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Collective leadership: harnessing the knowledge and skills of clinicians to transform health care

At a glance

There is strong consensus internationally that to meet the challenges facing today's health care systems and make the most of the potential opportunities of the future, the strategies, tactics and leadership approaches that may have worked in the past are no longer sufficient.

There is a growing body of evidence supporting transition to a new type of hospital leadership which is distributed to those with intimate knowledge of the day-to-day workings of a hospital. These leaders – clinicians (ie, doctors)[a] and other healthcare professionals - are best placed to understand how to improve organisational performance and influence care practices.

It means leaders in formal roles, starting at the board level, must understand what is needed to nurture a caring, collaborative culture and create the conditions in which responsibility, power, authority and decision-making is distributed within and throughout an organisation rather than at the top of a hierarchy.

When frontline clinicians and other health professionals have an opportunity to lead, with support from their organisations, they have been shown to have a meaningful impact on reducing acute admission hospital rates, reduce unwarranted variation in medical practice and improve the performance of their organisation financially and clinically in multiple ways.

Key factors impeding the development of distributed clinical leadership and broader collective leadership are cultural barriers, including the cultural divide between clinicians and managers; incompatible government policies and directives; and inadequate clinical staff capacity to implement the necessary changes.

The collective leadership model must be supported as a high priority by government. It requires a long-term strategy to bring about the required cultural change that nurtures collaboration, creativity, and innovation.

Significantly greater investment in the senior medical workforce is critical, recognising that adequate staffing is needed to enable staff to engage in and support such transformative change.

a) *Generally the term 'clinician' is used in this paper to mean 'doctor', though in some quoted text it has a broader meaning encompassing other health professionals*

At the fundamental 'atomic' level in any health system is the interaction of a patient and a caregiver, either in an inpatient, outpatient, community or home setting. … The nature and content of these interactions and the performance of the supporting processes and microsystems of care also determine the performance of health care delivery systems and assure safe, reliable and effective care… These processes and microsystems are largely under the day-to-day control of working doctors, and it is their leadership skills and behaviours that have the potential to significantly improve overall health system performance.

- Richard Bohmer, Harvard Business School, 2012[1]

Introduction

It is well recognised internationally that the scale and complexity of the challenges facing health systems are such that many assumptions of common leadership models are not well suited to delivering the changes that are needed to meet those challenges. Accordingly, there is a growing body of evidence supporting transition to a new phase of hospital leadership, one that places the clinical frontline and clinicians as crucial to leadership within organisations.[2] [3] [4] It is based on the argument – now widely recognised – that because health care processes and systems have become so complex, those in practice and with intimate knowledge of the day-to-day workings of a hospital or consulting room are best placed to understand how to optimise organisational performance and influence clinical practice.[5]

As a former New Zealand Minister of Health, Tony Ryall, acknowledged, the evidence shows stronger and more direct clinician involvement in leading initiatives to improve hospital service performance has led to a positive impact on productivity, infection rates, readmission rates, patients and finance.

There is also a clear, compelling and urgent need for leadership cooperation across organisations as well as within them, as health care is delivered increasingly by an interdependent network of organisations prioritising holistic patient care rather than fragmented components. That means leaders working collectively and building a cooperative, integrative leadership culture.

Again, the evidence shows to make progress in such transformational change across the system requires collective leadership from the 'bottom up', including a broader practice of leadership by clinicians and other front-line staff, rather than by designated managers alone.[6] [7]

Despite the widespread recognition of the importance of clinical – and broader collective leadership – to patient outcomes, there are some quite considerable barriers to implementing it in practice and it has struggled to gain much traction. This paper discusses the background and barriers to the development of distributed clinical leadership in New Zealand, and what is needed to clear the way for making more substantial progress.

What is 'distributed clinical leadership'?

The term 'distributed clinical leadership' appears to mean different things to different people. And, for some, it refers to the medical profession; for others it applies to the full range of professions providing health care.

This paper will concentrate mostly on distributed clinical leadership, interpreted as *medical* leadership, and predominantly refers to the medical literature. However, it is not intended to detract from the essential leadership role of health care professionals such as nurses, midwives, physiotherapists, and social workers, and frequently discusses distributed clinical leadership as part and parcel of a broader 'collective leadership' comprising all health care professions. A summary description of the latter, incorporating the former, is outlined below, borrowing largely from the publications, *Developing Collective Leadership in Health Care* and *Delivering a Collective Leadership Strategy for Health Care,* produced by the King's Fund in the United Kingdom.[8 9 10]

Collective leadership means the distribution and allocation of leadership power to wherever expertise, capability and motivation sit within organisations. The purposeful, visible distribution of leadership responsibility on to the shoulders of every person in the organisation is vital for creating the type of collective leadership that will nurture the right culture for health care. In such a culture, roles of leadership and 'followership' shift depending on situational requirements. Every member of staff has the potential to lead at many points in time, particularly when their expertise is relevant to the task in hand. It is also important to ensure all staff are focused on good 'followership', regardless of their seniority in the organisation.

In collective leadership cultures, responsibility and accountability function simultaneously at both individual and collective levels. They breed regular reflective practice focused on exploratory learning, safe innovation and making continuous improvement an organisational habit. By contrast, command-and-control leadership cultures invite the displacement of responsibility and accountability on to single individuals, leading to scapegoating and creating a climate of fear of failure rather than an appetite for innovation.

