicians to leadership roles on the basis of leadership and management skills. Clinicians who are experts in their clinical field do not necessarily also have the skills to lead and manage, and if their contribution is important, they may not be equipped to perform in these roles. Kaiser Permanente in the US, like Denmark and Sweden, address this issue by providing education and training in leadership and management for all clinicians.

**EMBEDDING CLINICIAN INVOLVEMENT**

Across the world, there is a growing recognition of the value of clinician involvement in decision-making and managing change. Once this value is internalised within the organisation, the next step is to create a system that reliably involves clinicians as essential team members, not one that involves clinicians as an afterthought. High performing systems and organisations have approached this in a number of ways.

**Culture**

It was clear from interviewing clinicians and managers in Denmark and Sweden that both societies are very egalitarian. Structures are flat and there was an expectation that people would speak up if they had concerns.

“when I tell my employees to do something, they are not going to say yes, they’re going to say why.”

*Clinical Director, Denmark*

There was also a clear sense that senior clinicians in these countries viewed themselves as part of a healthcare system which, in turn, is part of a community. In that respect, they spoke about **considering the needs of the whole** rather than their individual needs or just those of their department.
Creating such a culture where it doesn’t currently exist is no small task. In the UK, a number of **clinician-led social enterprises** have been established that provide a forum for like-minded clinicians to share ideas, learn from one another and influence others.

“Social enterprise is a means by which people come together and use market-based ventures to achieve agreed social ends. It is characterised by creativity, entrepreneurship, and a focus on community rather than individual profit.”

*(Talbot et al 2002)*

Diagnosis is one such enterprise, established by two doctors in training who recognised both the need for junior doctors to understand more about health services management and health policy, and the capacity within that group to contribute to shaping the healthcare system. Members of the enterprise act as learners and also as resources for each other and for the wider system when feedback is requested. The group is consulted and paid on a formal basis by government and also organises events for face-to-face networking and learning.

Foreign to Australian ears, was the expression of pride and even ‘love’ for a nation’s health system. These emotions were expressed on a number of occasions in reference to the National Health Service in the UK, and the systems of Denmark and Sweden. A senior UK leader and manager postulated that Australians, given a threat to Medicare, would be equally defensive of the Australian healthcare system.

Another approach taken in the UK to changing culture is through clinical education, providing foundation knowledge about healthcare systems and the challenges they face, engendering a sense of responsibility for addressing them, while acknowledging that it will take a generation to know if this has made a difference.

**Structure**

Opportunities for clinician involvement must be identified or created where they do not currently exist. If such involvement is valued, then the recognition of clinicians as members of the healthcare leadership and management team should lead to ‘a seat at the table’ wherever decisions are made regarding planning, resource allocation and implementation.
The first way in which structure supports clinician involvement is through **formal positions**. As described previously, Danish hospitals have both medical and nursing Vice-Directors at hospital management level and then medical and nursing clinical co-directors at department level. Across the UK, all Strategic Health Authorities have Medical Director positions.

**Quality recruitment processes** to these positions are also vital. In Denmark, the senior clinician managers felt that processes for recruitment and succession planning are improving.

“Historically in Denmark we have had that the most skilled physician was the one who got the head of the department. Then it went to head of department is last man out of the door. That was because there is no career for a physician to go for to be head of the department. Because you are degrading your skills in medical science. So it has been a side way. But nowadays a lot of us are making it a career.”

Senior clinical leader, Denmark

A number of the Danish clinicians and managers interviewed described clear schedules of multiprofessional and multidisciplinary **meetings between clinicians and managers**. The purpose and outcomes of these meetings varied from strategic or operational planning, to reporting on progress and offering support.

