ASMS SNAPSHOT

ASMS TOI MATA HAUORA

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Preliminary findings from the 2018/19 survey on Distributed Clinical Leadership

Introduction

There is strong evidence that health services led by clinicians improves patient outcomes and makes better use of available resources. High-quality health care requires service-specific knowledge which is constantly changing. Further, the quality of the health service as a whole is determined by the quality of 'front line' clinical practice. It is well recognised that 'command-and-control' leadership is incompatible with participative environments needed for effective patient centred care.

Distributed (also known as 'distributive') clinical leadership (leadership from senior doctors and dentists) is required to ensure clinicians can deliver services based on the best evidence adapted for local needs. Distributed clinical leadership (DCL) is not limited to the DHB as an institution but includes responsibility for patients and the public health system as a whole. It is much broader and extensive than formal clinical leadership (for example, clinical leaders (CDs) and heads of departments (HoDs).

The 2019 Distributed Clinical Leadership survey was released to ASMS members in two parts. Initially the survey was released in late 2018 but, due to a poor response rate, it was sent out again in March 2019 to those who had not responded to the initial survey. The overall final response rate was 26% (1158/4407), which was in line with previous responses rates to DCL surveys in 2015 (1182/3737- 32%) and 2013 (1060/3573- 30%). The poor response rate is noted as a significant limitation of this research but, nevertheless, the survey data provides an important measure of the views of members concerning their workplace environments and relationship with DCL.

This brief report compares key questions posed in the 2019 survey with the answers from previous years. It then delves into overall trends before examining DHB-specific responses to key questions.

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Results

As outlined in Figure 1, there is little change in terms of members views concerning the culture of their DHBs in supporting DCL. While fewer answered 'no', there was a slight decrease in those answering 'yes' and the proportion of people who were undecided had grown. Similarly, as detailed in Figure 2, a much larger proportion disagreed that their Chief Executive was working to enable effective DCL and the proportion of those answering either 'a great extent' or 'some extent' had declined since the previous surveys. A very similar trend was found in members' views concerning the role of their DHBs' senior management (Figure 3).