Leadership comes from both the leaders themselves and the relationships among them. There are high levels of dialogue, debate and discussion across the organisation (top to bottom and end to end) to achieve shared understanding about quality problems and solutions. It is about developing mutual trust and respect between individuals, groups, teams and departments across the organisation. These relationships form the basis for collaboration that transcends organisational structure and creates synergies, innovation and efficiencies at various levels. Organisational performance does not rest simply on the number or quality of individual leaders. What counts is the extent to which formal and informal leaders work collectively in support of the organisation's goals and in embodying the values that underpin the desired culture.

Collective leadership focused on improvement should ensure that teams at all levels collectively take time out to review and improve their performance.

Most importantly, collective leadership requires the complete dedication of the Board and leadership team to empower all staff as leaders, and trust in the process of collaboration in the organisation as the foundation for its leadership culture. This takes time, resources, sustained energy and persistent commitment.

Background

'Clinical leadership' is often used interchangeably with 'clinical governance', though the latter has been interpreted as the system where clinical goals are set and reported on, while 'clinical leadership' is the operational system that allows health workers to do what is needed based on these goals.[11]

In New Zealand clinical leadership was promoted by successive Health Ministers in the 2000s via their annual 'Letter of Expectations' to the district health board (DHB) Chairs outlining the Minister's expectations over the next financial year. These letters delivered a message to DHBs to promote and implement clinical leadership as a priority. Little progress was made in practice, however. With a change of government in 2008 the new Minister of Health emphasised the importance of the policy more strongly through the 'Letter of Expectations', acknowledging that clinical leadership was "internationally recognised as a fundamental driver for improved care", and assembled a professionally-led working group to prepare policy advice on how to advance clinical leadership. That working group produced a report, *In Good Hands*,[12] including a series of recommendations, which the Minister endorsed and instructed DHBs to implement. [13] They included:

- DHBs and their governing boards create governance structures that ensured an effective partnership between clinical and corporate management, with quality and safety at the top of all meeting agendas;
- Each DHB CEO should enable strong clinical leadership and decision-making throughout their organisation;
- Clinical governance should cover the entire patient journey, with clinicians actively involved in all decision-making processes and with shared responsibility and accountability with corporate management for both clinical and financial performances;
- Decision-making should be devolved to the appropriate clinical unit or teams within DHBs and their hospitals;
- DHBs should identify and support actual and potential clinical leaders including investing in training and mentoring.

Later that year the Director-General of Health's Senior Medical Officer Commission (SMO Commission) made further recommendations that DHBs and the Ministry of Health develop effective clinical leadership and participation, and that DHBs initiate and monitor an ongoing programme of specialist leadership development. This was also endorsed by the Minister.[14]

Clinical leadership in the context of these policies is much more comprehensive than formal positions of clinical leadership such as chief medical advisers and clinical directors. It is *distributed* clinical leadership inclusive of wider clinical engagement that potentially includes all or most senior medical and dental officers. It means 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).

Again, despite the policy intent to ramp up distributed clinical leadership, little progress was made, as discussed below, and political interest waned. For the first time since the early 2000s, the Minister's 'Letter of Expectations' for 2016/17 contained no reference to the importance of clinical leadership. Following another change of government, this omission has continued.

Importance of distributed clinical leadership and broader collective leadership

As health care organisations internationally attempt to cope with increasing need for their services, they are faced with the difficult task of trying to balance the allocation of scarce resources to individual patient care and the care of communities and populations.[15]

Moreover, the literature indicates the complex-adaptive nature of health care services, including their complex interdependencies, relationships and contradictions, suggests that healthcare delivery defies traditional paradigms and approaches to management.[16] The experience of escalating complexity on a practical and personal level can lead to frustration and disillusionment, in part because the traditional ways of 'getting our heads round the problem' are no longer appropriate.

> *Newton's 'clockwork universe,' in which big problems can be broken down into smaller ones, analysed, and solved by rational deduction, has strongly influenced both the practice of medicine and the leadership of organisations. For example…conventional management thinking assumes that work and organisations can be thoroughly planned, broken down into units, and optimised. But the machine metaphor lets us down badly when no part of the equation is constant, independent, or predictable.*
>
> - Plesk, GreenHalgh, *British Medical Journal*, 2001[17]

To cope with escalating complexity in health care, reconciling limited resources with increasing health care needs requires more creative approaches from the leadership and, sometimes, difficult trade-offs. The growing evidence shows clinicians are best suited to make these trade-offs and find innovative solutions to the many 'wicked problems' facing modern health care because they understand both the medical science and the organisational imperatives – what is possible, and what is doable and affordable. Successful transformation of health care organisations is therefore largely a bottom-up process, sanctioned and nurtured from the top.