Another important means of embedding clinician involvement is through providing **quarantined time** for leadership and management activities. Particularly where there are clear roles and responsibilities for the clinician, adequate time must be provided to carry them out. The amount of time allotted varied from country to country, and amongst organisations. In the Danish hospitals, medical and nursing heads of department had either fulltime or close to fulltime management appointments. They also had very clear accountability for outcomes, quality and costs. In Sweden, however, the department heads estimated that they had perhaps 0.2 FTE in which to perform their non-clinical duties. They felt that this was insufficient but were unable to reduce their clinical loads to accommodate an increase. The quarantined time was similar for the US Kaiser Permanente doctors in department management positions.

Distributed or shared leadership models exist as a matter of course in many healthcare organisations and many disciplines, with different people assuming the lead in different circumstances. Recognition of this and reflection on the pool of skills that already exists within teams is a good place to start in embedding clinician involvement in planning services and leading ongoing improvement.
Networks

As well as the social enterprise Diagnosis, numerous networks of clinicians and of clinicians and managers can be found across the UK, Europe and the US. The goals of these groups range from mutual support, to education, dissemination of information and driving change. In some cases, they were established and led by government and in others, by junior clinicians.

The Network (www.the-network.org.uk), for example, is an on-line forum for medical students, junior doctors, recently graduated GPs and specialists, and other healthcare professionals with the slogan “Connect people, share knowledge, improve care.” Members have a shared interest in clinical leadership and medical management and offer a resource for groups who wish to engage with junior health professionals. The group supports recognition of the ‘untapped potential’ within the junior clinician pool for leadership and involvement in health reform. Since establishment in 2010, almost 2000 clinicians have joined.

The NHS Clinical Leaders’ Network (www.cln.nhs.uk) has 3 core principles:

- “Support clinical leadership engagement
- Improve NHS clinical service delivery
- Enable clinicians to influence policy implementation by giving them direct access to local and national policy leads”

The program has a distributed model, led by individual Strategic Health Authorities. Clinicians participate in action learning sets, working on service improvement projects aligned with local needs. There are over 1000 clinicians involved across England and all 10 Strategic Health Authorities conduct a local program.

Another model for networks is the Senior Leadership Network in Denmark, which provides a facilitated forum for national and regional managers and clinician leaders to learn together and to provide a shared pool of expertise and experience. This is supported by the corresponding unions who have lobbied for more such networks to be established and supported by government.

Education and training

Clinical education and training, and in particular, medical training, is long and requires sustained effort by individuals toward achieving excellence in clinical knowledge, skills and behaviours. In medical specialty training, the apprenticeship model predominates, creating an opportunity for role modelling by skilled clinicians but rarely by skilled managers. Assessment drives learning and places little emphasis on leadership and management. It is therefore little wonder that most clinicians feel ill-equipped to take on roles outside their field of expertise. In addition to leadership and management skills, an understanding of public health, the healthcare system and health policy support the ability of clinicians to contribute to decision-making in health.
There are two main ways in which leadership and management training is occurring in leading healthcare organisations and these appear to overlap in many cases – through national and local programs. At a national level, both the UK and Denmark have mandated such education for all clinicians although there is yet to be a complete rollout. In the UK, the NHS Institute for Innovation and Improvement led the development of the Medical Leadership Competency Framework and Curriculum. Supported by the Academy of Medical Royal Colleges and the Deaneries, these competencies will form part of the curriculum throughout the continuum of medical education. The Faculty for Medical Leadership and Management was established in 2011 and has now reached 1350 members. It is also supported by the Academy, and provides oversight of such education and training, signposting to existing courses and continuing to raise awareness. In Denmark, the Regions have developed leadership and management education and training programs and provide time to attend. In addition, the Danish Medical Association, supported by the Regions, provides a year-long experiential program for senior doctors in leadership positions.

High quality resources for education and training in quality improvement, clinical redesign and managing large scale change are available to international participants through organisations such as the Institute for Healthcare Improvement in the US and the BMJ Quality group in the UK. These supplement local support provided by health services and hospitals.