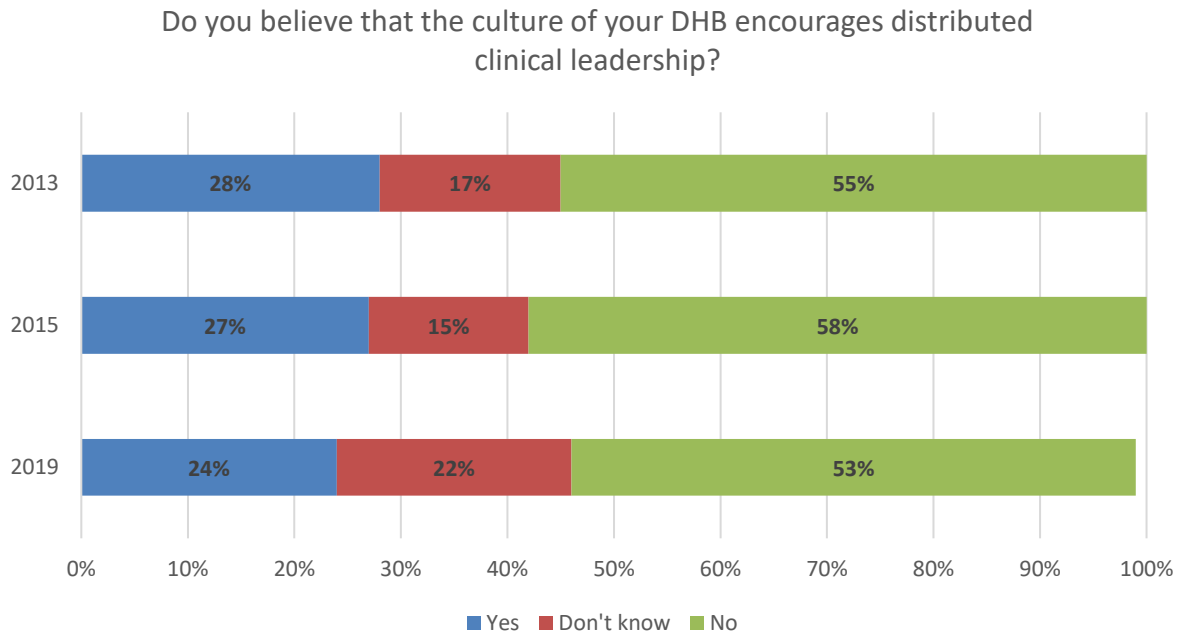

Figure 1: Comparative answers 2013-2019 DHB Culture

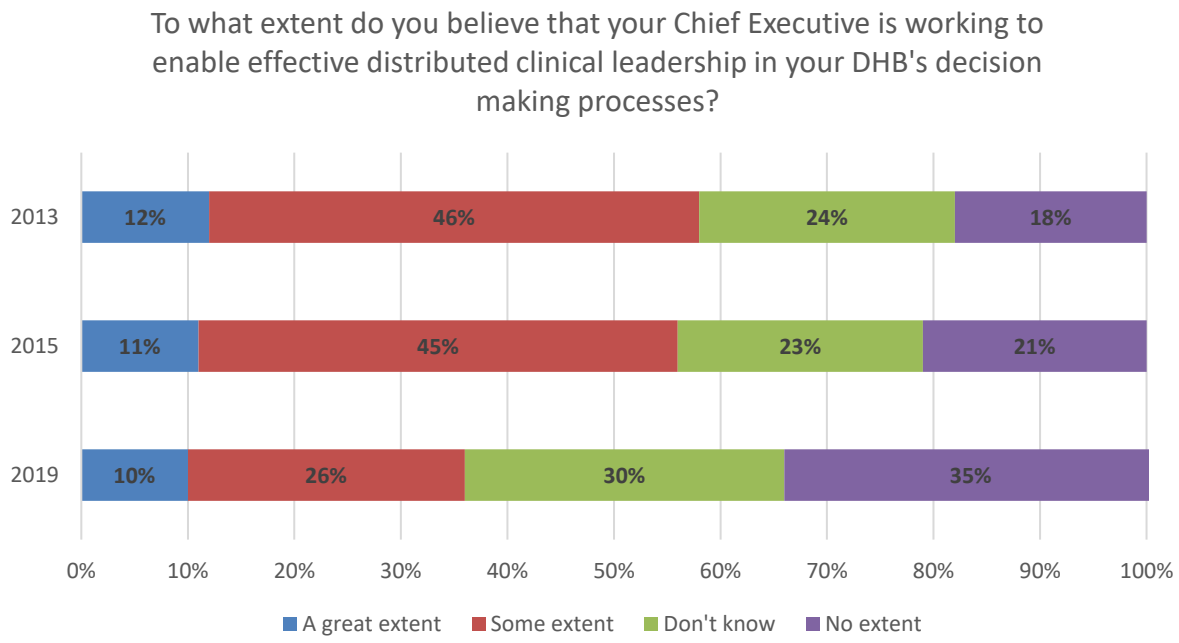

Figure 2: Comparative answers 2013-2019 Chief Executive role

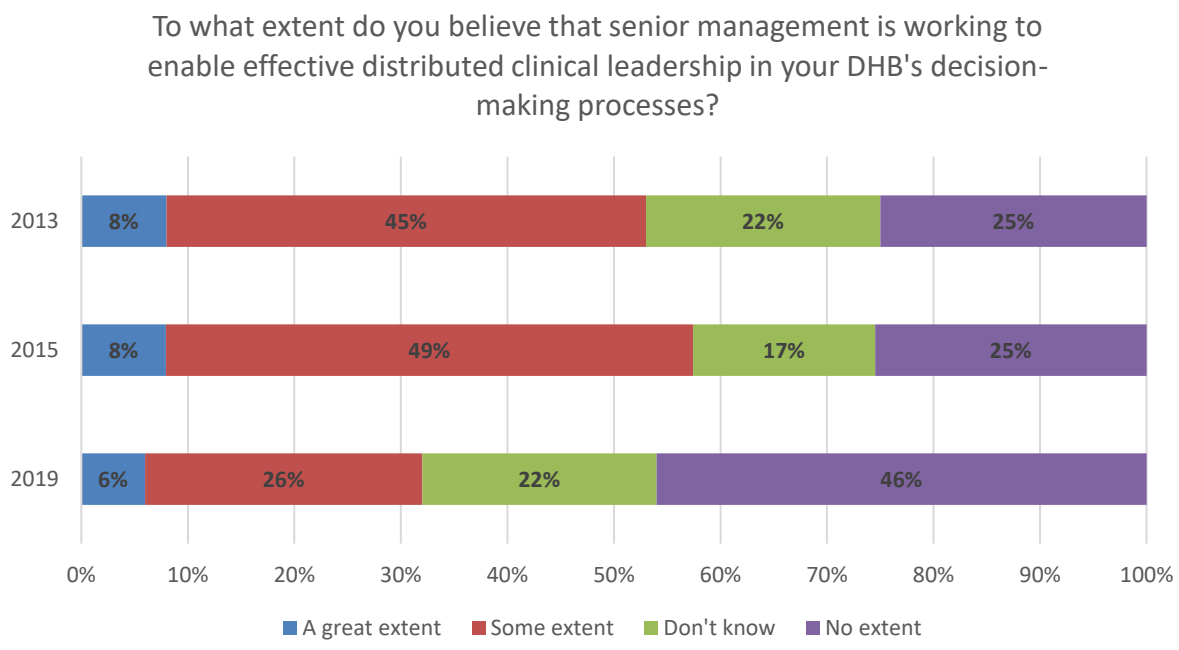

Figure 3: Comparative answers 2013-2019 Senior Management

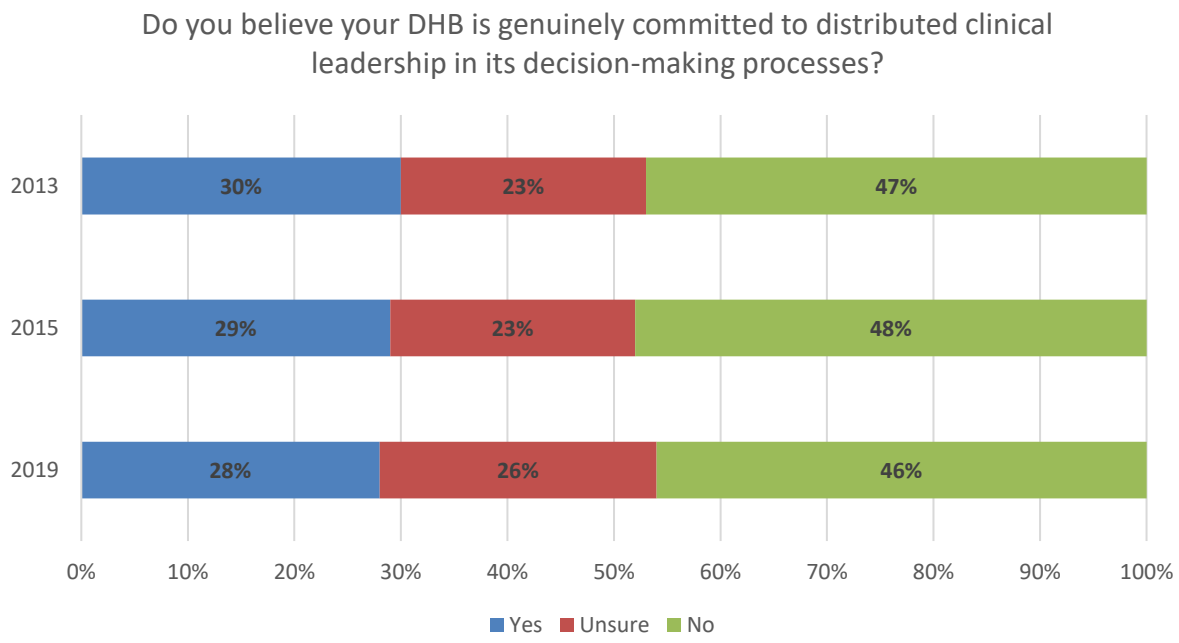

Figure 4: Comparative 2013-2019 DHB commitment

Very little had changed in terms of members' views concerning whether their DHB was genuinely committed to DCL in its decision-making processes (Figure 4). When broken down by DHB (Figure 5), the 2019 responses revealed more than half of respondents held positive views in South Canterbury (64%) and Whanganui (53%), with Canterbury (n=120) a close third (49% 'strongly agree' and 'agree'). This was a change from the 2015 survey where Canterbury, Northland and Hawke's Bay were ranked in the top three (53%, 53% and 50% responding 'yes' respectively). Wairarapa DHB fell to the bottom of the rankings in 2019 (0% 'strongly agree' or 'agree' 2019 compared with 22% responding 'yes' in 2015).