In describing examples of improved performance, one paper notes that *improvements happened because clinicians (most notably doctors) played an integral part in shaping clinical services.*[18] [19]

When frontline clinicians have an opportunity to lead, with support from their organisations, they have been shown to have a meaningful impact on both intermediate medical outcomes (eg, error rates) and terminal outcomes (eg, readmission and mortality rates). Better teamwork and inter-professional communication, standardised care processes and process compliance, and organisational and team-level culture have all been shown to have a positive impact on outcomes in both surgical and medical settings.[20] [21]

Distributed clinical leadership is also widely recognised as critical to reducing unwarranted variation in clinical outcomes.[22] [23] For example, in 2016 emergency admissions from the ward to a hospital intensive care unit varied widely by DHB, from 2.4 to 18.9 per 1,000 hospital admissions.[24] However, the extent to which such variation is warranted or not is hard to establish because of complexity in health care delivery, population health needs, and the multitude of factors that combine to create variation. Combining various sources of information and contextualising data are critical to establishing the extent to which variation is unwarranted.[25]

A clinically-led programme in the UK, 'Getting It Right First Time' is taking such an approach, "moving beyond the issuance of guidance, or best practice pathways, or other forms of exhortation or audit. It can lead to practical discussions, unit by unit across the country, on the means to raise quality, and thus save money locally … For it to succeed, however, requires not just the clinical engagement …, but also the managerial engagement and action…".[26]

The evidence also shows that organisations in which clinicians take a leadership role and are more engaged with maintaining and enhancing the performance of the organisation perform better financially and clinically.[27] [28]

Australian researchers have found "recent inquiries, commissions, and reports have promoted clinician engagement and clinical leadership as critical to achieving and sustaining improvements to care quality and patient safety".[29]

While this paper concentrates on medical leadership, the literature shows similar findings for broader collective leadership including doctors and the broader health care team.

For example, a UK study investigating health and safety factors in eight health care organisations found that in the best performing hospitals there was high staff engagement in decision-making and widely distributed leadership across health professional groups.[30] [31]

Such collective leadership has been described as the distribution and allocation of leadership power to wherever expertise, capability and motivation sit within organisations. In such a culture, roles of leadership and 'followership' shift depending on situational requirements.

At a system level, collective leadership cultures for high-quality care reach beyond the boundaries of specific organisations. They provide the basis for the creation of such cultures across the whole system, forging an integrated network of organisations. In recognising that organisations cannot work in isolation to achieve the best possible care, it follows that their cultures need to be conducive to interdependent working within and across the system. This is a core argument for collective leadership.[32]

Data from the UK National Staff Survey reveal that staff engagement trumps all other measures (staff satisfaction, leadership, human resource management practices) as the best overall predictor of NHS organisations' outcomes. It predicts patient mortality (in the acute sector), care quality and financial performance, patient satisfaction, and staff absenteeism, health and wellbeing across all sectors.[33]

The New Zealand SMO Commission also emphasised the importance of nurturing staff engagement and distributed clinical leadership: "In this time of workforce shortages and steep growth in service demand … people are already working hard, so the greatest gains will come from working smarter. Innovation is needed, and the most creative ideas are usually generated closest to the service delivery level. SMOs and other health professionals need to have the opportunity to generate and test new ideas, the enthusiasm to want to do so, and managerial colleagues who will support them in this."

'Progress' on distributed clinical leadership to date

In 2010, a national survey of ASMS members (representing more than 90% of the DHB-employed senior medical workforce), conducted by Professor Robin Gauld of Otago University, was undertaken to gauge their perceptions of the extent to which the Minister's instructions to foster clinical leadership had been acted upon by DHBs. Questions developed for the survey study were designed to assess progress on key recommendations from the Ministerial Working Party, including those listed above. From the respondent data obtained, the survey authors developed a Clinical Governance Development Index (CGDI) which gave each DHB a score and, in turn, an overall score for New Zealand. [34] [35]

Overall it revealed a national mean score of 5.41 out of 13. No DHB attained a 50% score. It also revealed that clinical workloads were such that only 20% of respondents reported they had enough time to engage in clinical leadership activities or development programmes.

ASMS has conducted three subsequent national surveys of its members, in 2013, 2015 and 2018/19, with a range of questions including respondents' views on whether the culture of their DHBs encouraged distributed clinical leadership and the degree to which management supported distributed clinical leadership. Some of the key results are presented in Figures 1-4.[36]