In the UK, as a result of Lord Darzi’s reforms, a number of innovative Clinical Fellowships were created for GPs in training, newly qualified GPs and specialist registrars. These are one year positions in acute, foundation, mental health and primary care settings during which the Fellow is mentored by their medical director and is expected to lead on a major project in clinical service redesign, quality improvement or towards increasing leadership capacity. A leadership development programme is also provided that aims to support the organisational and leadership skills necessary for their future roles as consultants and clinical leaders. The Fellowships for Clinical Leadership program was acknowledged in the Healthcare People Management Association’s Excellence in Human Resource Management Awards in 2010. An evaluation of the first year of the program showed a significant impact on the individuals involved, a measurable output in terms of service improvement projects and early indications of cultural shift with regard to the desirability of leadership and management positions for clinicians (Stoll et al 2011).

In the Imperial College Healthcare NHS Trust, London, the “Paired Learning Program” places a registrar level doctor with a manager with the aim of providing insight for both into the different challenges of the other’s role. The pair negotiates opportunities to accompany each other in work situations a number of times over an eight month period as well as attending leadership and management education sessions. They are encouraged to reflect on the experiences. Evaluation of the first program showed that participants felt the experience was valuable, although more so for the managers than the clinicians.
**Rewards**

While, for nurses and allied health staff, management roles may increase earning capacity, for doctors this is rarely the case. Base salaries may be higher but payment for after-hours work means that clinical work remains better remunerated. Coupled with the perceived lack of value in clinician involvement and negative feedback from peers, a reduction in income may be the final deterrent for doctors to take on formal leadership and management roles. Even where there is no reduction in income, there is also no reward for taking on extra responsibility. This was the case in the UK, Denmark and Sweden.

**Supporting innovation**

Frontline clinicians are a rich source of ideas for ways to improve healthcare but their ability to develop, implement and evaluate such ideas is hampered by a lack of time, skills and other resources.

Jönköping County Council in Sweden shows very visible support for innovation as well as for leadership and management education and training. Qulturum, led by Göran Henriks and housed in a purpose-built facility, provides a space for thinking differently while learning skills in quality improvement. Despite being within the grounds of the Ryhov County Hospital, the environment feels miles away from the clinical world. Göran Henriks speaks about creating the future we wish to see and has established a team and a program that is based in a belief in the potential in all their staff – that everyone is capable of doing great things if given the opportunity and support to do so.

The networks discussed previously also provide a forum to share and discuss innovation, to seek advice and to highlight successes.

Kaiser Permanente’s Sidney R. Garfield Innovation Centre selects and funds innovative processes and devices, supported by a team of technological and clinical experts from prototyping through to implementation. Innovations that provide clear benefits to patients, staff and the organisation are disseminated throughout the Kaiser group.

One model for creating opportunities to discuss an idea with commercial potential is Partners Innovation Fund’s “Pitch Day” where clinician entrepreneurs or researchers can gain information and advice in confidence to further their innovation.
**Shared accountability**

Q. “...as the clinical director you have responsibility for budget.”

*Clinical Director (Denmark): “Yes”*

Q. “To what degree are you accountable for that...”

*CD: “Totally.”*

Q. “There’s no excuses?”

*CD: “Not at all. I would be fired.”*

In Denmark and Sweden, the heads of department interviewed had a clear understanding of their responsibilities and accountabilities. In Denmark in particular, the clinicians felt adequately skilled and supported in these roles. The hospitals visited offered various forms of support from regular meetings, access to business managers to education and training. The environment supported clinician leadership and clinicians saw it as natural to take on such roles. The Vice-Director at one hospital described the orientation process for new heads of department:

“When a new head of department is employed, one of the first things is that they participate in one of our meetings. We meet every Tuesday from 9:00 - 12:00. They’re invited for half an hour or an hour, whatever it takes to meet the ones they haven’t talked to and so we can say welcome and hear a little bit about what they think now. We have an introduction program where we try to make sure that new head of department people are meeting the department of economics and planning and HR and so on in order to learn how they can use them and how much help can they get.”