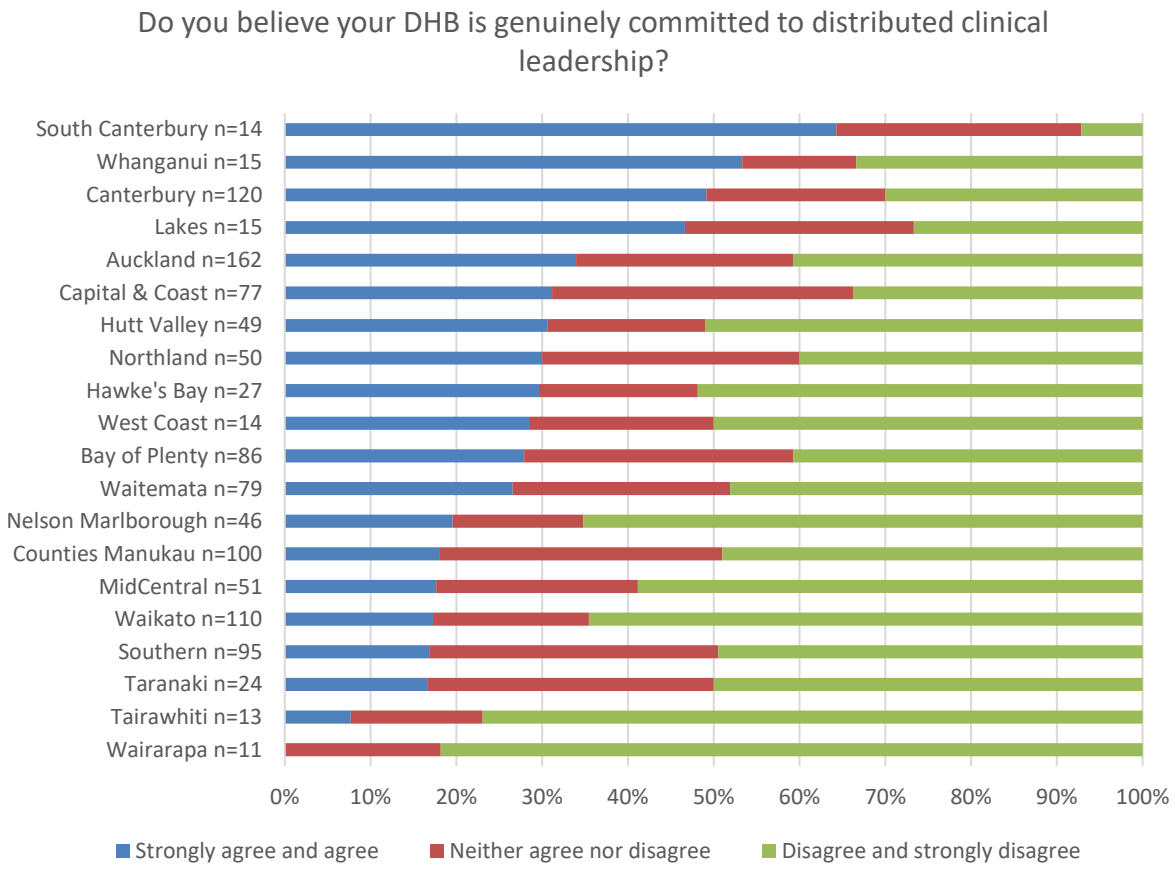

Figure 5: DHBs commitment to DCL

As detailed in Figure 6, the smaller DHBs of Whanganui and South Canterbury again topped the table with over 50% of respondents from Canterbury also agreeing that their Chief Executive was working to enable DCL. No respondents from Wairarapa agreed with this sentiment and very few thought their Chief Executive was enabling DCL at Tairawhiti and Southern (8% and 18% 'to a great extent and to some extent' respectively). This was another change from the previous 2015 survey where DHBs of West Coast and Canterbury topped the charts (89% and 84% 'to a great and to some extent' respectively). At the bottom, Wairarapa remained poorly ranked while Tairawhiti dropped from 7th to 19th and Southern from 12th to 18th in the 2019 rankings. On a positive note, Hutt Valley DHB significantly rose in the rankings from 19th in 2015 to 7th in 2019.

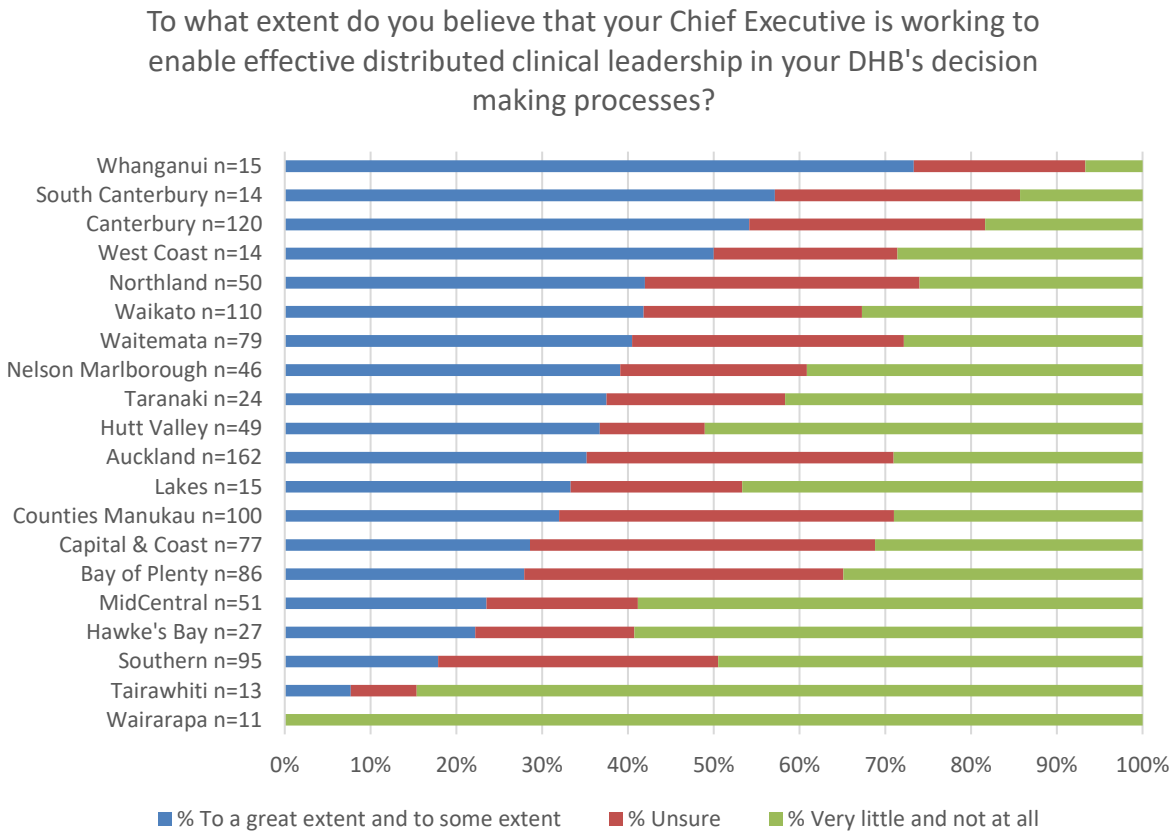

Figure 6: DHB specific views on role of Chief Executive

In the 2019 survey we introduced a suite of new questions to investigate DCL in more detail. These gauged whether members feel they have sufficient information about DCL and adequate opportunities for training and time to engage with DCL in practice. As detailed in Figure 7, while a third feel they have sufficient information regarding DCL, they felt they had limited opportunities for training, and little time. Figure 8 details the main reasons respondents felt they had limited time for DCL.