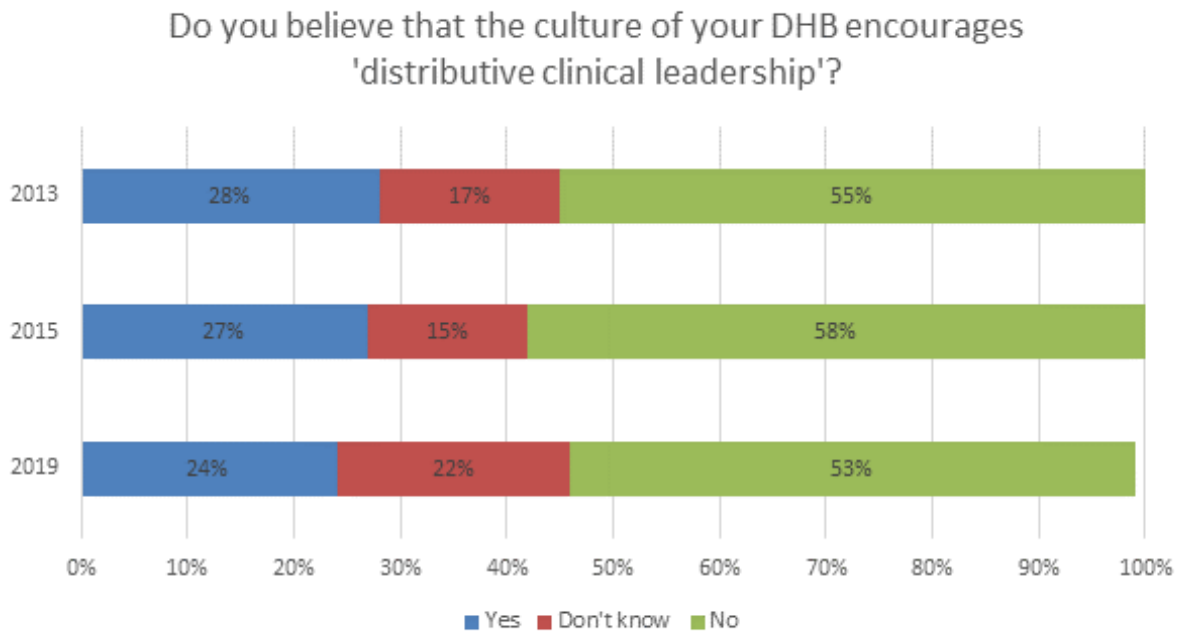

Figure 1: Comparative answers 2013-2019 DHB Culture

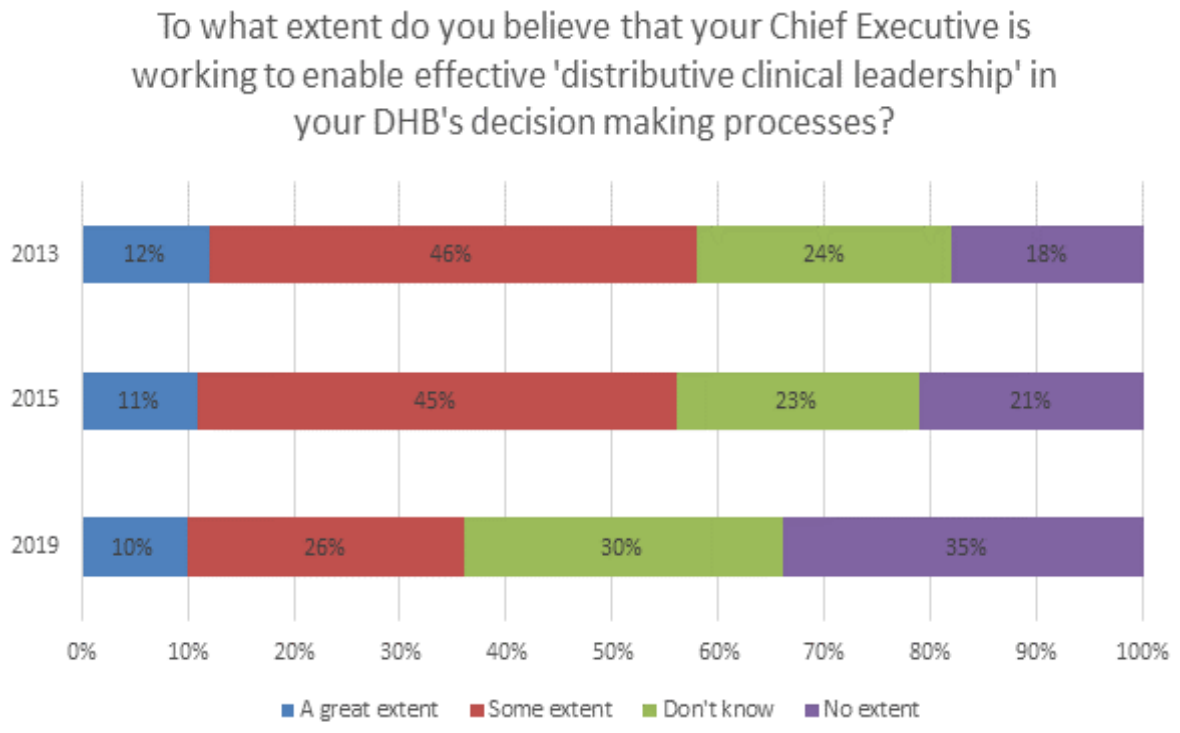

Figure 2: Comparative answers 2013-2019 Chief Executive role

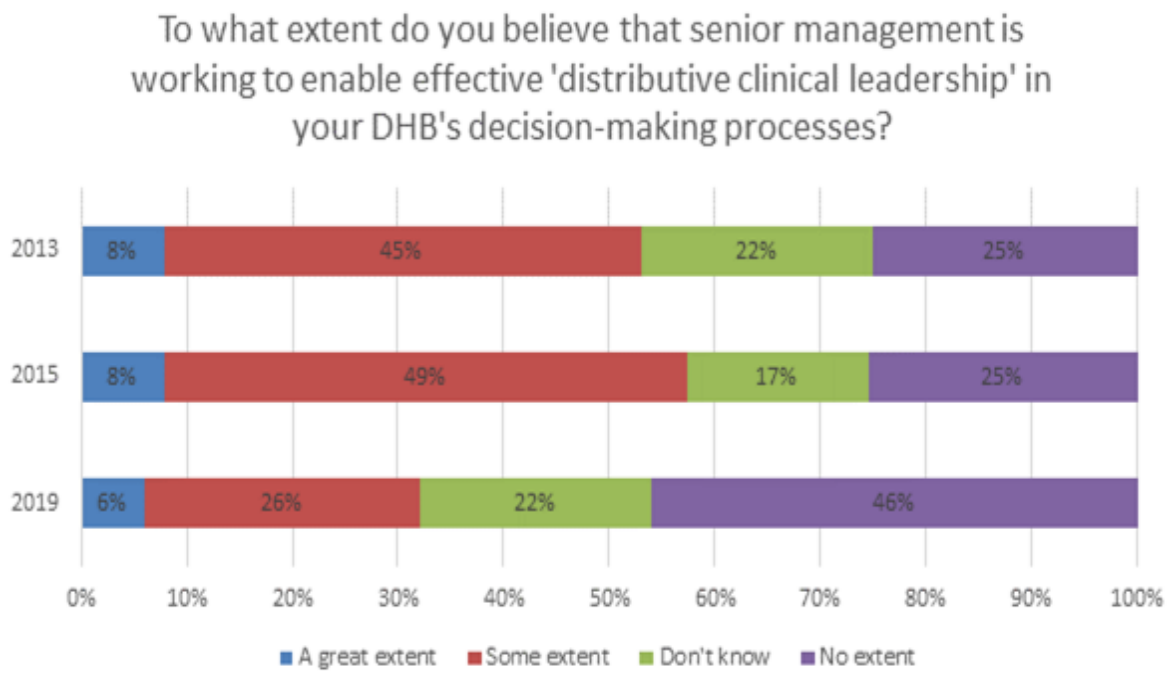

Figure 3: Comparative answers 2013-2019 Senior Management

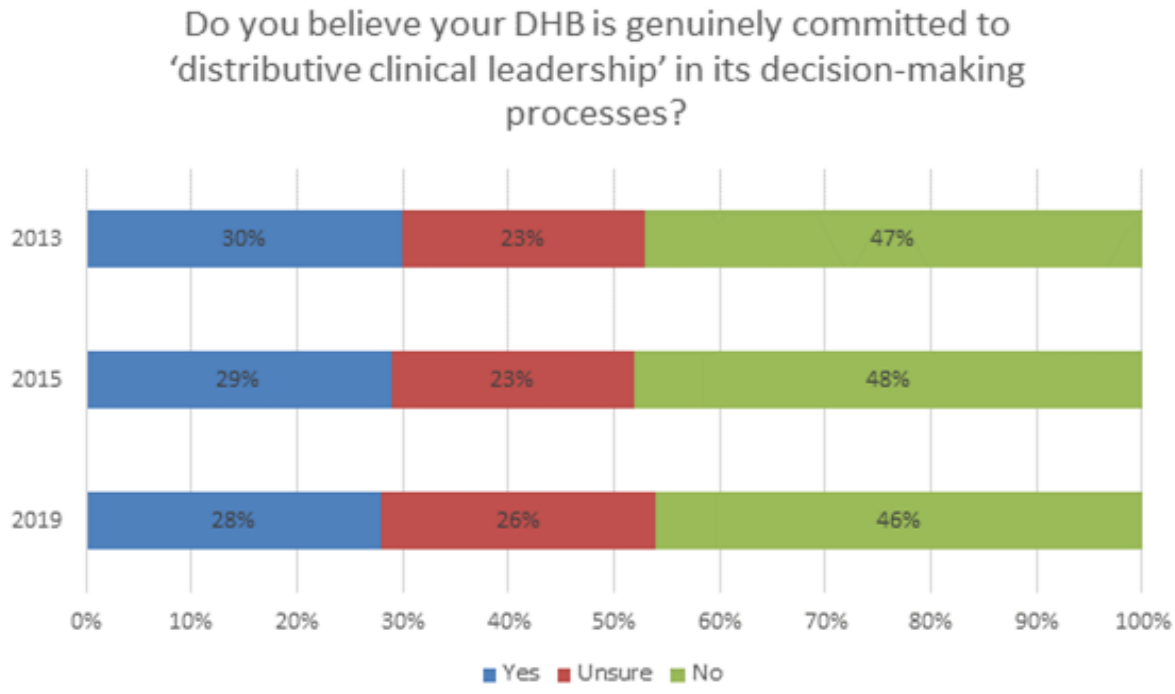

Figure 4: Comparative 2013-2019 DHB commitment

As summarised in these charts, between 2013 and 2019 there is little change in members' views concerning the culture of their DHBs in supporting distributed clinical leadership, with less than 30% responding positively in each survey. The trends indicate a decline in chief executives' perceived support to enable distributed clinical leadership. A similar trend was found in members' views concerning the role of their senior management. There is little change in the perceptions of DHBs' overall commitment to distributed clinical leadership; as with the views on the culture, less than 30% of respondents believed there was genuine commitment to distributed clinical leadership from DHBs.

The overall conclusion is that the cause of distributed clinical leadership had not advanced since the publication of *In Good Hands*; if anything, as time has gone on, it has got worse.

In the 2018/19 survey new questions were added seeking members' views on whether they had sufficient information on what distributed clinical leadership means in practice, and whether they have sufficient opportunities for training in collective leadership. Respondents were also asked whether they believed they had sufficient time to engage in distributed clinical leadership, enabling a comparison with the responses to that question with those of the initial survey undertaken by Professor Gauld in 2010.

A third of respondents agreed or strongly agreed that they had sufficient information; 20% felt they had sufficient opportunities for training; and, repeating the findings of the 2010 study, just 20% reported having sufficient time to engage in distributed clinical leadership.