In addition, the managers spoke about a shared responsibility:
At Kaiser Permanente, Dr Amy Compton-Phillips described the pinnacle of clinician involvement to be shared accountability with managers and other members of the health care team. When all members of the team share common goals, believe in the value of each other’s contribution and when each member acknowledges their own value and accepts joint responsibility for the outcomes, quality and costs, then behaviours flow from this. Managers ensure that there is clarity of responsibilities and accountabilities for all team members, that all team members are appropriately skilled for the roles and that there is adequate time and resources to support delivery. Clinicians transparently accept the responsibility and understand the ways in which they are accountable, their reporting lines and mechanisms.

**KNOWLEDGE, SKILLS AND BEHAVIOURS REQUIRED FOR CLINICIAN INVOLVEMENT IN DECISION-MAKING**

**Leadership and management**

All countries visited had some form of leadership and management education and training available. In Denmark and the UK, there was either a mandatory component for all clinicians, or it is woven into basic or specialist training.
The Medical Leadership Competency Framework provides the only nationally endorsed curriculum seen.

**Quality improvement/clinical redesign/large scale change**

Increasingly, this is becoming an element of leadership and management training. In Jönköping in Sweden, frontline clinicians routinely participate in “process groups” with responsibility for a process in their department. Quality improvement is second nature. While the frontline clinicians may not link these actions to the presence of Qulturum, it is likely that the visible ‘quality culture’ is no accident, but rather the result of spread of ideas from trained clinicians over time.

**Public Health and Health Policy**

An understanding of the health system at a broad level and of the ways it does or does not meet the needs of the population has been identified by junior doctors as a gap in their knowledge. A number of the networks described previously address this deficit through education and exposure to policy and public health experts. Many of the leading clinicians interviewed counted a public health qualification as integral to their leadership skill set and a significant source of their motivation to take on roles of responsibility and accountability.

**“Executive presence”**

Finally, what makes a clinician an effective contributor to important decision-making processes?

One senior clinician/executive described the package of ideal knowledge, skills and behaviours as “executive presence” – where collaborating decision-makers trust that the clinician comes with a broad agenda, well-informed and open.

In answering the same question, the NSW Minister for Health didn’t hesitate. She described a clinician who not only led his peers, but also his community, to make decisions for the good of all, today and for the future.

**CONCLUSIONS AND RECOMMENDATIONS**

Internationally, there is a growing certainty that sustainable and ongoing improvement in healthcare systems depends on a strong partnership between patients and carers, clinicians, managers and government along with the communities they serve. This project looked at the role of clinicians, a focus shared in the UK and Scandinavia, where extensive resources are being directed towards the education and training of clinicians in leadership and management skills. However, merely possessing such skills will not ensure that clinicians are able to contribute to decision-making and managing change. The environment in which they work must be a supportive one in which responsibility and accountability for health
Outcomes quality and cost is shared by the entire healthcare team. Opportunities must be made available and support provided to encourage worthwhile involvement. International reforms acknowledge that shifting the system will require a generational change, and also that the time to start is now.

The recommendations from this study are:

1. That all clinical education and training contain a component that addresses leadership and management knowledge, skills and behaviours. All clinicians must have the foundation competencies, with more advanced skills training for those in more senior roles. Interprofessional and interdisciplinary learning should be an underlying principle.

2. That there is a requirement for government, Local Health Districts/Networks, hospitals and community services to include active clinicians, from the outset, in the teams involved in strategic planning, priority setting, resource allocation, consultation processes and implementation of health care services.

3. That opportunities are created for clinicians, and in particular, junior clinicians, for experiential learning in leadership and management, based on international examples, such as attachments to senior leaders, involvement in major redesign and reform projects and programs, and interprofessional learning with managers.

4. That health care organisations support clinicians to share responsibility and accountability for health outcomes, quality and cost with managers through

   - Appropriate recruitment
   - Education and training
   - Access to content experts eg business managers, data and IT
   - Clear responsibilities and accountabilities
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