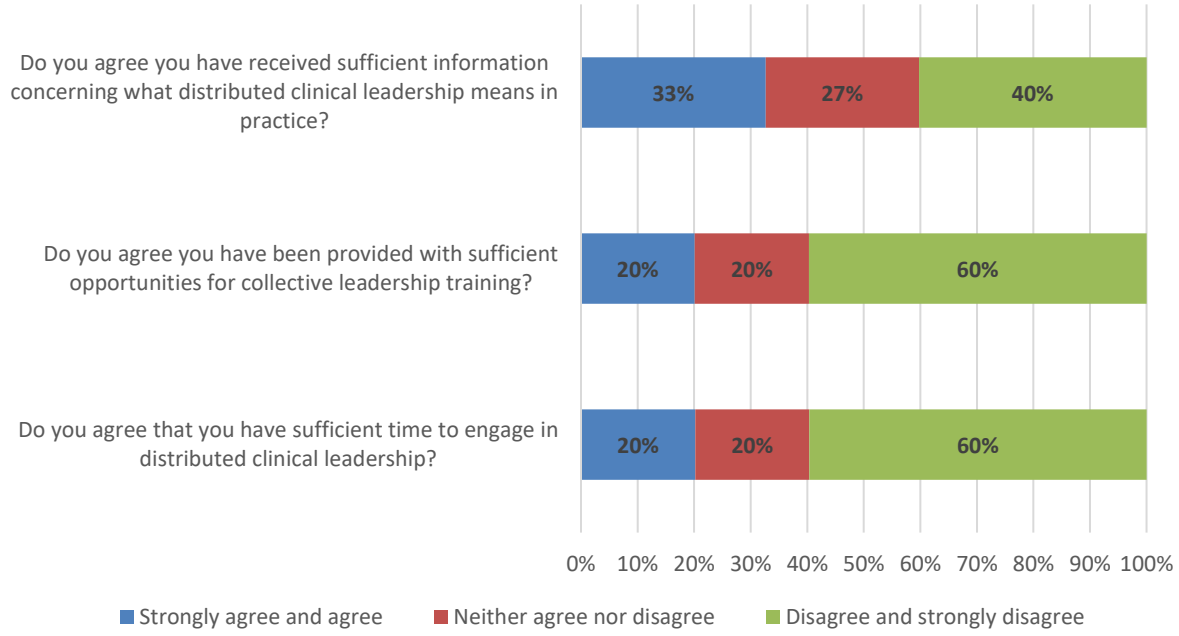

Figure 7: Questions regarding opportunities for DCL

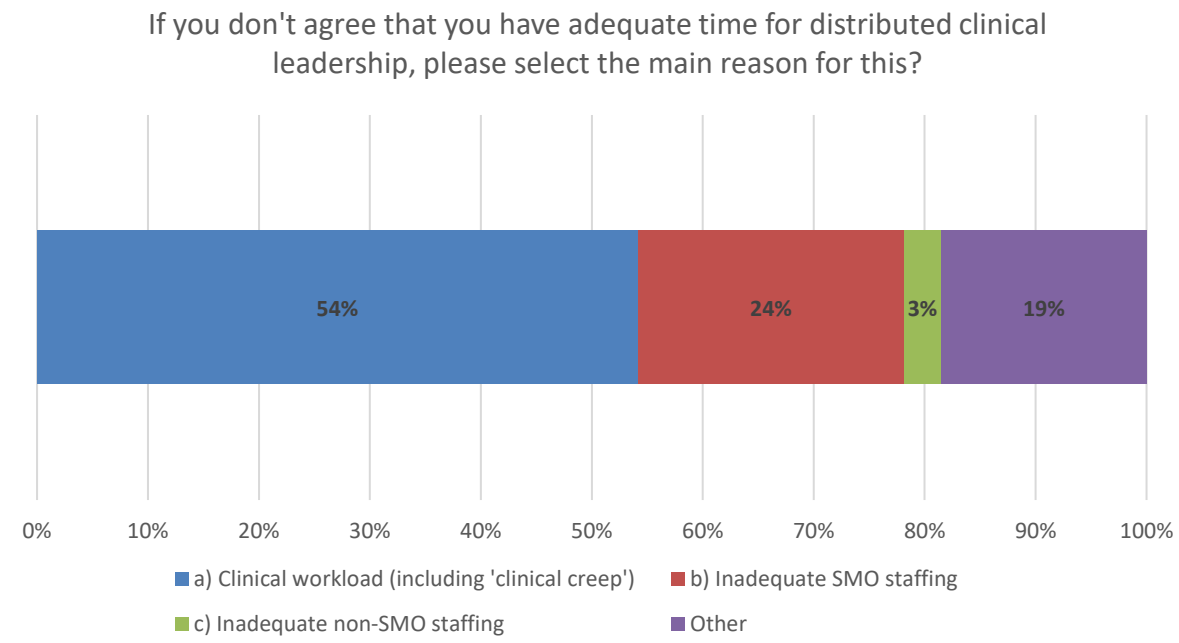

Figure 8: Reasons for inadequate time for DCL

Significantly, many wrote under 'other' that all the reasons were relevant (the question was structured in such a way that respondents had to select one reason). Qualitative comments included the following:

- "The demands of clinical leadership require much more time allocated to it than the DHB provides. This and remaining clinically competent require more sessions than a working week provides" "severely constrained by inadequate SMO and job creep workload -finally getting some relief but has taken years to get agreement for more staff -even to replace those retired"
- "Inadequate clinical support staff is a very big issue in our department."
- "Workload appears the immediate reason but the larger reason is that there are not the routes to participate"
- "Time is not the issue. Lack of support by most senior management is. Management not receptive to ideas from clinical staff, pathways between managers and clinical leaders are opaque and appear to be poorly developed"
- "Process and policy centred service provision ("top-down") creates inefficiencies on the clinical floor, thus all too often compromising the quality of the medical outcome for the patient, and ultimately (unnecessarily too often) the safety of individual patients. Patients SAFETY is declared to be the responsibility of an individual clinician. Clinicians are micro-managed according to financial (KPI) > political (hospital policies and protocols) goals. Proof? - Throughout all departments, the DHB does extensive reporting about patient throughput and financial cost centre spending per SMO, but there is no measurement of clinical parameters, let alone medical outcome (the latter has been replaced by patient satisfaction surveys which get "team celebrated"; complaints always fly under the radar and hit individual clinicians)"
- "It is clinical workload, but also a lack of commitment from the DHB executive to involve SMOs in vital issues except mere symbolically".

When the data was analysed on a DHB-specific basis (Figure 9), it was notable how DHBs which felt they had time for DCL corresponded with those which felt they had a good culture and good support from their senior management and Chief Executive. Similarly, we noted DHB-specific views concerning the impacts on their time for DCL (Figure 10) with DHBs such as Taranaki, Whanganui and Wairarapa emphasising the burden of their respective clinical workloads.