Barriers to distributed clinical leadership

Key factors impeding the development of distributed clinical leadership and broader collective leadership in health care organisations are cultural barriers, incompatible policies from the centre and inadequate clinical staff capacity to implement the necessary changes.

The culture of health care organisations is probably the most commonly cited impediment to developing a dispersed, collective leadership approach to transformational change. This is reflected in the results of the surveys discussed above. Over the past few decades, attempts to reform health care systems based on commercial business rules, and the imposition of austere funding constraints, have created a culture of management based on a dominating top-down leadership approach to the exclusion of other leadership approaches, such as 'affiliative' – creating trust and harmony – or 'coaching'.[37]

The authors of a series of papers examining leadership in complex health environments concluded that: "Perhaps the biggest barrier to these [relational] approaches prompted by complexity thinking are the incumbent leaders of health systems who have risen within the hierarchy based on command and control methods".[38]

New Zealand's SMO Commission made similar observations, noting the "low morale and loss of goodwill among an increasingly disenfranchised [SMO] workforce" was "largely a product of the health reforms of the 1990s, which introduced a culture to the public health system that has devalued clinicians and proved detrimental to effective working relationships and service delivery".[39]

An appraisal of Canterbury DHB's 'Canterbury Initiative', praised internationally as an example of how to achieve integrated care between hospitals and community-based services, considers the critical importance of overcoming a controlling and mistrustful environment. [40]

> *Arguably the biggest change Canterbury has made … is to re-invest in the professional pride of clinicians and other staff – taking significant steps to re-empower them to make change themselves after a long period of managerialism. This was a view that stemmed in large measure from the 1980s analysis in many anglophone countries that one of the biggest problems in public services in general, and health in particular, was 'provider capture'.*
>
> - The King's Fund, 2013[41]

Management approaches both in New Zealand's health system and those of comparable countries have tended to be typified by laying down demanding targets, leading from the front, often being reluctant to delegate, and collaborating little. They are the consequence of the health service focusing on process targets, with recognition and reward dependent on meeting them. [42] [43] [44, 45]

> *Hospitals are complex socio-political entities, and the ability for engagement and leadership among clinicians can be hampered by power dynamics, disciplinary boundaries, and competing discourses within the organisation. The tension inherent between clinical and administrative discourses is evidenced in the findings from the evaluation of clinical directorate structures in Australian hospitals, with close to two thirds of medical and nursing staff surveyed reporting the primary outcome of such structures was increased organizational politics…*
>
> *Despite a policy agenda to foster clinical leadership, there are reports that managerial imperatives can instead primarily focus upon fiscal efficiency or organisational political imperatives, with various factors colluding to silence concerns of clinicians.*
>
> – Daly et al, *Journal of Healthcare Leadership*, 2014[46]

Clinicians often object to having to practise to externally created detailed specifications, while managers bemoan a lack of cooperation. These tensions are exacerbated by doctors' tendencies, often, to be conservative individualists rather than team players, with a focus on autonomous decision-making and personal achievement. They are recruited for and schooled in individual, not collective, action; efficacy through self, not others - the opposite of what is needed for collective leadership.[47] [48]

Managers and clinicians have not only become alienated from each other but, as pressures on health services have mounted, have tended to blame each other when things go wrong or fall short of expectation, creating mistrust and cynicism from both 'sides'.[49] [50]

Staff in many hospitals have become accustomed to, and often disillusioned by, 'flavour of the month' initiatives that are launched with much fanfare only to disappear when results do not materialise as expected. As one respondent to a qualitative study on the implementation of an initiative introduced in Southern DHB commented: "This is another effort and just one of their things, and like other things it will come and go". [51]

Of the many impediments to distributed clinical leadership, management's inability or unwillingness to transfer power to the medical frontline is considered a major one. The prevailing model of the delivery organisation as a repository of key resources and primarily responsible for providing those resources through services has led to a focus on operational administration and management. National targets and performance indicators are largely operational – waits and delays, resource utilisation rates, intervention rates, etc – and focus on the transactions of care delivery.[52]

Doctors' cynicism about management's motives for introducing a new policy or initiative, especially when it appears to be primarily a cost-cutting measure, has also led to a reluctance for senior doctors to step up into formal leadership roles – often cynically referred to as a move to the 'dark side'. As a literature review on engaging doctors in leadership puts it: "At worst, medical directors and clinical directors will be used as go-betweens in a familiar book-balancing exercise that involves closing wards periodically, not filling vacancies, and cancelling operations." [53]

The destructive effects of the clinical-management cultural divide, and missed opportunities to harness the innovative capabilities of the clinical workforce, are illustrated in a commentary contrasting examples of engagement and disengagement:

> *The solicitation of employee suggestions for improvement is a central tenet of the Toyota Production System principle of Kaizen, continuous improvement. Toyota reports not only that it receives over a million employee-generated ideas for improvement, but also that the majority of these (95%) were put to practical use… In contrast, a recent survey of junior doctors in the United Kingdom found that only 10.7% reported that they had had their ideas*
>
> *for change implemented, sending a strong message that their involvement in system improvement is not really valued, irrespective of any rhetoric to the contrary.*[54]
>
> - Richard Bohmer, Harvard Business School, 2012[55]

The 'us and them' environment is to some extent reinforced by government policies that reflect top-down control. In particular, centrally mandated targets – predominantly relating to operational efficiency measures such as delays and waiting times – have been the focus of much medical concern. Although such targets have been credited with significantly improving service performance, they have also been held responsible for patient harm by reducing patient focus and care integration.[56] [57] [58]