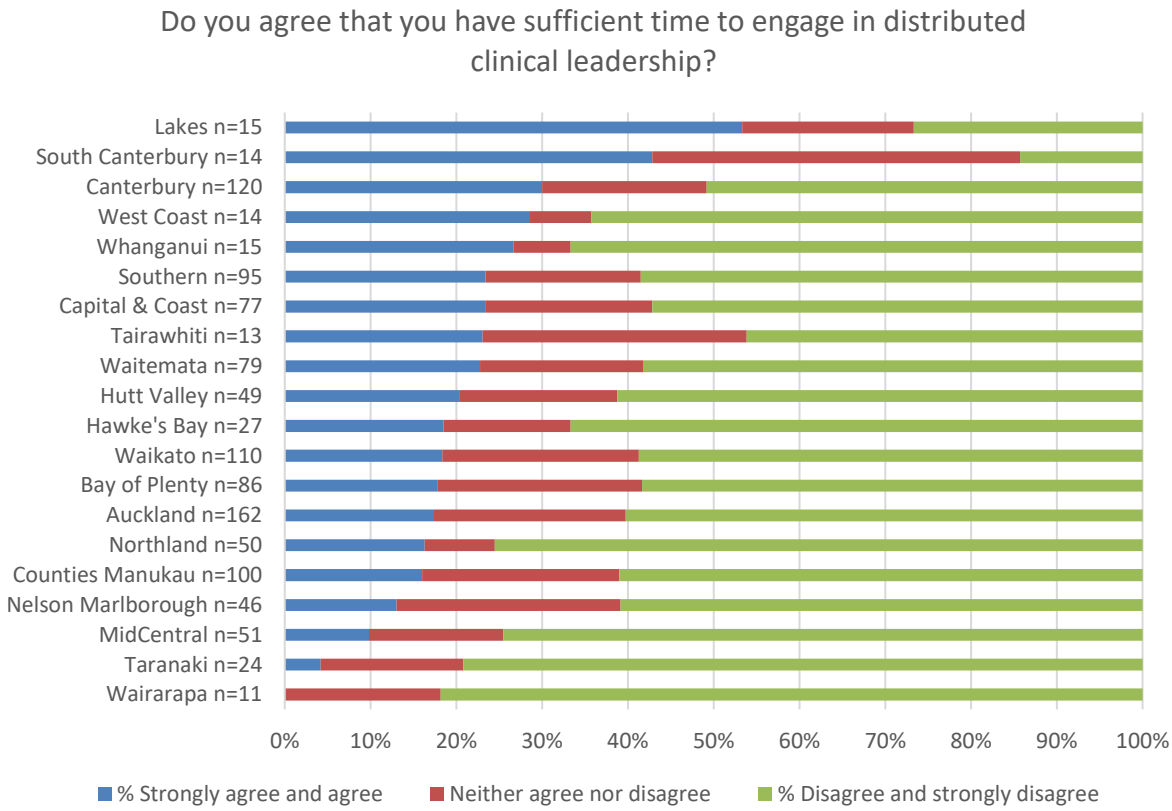

Figure 9: DHB specific views concerning time for DCL

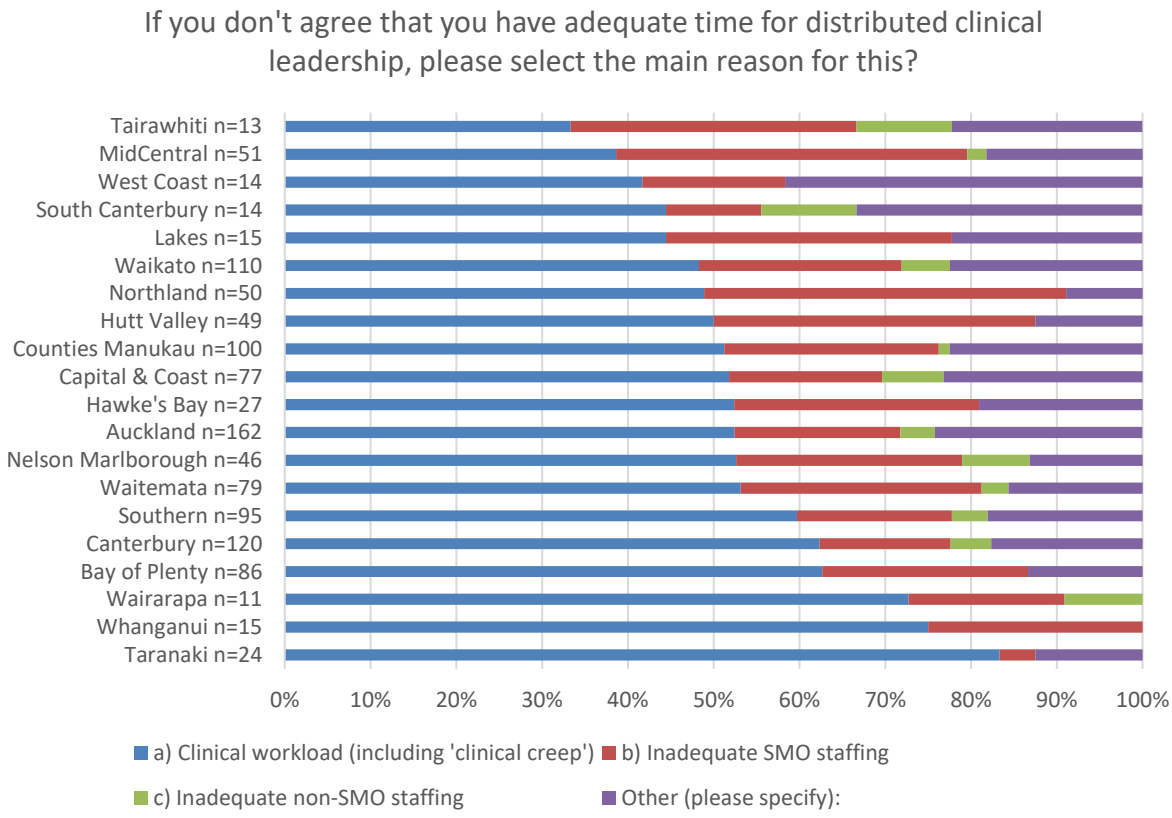

Figure 10: DHB specific views concerning lack of time for DCL

We also asked members whether they feel able to speak out on issues concerning minimum standards. Reassuringly, the vast majority felt able to speak to their colleagues about such issues with more than half agreeing that they felt able to speak out to their clinical head, the ASMS and respective service managers. Perhaps more worryingly, less than half of respondents felt able to speak out to their CMO or equivalent, and only a quarter felt able to discuss with their Chief Executive (Figure 11). The following figures detail the specific responses about speaking out by DHB.

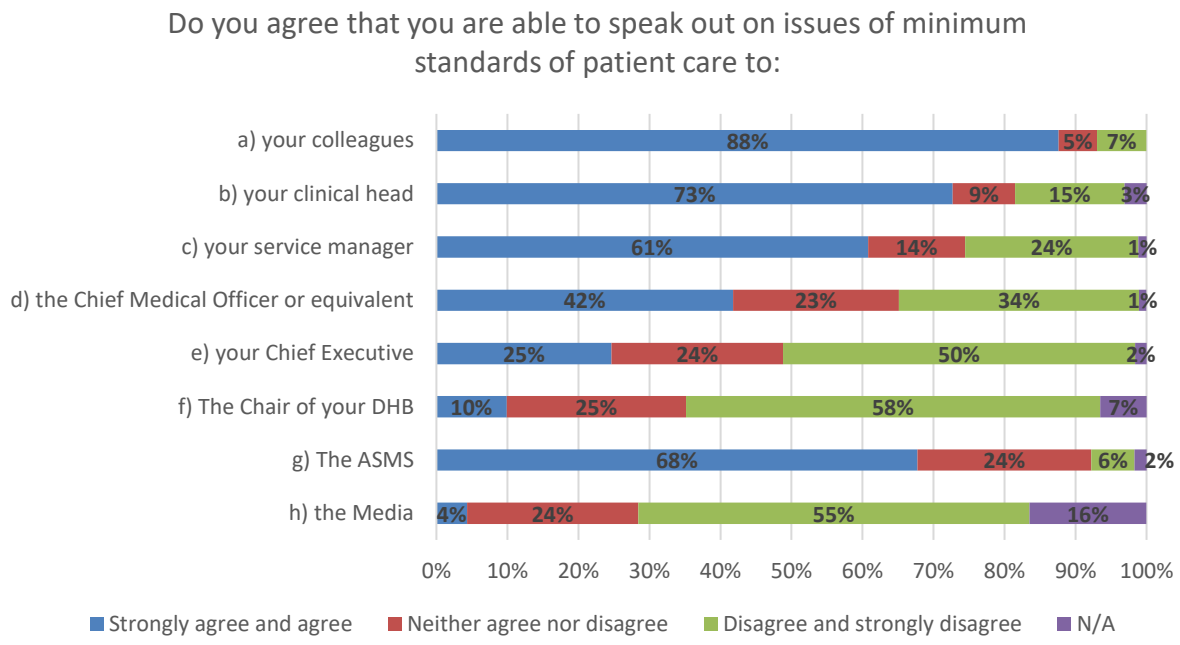

Figure 11: Summary views on speaking out

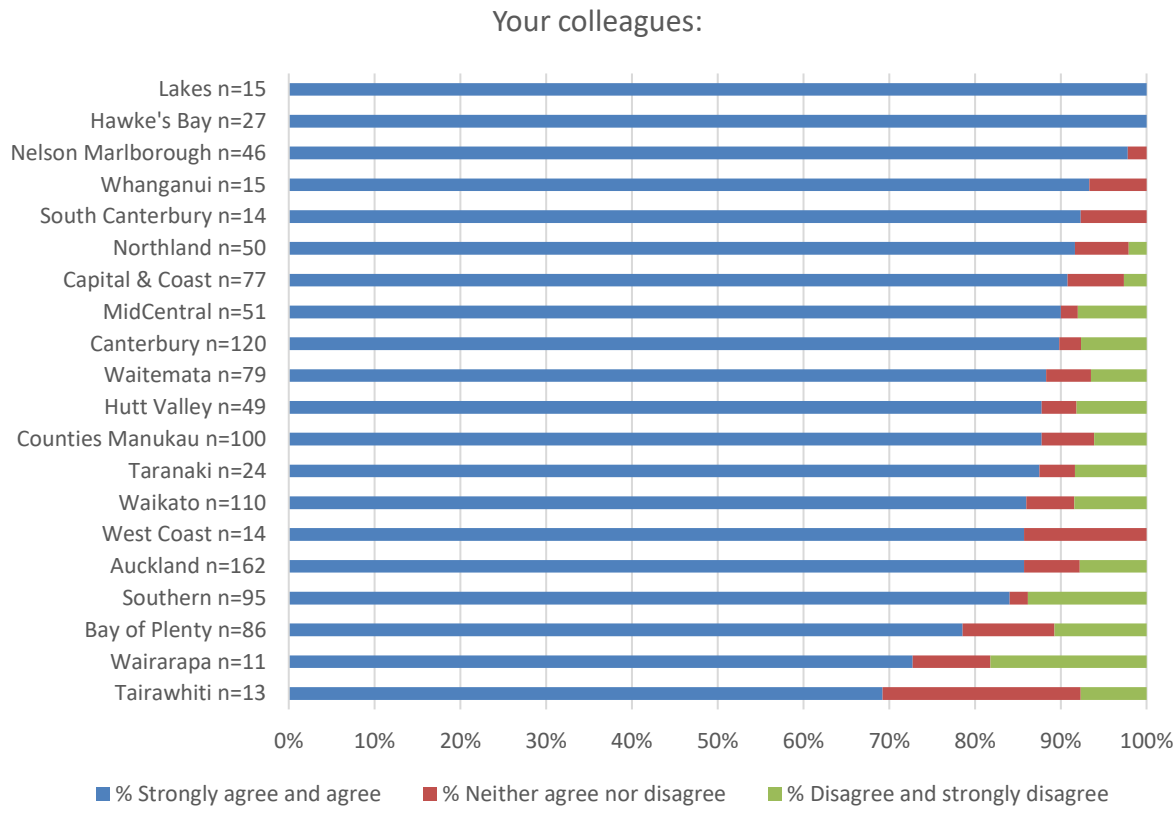

Figure 12: DHB specific responses on speaking out to colleagues

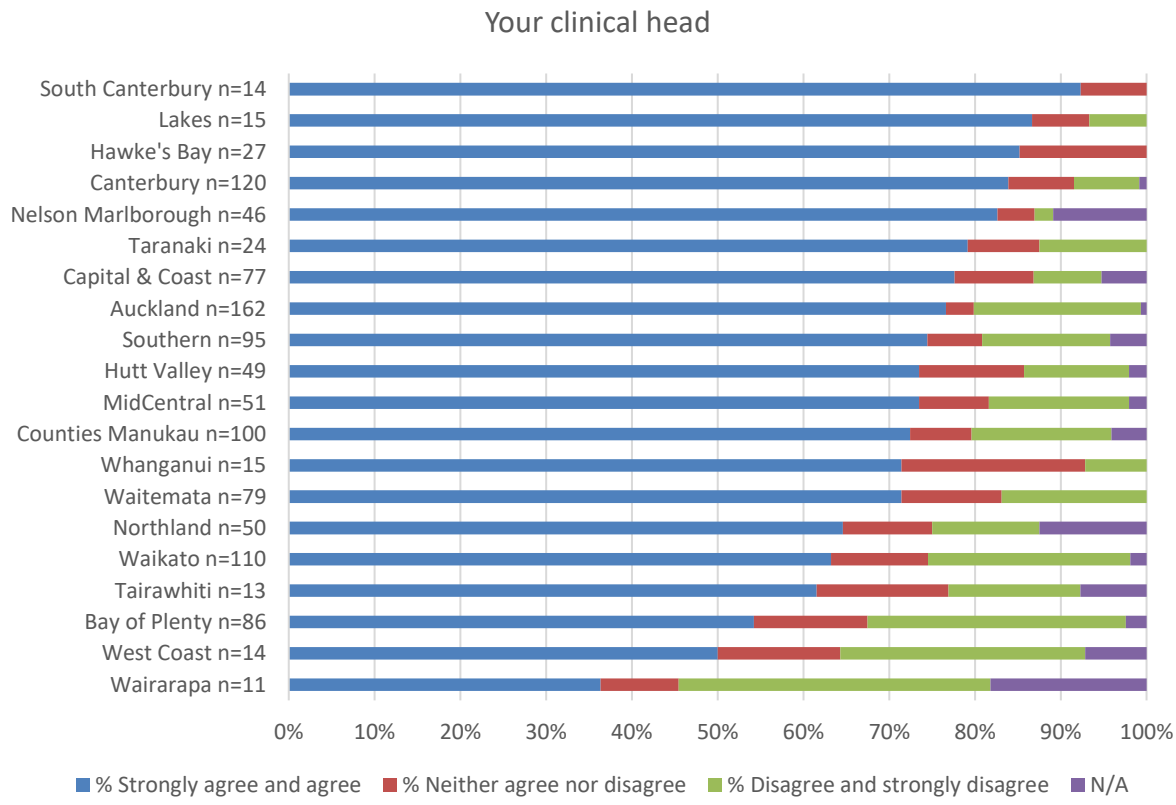

Figure 13: DHB specific responses on speaking out to clinical heads