Some argue that it is a major *cause* of the disconnect between management and those delivering the services. As a former senior government health official commented: "…ministers from successive governments have become besotted with targets – technology has enabled ministerial insight into the very heart of health services, and offers the opportunity to micro-manage these interactions like never before".[59]

Though New Zealand's DHBs are responsible for ensuring the provision of health and disability services to their areas, and were set up in 2000 to "evolve towards maximum autonomy as they become capable",[60] only a small proportion of their government funding is for discretionary spending (9% has been reported by one DHB). The rest is tagged to certain services and initiatives by the Ministry of Health.[61]

While the Minister of Health ended the public reporting of health targets in 2018, they remain in place until a new set of performance measures are developed; at the time of publication it was not known what form those measures would take. Further, the Minister has continued to omit in his 'Letter of Expectations' to DHB boards the importance of developing a culture of clinical leadership, indicating the policy which was previously considered "a fundamental driver for improved care" is now a low priority.

Another common barrier to fostering the cultural change necessary to develop distributed clinical leaders and broader collective leadership is the long timeframe it requires, which usually does not fit comfortably with political agendas. [62] [63] [64] [65] [66]

> *One of the consequences of rapid turnover among politicians and of short-time horizons is lack of consistency and a tendency towards hyperactivity. This militates against the commitment seen in high-performing organisations to a long-term vision of improvement that is well communicated and understood. Another unfortunate tendency is for politicians to reorganise the NHS on a frequent basis. Inevitably, this distracts attention from the much more important issues of quality improvement and service transformation.* [67]

Attempts to bring about transformational change have also been thwarted by tight funding constraints, combined with consequential staff shortages and government expectations to meet its performance targets, which means many clinicians and other health staff have no time to engage in service improvement initiatives.

Heads of Department in eight DHBs have assessed their senior doctor staffing capacity "to provide safe, quality and timely health care" as more than 20% short, on average, in surveys undertaken between 2016 and 2019.[68] And the national surveys of ASMS members in 2010 and 2018/19, discussed above, found in both cases that just 20% of respondents agreed they had sufficient time to engage in distributed clinical leadership.

The impact of inadequate funding, staff shortages, and time pressures for clinicians to engage in activities outside of their normal clinical workload, leading to a lack of distributed clinical leadership, is highlighted in a qualitative evaluation study of the introduction of an online clinical and referral information tool, HealthPathways, at Southern DHB.[69]

The HealthPathways programme has been successfully implemented at Canterbury DHB, where it was initiated by a group of Canterbury DHB hospital doctors and GPs and other health professionals with an aim of improving referral processes and communication between them. It is now recognised internationally as a step forward from other online clinical guidance systems.

However, the evaluation of its introduction at Southern DHB found "multiple failures of the implementation process". Whereas the Canterbury DHB had invested the time and resources to establish strong trusting relationships and strong staff engagement to enable the changes to be led through collective leadership, with collective responsibility, Southern DHB failed to do this.

Their study found a "poor implementation climate. There was also a lack of readiness to implement, notably a lack of funding to allow for dedicated time for secondary and primary care clinicians to meet and interact meaningfully as part of HealthPathways development". Failures were "at least in part due to a continued environment of financial austerity and a need for the DHB to 'balance its books'."

Significantly, HealthPathways in Canterbury DHB commenced prior to successive years of real-term funding cuts to DHBs since 2009/10.[70] Consequently CDHB was not confronted at least to the same extent with the same pressures that Southern DHB (and other DHBs implementing the programme) is now facing.

Discussion: Achieving successful distributed clinical leadership

There is strong consensus internationally that to meet the challenges facing today's health care systems and make the most of potential opportunities in future, the strategies and tactics that may have worked in the past are no longer sufficient.[71]

The leadership that has worked in the past is equally ill-suited to overcome the demands resulting from a changing demography and increasing complexity of health care delivery. [72] There is growing recognition that while designated leaders in positions of formal authority within hospitals play a key role in administration and espousing values and mission, such leaders are limited in their capacity to reshape fundamental features of clinical practice or ensure change at the frontline.[73]

Those who seek to improve the performance of an organisation should "harness the natural creativity and organising ability of its staff through such principles as generative relationships, minimum specification, the positive use of attractors for change, and a constructive approach to variation in areas of practice where there is only moderate certainty and agreement".[74]

Collective leadership, including distributed clinical leadership, is the required model to achieve this.[75]

It means leaders in formal roles, starting at the Board level, must not only understand what is needed to nurture a caring, collaborative culture but also to pay conscious, deliberate attention to creating the conditions in which responsibility, power, authority and decision-making is distributed within and throughout an organisation rather than at the top of a hierarchy. For collective, distributed leadership (and followership), all staff must be engaged.

It means that leaders must emphasise collaboration as a key principle of success and embrace their organisation as a learning organisation in which the capabilities of individuals and teams are continually enhanced. And it means that organisations must span their boundaries and work together, rather than implement effective leadership within organisational silos.