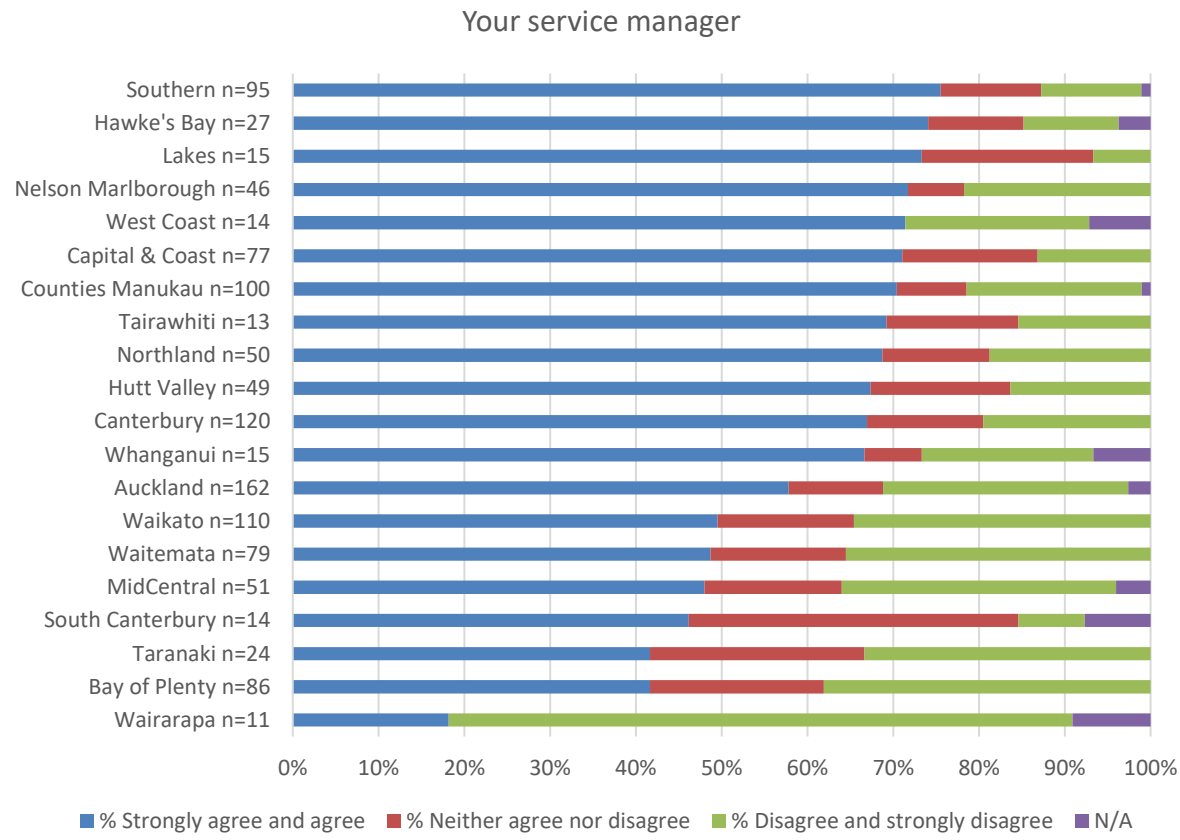

Figure 14: DHB specific responses on speaking out to service managers

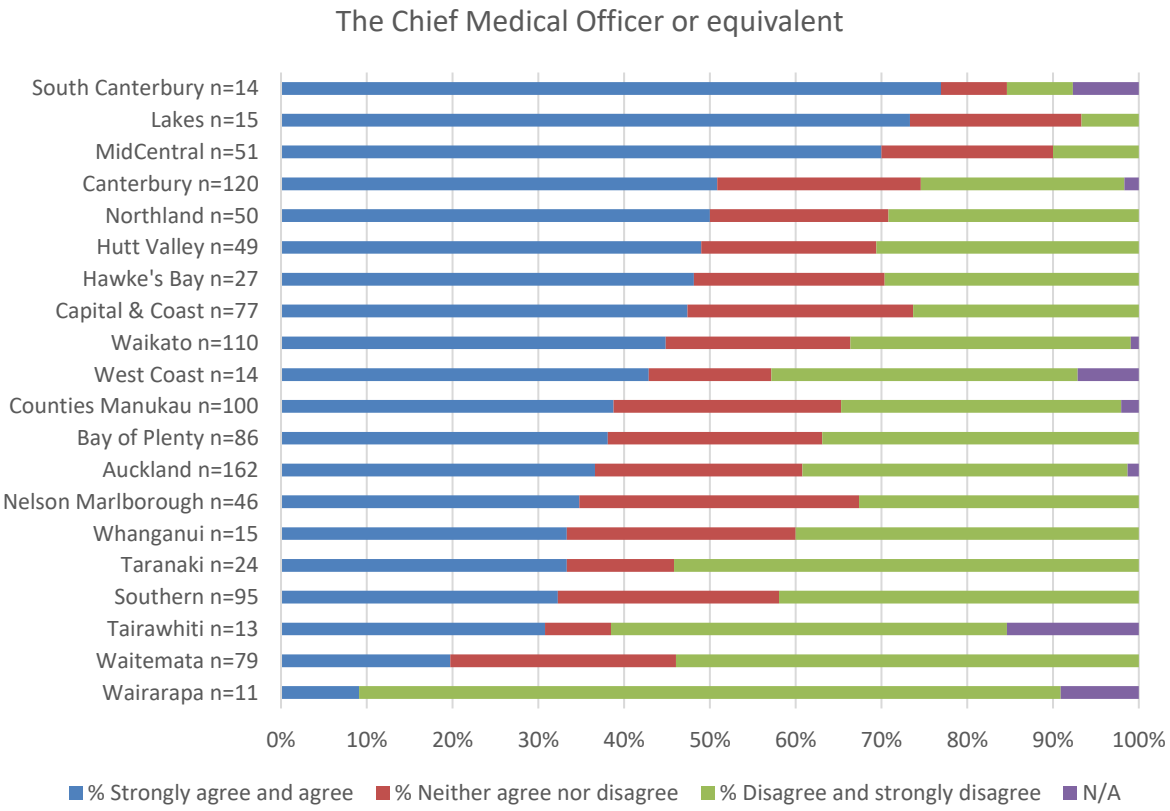

Figure 15: DHB specific responses on speaking out to Chief Medical Officer or equivalent