The complete dedication of the board and leadership team to empower all staff as leaders, and trust in the process of collaboration in the organisation as the foundation for its leadership culture are keys to success.[76]

In New Zealand's DHBs, there are five key positions that help shape an effective medical culture of clinical leadership. These are the Chief Executive; Chief Operating Officer (or general manager of the largest hospital or service grouping in each DHB); the Chief Medical Officer; Funding and Planning leadership; and human resources/employment relations leadership.[77]

The many benefits of DHB management purposefully striving to support a professional culture of clinical leadership "at all levels of staff" have been demonstrated in a project evaluating quality improvement (QI) strategies and outcomes in four DHBs.[78] Across all participating DHBs staff were empowered to develop QI ideas and projects on the basis that "change was about the best outcomes for patients rather than just saving money [though savings were achieved], because they were involved in designing the change". The evaluations showed clear improvement in a range of patient outcomes, with some outcomes markedly improving.

In Whanganui DHB, where the project focused on acute mental health services, changing the culture began with a deliberate aim of "increasing joy and pride in work". The evaluation report noted: "This attitude has successfully spread through the organisation and the culture change has been pronounced". The resulting improvements in patient outcomes across a range of measures coincided with a dramatic increase in staff satisfaction. In 2012, around 62% of staff reported overall satisfaction with their work. This increased to 100% in 2015.

The literature shows that when health organisations nurture the values underlying health professional cultures, especially when improving patient outcomes is clearly stated as the priority goal, patient satisfaction is higher, health care delivery is more effective, there are higher levels of innovation in the provision of new and improved ways of caring for patients, lower levels of staff stress, absenteeism and turnover, and more consistent communication with patients.[79]

People who are drawn to health care want to focus their life's work on something good: helping patients. Altruism is core to the identity of physicians and virtually everyone else in medicine. Health care leaders cannot succeed without making it explicit that they share and will act on the same aspiration.[80]

First and foremost, distributed clinical leadership and broader collective leadership must be supported as a high priority at the highest level of the system, by elected governments and government officials – the latter being especially important, recognising that it requires a long-term strategy well beyond the length of time that ministers hold office.[81]

The Minister of Health's annual 'Letter of Expectations' to DHB provides a vehicle in that respect and reinstating clinical leadership as a "fundamental driver for improved care" would be a positive start. However, given DHBs' poor response to acting on ministerial expectations on clinical leadership in the past, a stronger emphasis on delivery is necessary.

Paradoxically, it is sometimes necessary to use command-and-control to move the organisation away from command-and-control.

- The King's Fund[82]

Advocating a collective leadership strategy in the UK, a King's Fund report calls for "Every board [to] ensure that it understands the leadership capabilities required in future, how these are going to be developed and acquired, and what organisational and leadership interventions will enable them to be delivered". Boards must then assure themselves, and the Minister, and the public – through regular monitoring reports – that the collective leadership strategy for their organisation is implemented as "the challenges that face health care organisations are too great and too many for leadership to be left to chance or to piecemeal approaches". [83]

Monitoring the progress of collective leadership strategy must also recognise the long timeframe necessary to bring about the required cultural change, with all the complexity involved.

An Australian study on a leadership and team-building initiative found that forming and maintaining teams requires a lot of effort. "Even finding a time for team members to meet in a busy and fragmented work setting poses a challenge. Transforming a newly formed group of clinicians from different disciplines into an effective team takes time. Team members are likely to have different interests, opinions and interpretations of key terminology… Improving skills in facilitation, negotiation and conflict resolution helps team members achieve consensus."[84]

A study on medical engagement in the UK identified the lessons from seven NHS organisations with the highest levels of medical engagement. All acknowledged it took time and was often challenging, and disengagement could be sudden and precipitous. But they highlighted consistent benefits such as successful initiatives, innovation, staff satisfaction and retention, improved organisational performance and better patient outcomes. The organisations emphasised that engagement should be persistent and reach the entire medical workforce.[85]

Finally, lack of resources, including under-investment in staffing, is a commonly cited barrier to implementing collective leadership and, specifically, distributed clinical leadership. This is clearly expressed in the surveys of DHB Head of Departments discussed above. Adequate funding is critical to enable DHBs to employ sufficient staff to engage in bringing about what amounts to fundamental cultural changes.

The current Government's new approach to devising Budgets for New Zealanders' wellbeing, focused on strengthening the country's four 'capitals' – human, social, natural and financial/physical (described collectively as economic capital)[86] – provides an opportunity to reassess how health budgets are formulated.

It has been argued that when human capital, social capital and the organisational context complement and enable each other – as they would in a system-wide adoption of collective leadership – they produce intellectual capital "which in turn drives value creating processes such as dynamic capabilities, innovation, efficiency and collaborative working". [87]

It further is argued that "intellectual capital is increased when skilled and motivated employees are directly involved in determining what work is performed and how this work is accomplished, and the routines and processes that act as the glue for organisations can either enhance or disable co-operative working and the development of knowledge". [88]

Those responsible for formulating government health budgets, then, are presented with a stark choice when weighing up the requirement to be 'fiscally responsible' (under the Public Finance Act 1989) and how to progress towards budgetary well-being goals.

Should the government invest in the collective economic capital of our health service workforce to advance a policy of collective leadership that is "characterised by strong identification with the organisation and a drive to be involved in decision-making and innovation to improve the delivery of care", and where the staff experience of work "is involving, at times exciting, meaningful, energising, affirming, stretching and connecting"? [89]

Or should the government continue to pursue a policy of fiscal austerity, where the staff experience of work has often been described as "surviving from day to day"?

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