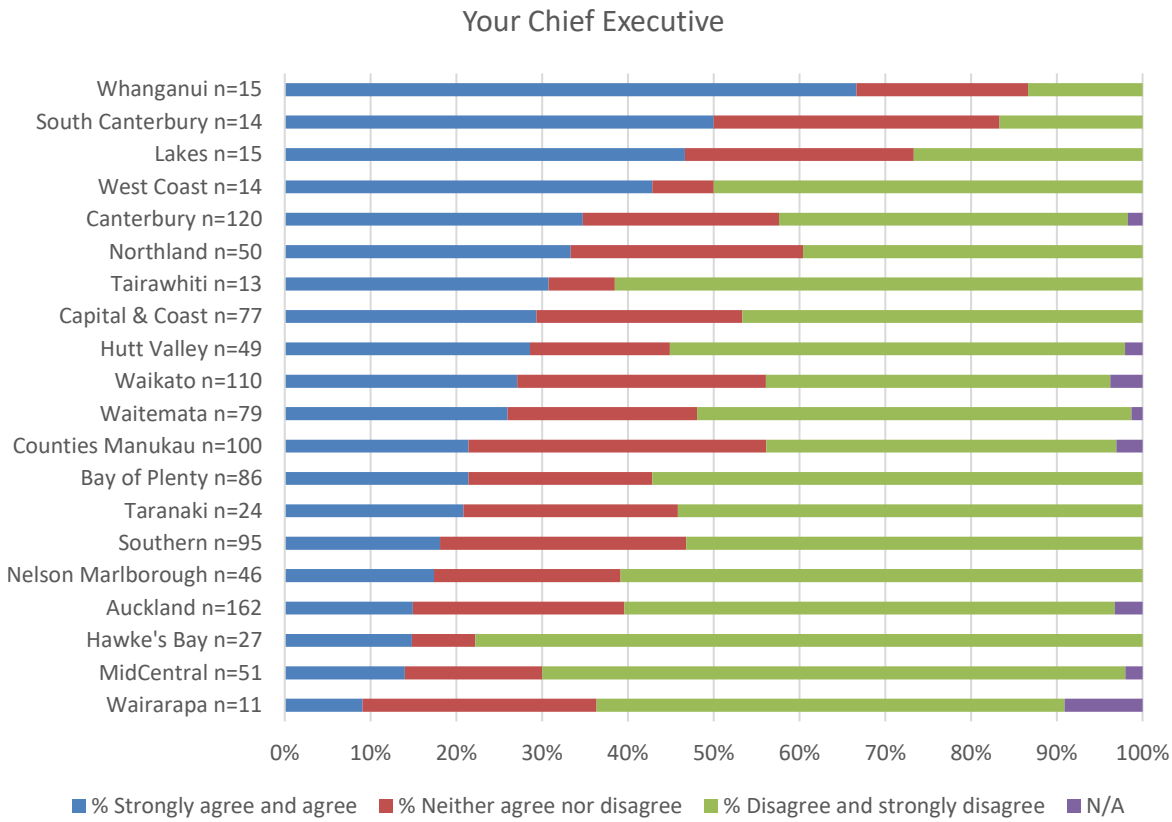

Figure 16: DHB specific responses on speaking out to Chief Executive

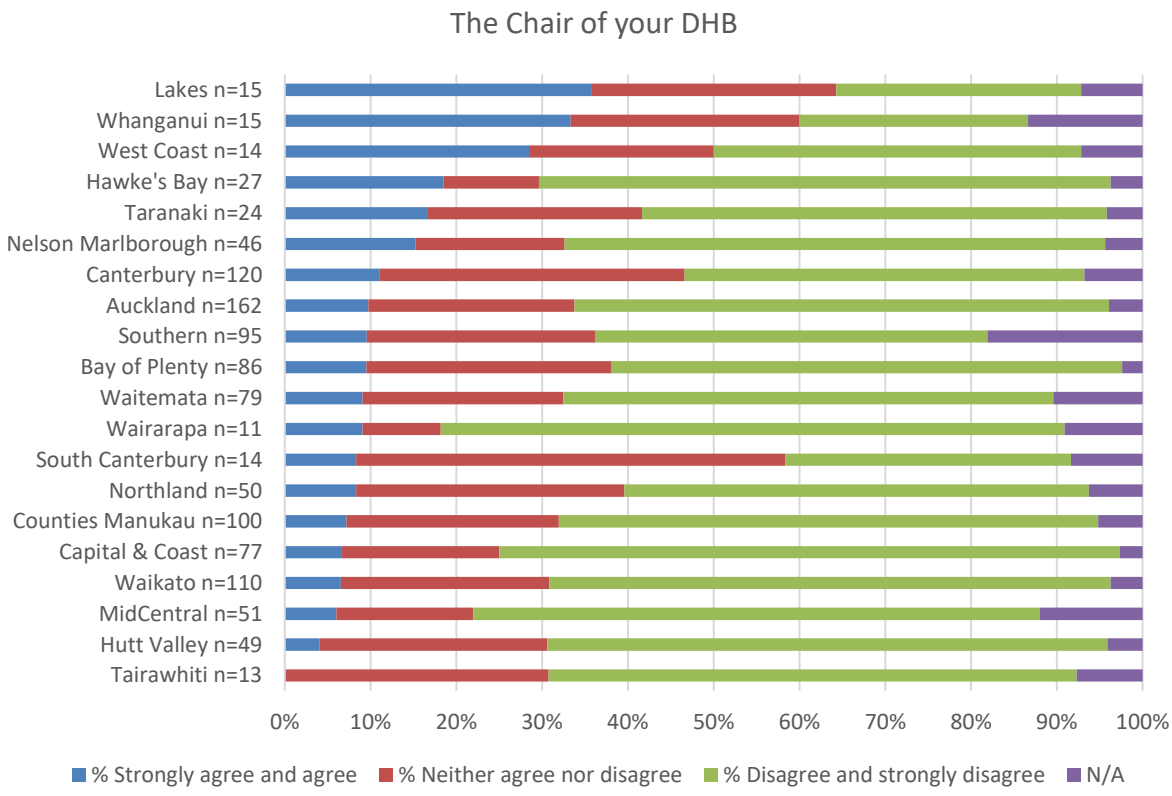

Figure 17: DHB specific responses on speaking out to Chair of DHB

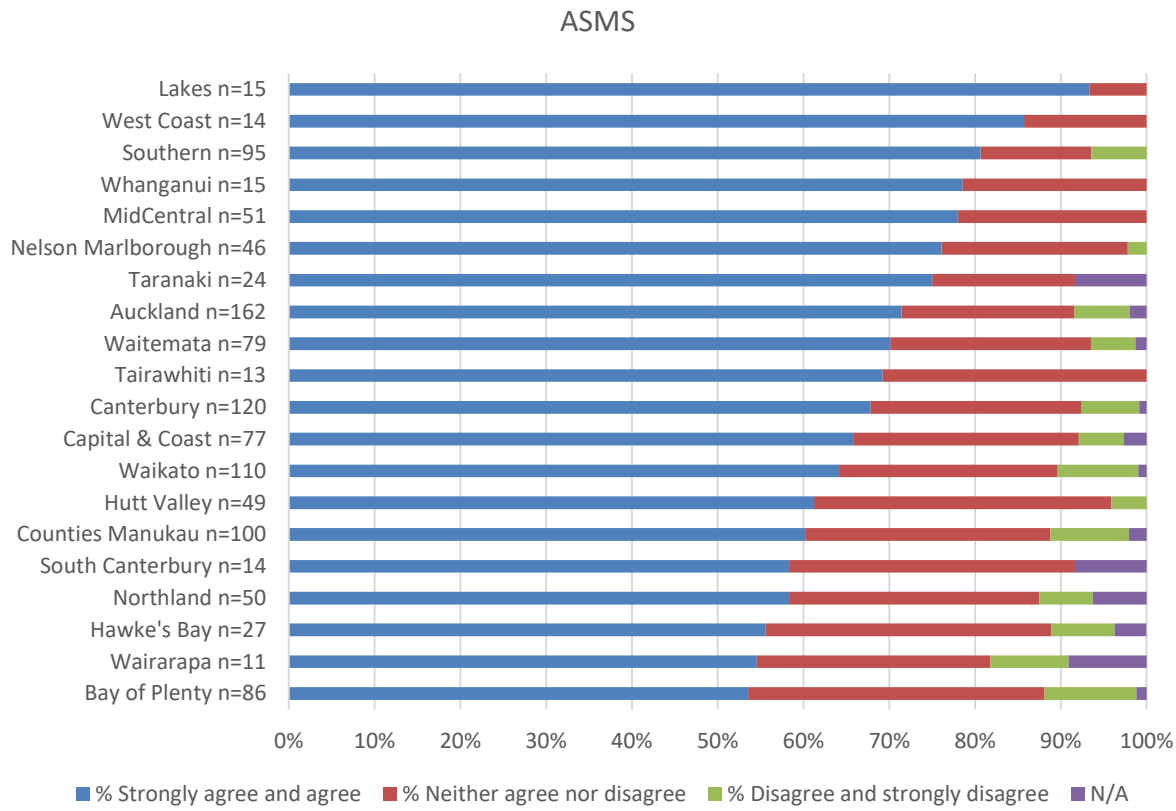

Figure 18: DHB specific responses on speaking out to ASMS

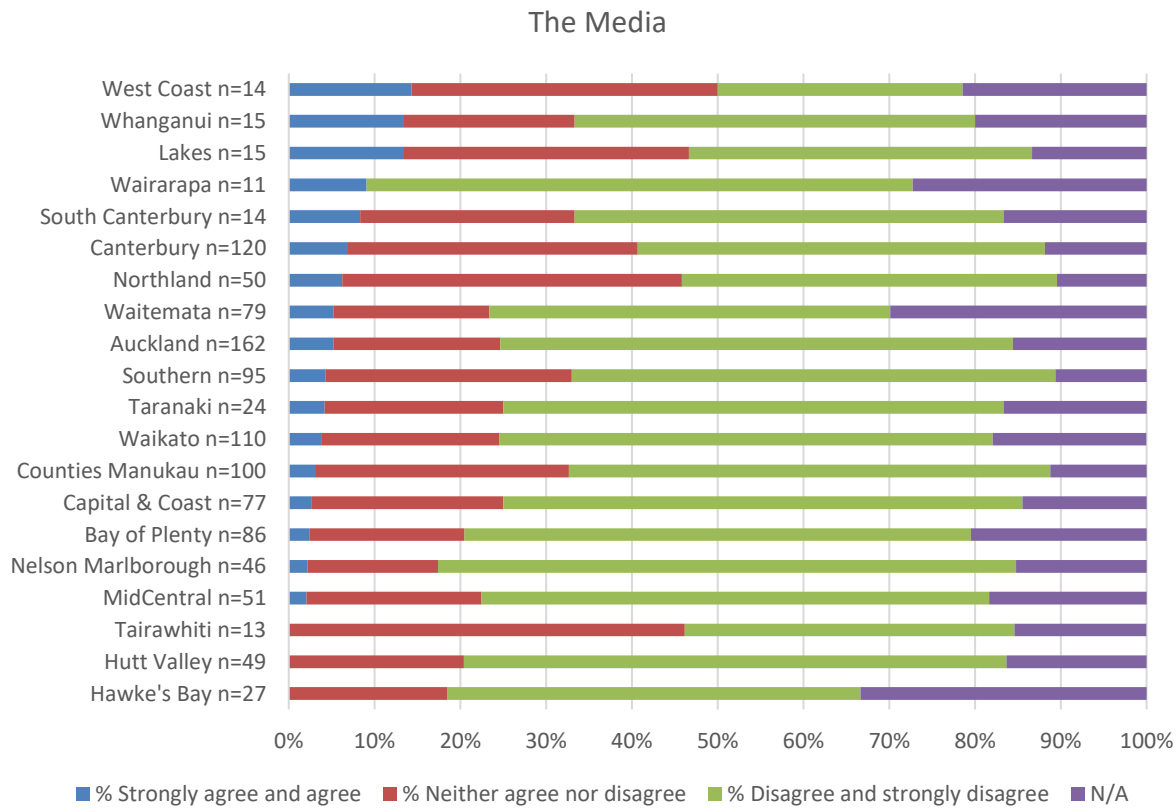

Figure 19: DHB specific responses on speaking out to media