

Clinical Directorates Underpinning Principles & Operating Framework

Introduction:

The introduction of the Clinical Directorate model in 2009 incorporating “executive authority” for the clinical director was described as one of the most significant changes to occur in the Irish Healthcare Service for many years. This new model was heralded to represent an unprecedented opportunity for change through clinical leadership.

The purpose of the clinical directorate model was to achieve the best clinical outcomes and experience for patients within the available resources through the involvement of clinicians in leadership positions, working closely with other key staff including management, nursing and health and social care professionals in a collaborative manner. It was introduced however without any reform of the existing system of management, without a project plan to outline this significant proposed change and without a mandate to the acute hospital system for implementation.

Background:

There is international evidence that the level of clinical leadership in hospitals and hospital groups correlates with hospital performance and even clinical outcomes (1). Effective governance arrangements recognise the inter-dependencies between corporate, financial and clinical governance across the service and integrate them to deliver high quality, safe and reliable healthcare.

The first cohort of Clinical Directors was aligned to acute hospitals and Mental Health Directorates (MHD). Hospitals and MHDs operated within a larger regional system of four HSE regions, each of whose resources were managed by Integrated Service Area (ISA) Managers answering to one of four Regional Director of Operations (RDO). The announcement of Hospital Groups as a transition to Independent Hospital Trusts promised to change both the clinical and managerial landscape (2) and the transition towards Hospital groups is being project managed through the Systems Reform Group and PWC.

“The formation of Irish acute hospitals into a small number of groups, each with its own governance and management, will provide an optimum configuration for hospital services to deliver high quality, safe patient care in a cost effective manner. Grouping hospitals will allow appropriate integration and improve patient flow across the continuum of care” (3).

The original paper outlining the national framework for the Clinical Directorate model (4) predated the Hospital group structure and it has become clear that as hospital groups evolve into independent networked units; the model for clinical directors is being adapted to suit local needs. It would be naïve to consider that one rigid structure would fit all sizes.

This paper outlines key underpinning principles that are needed to support an effective clinical directorate model and indicates the minimum specifications for a framework upon which a group or CHO clinical directorate model could be structured as part of impending reform. The outline of “minimum

specifications”, as opposed to a prescriptive model, will allow for flexibility between Groups and CHOs and is based on the quality improvement methodology of Front Line Ownership (5).

Underpinning principles:

The principles that should underpin an effective Clinical Director model are eight generic principles that are fundamental for any hierarchical model within a complex environment such as healthcare.

They have been identified as factors cited repeatedly during interviews with Clinical Directors and their teams nationally and many are the same as the principles underlying good governance (6). This is not an exhaustive list; there are other factors that may influence how well or poorly this structure works, including geographic challenges, availability of backfill, clinical speciality etc. These factors are considered operational issues and are not the subject of this paper.

They are

- Support
- Effective Leadership
- Authority
- Accountability
- Clarity of Role and Reporting relationships
- Communication and Information
- Commitment to Quality Improvement
- Access to Training and Education

SUPPORT

The clinical director model requires support at all levels in order to succeed. Support must continue from the Leadership team of the HSE, through the Clinical Director Programme to the Hospital group/CHO and individual hospital management teams/community based clinical teams. The level of support at Hospital level varies across the country and appears to be directly related to how successful the model is perceived to be by the clinical directorate teams.

Support for the model requires visible demonstration at national level with the development of a plan to implement the clinical director contract through the vehicle of the systems reform group.

It requires to be sustained through the hospital group executive management teams by demonstrable and measurable outcomes of implementation progress. Support from local hospital management teams will be encouraged from the national lead and will be sustained on the development of relationships and mutual trust in the Clinicians undertaking these roles.

Recent surveys of clinical directors working in the Irish healthcare system show they feel high levels of support from their senior executive colleagues and moderate support overall from clinical colleagues (6).

The introduction of individual clinical directors should not replace smaller units (microsystems) and in fact their success relies on small, well led clinical units for delivery of good quality patient centred care, allowing clinical directors to work in a more strategic than operational environment.

The introduction of the clinical directorate model requires support both from senior management executives and also from clinical teams within directorates in order for the model to be successful. Structured units at the level below clinical director (ward, department, division, community based clinical team) require recognition, support and resourcing.

Development of clinical leadership at the level below the clinical director (i.e. within directorates) will distribute leadership more widely within the organisation. Promoting microsystems and introducing front line ownership methods allows carers to adapt and modify best practice locally with a greater chance of sustained improvement.

Principle 1, Support

HSE Leadership team
National Clinical Director Programme
Hospital Group CEO, Executive Team and Hospital Group Board
Local Hospital CEO and Management Team/CHO CO Management Team
Directorate Team Members (Nursing, Business Managers, Allied Health Professionals)
Local finance and HR personnel
Clinical Leads for services
Consultant colleagues

Minimum Specifications for Operational Framework

National- Implementation Plan to be devised and implemented through all strands of the Health Service Improvement Programme
Clinical Director Programme – continue to support and provide educational and networking opportunities for CDs and ECDs
Hospital Group/CHO - implement the CD job description according to a national implementation plan
Hospital Executive/CHO Management Team- promote a culture of clinical leadership and realise the value in terms of patient outcomes and quality improvement
Clinical Leads and Microsystems – should be encouraged to support the directorate structure from the bottom up
Clinical colleagues – a culture of support and recognition of the need and benefits of clinical leadership should be fostered

EFFECTIVE LEADERSHIP

Leadership is fundamental to an effective clinical directorate model. There is a wealth of literature on the attributes of leaders and the benefits of good clinical leadership in healthcare resulting in improved outcomes for patients. Leadership skills are largely inherent but can also be developed and honed through training and with support from the organisation and the members of the clinical directorate team.

Effective leadership should engage both clinicians and other healthcare professionals to create teamwork and to develop an open and questioning culture, which enables change and service improvement. Effective leadership empowers the whole multi-professional team to influence the standard of care delivered (7).

Principle 2, Effective Leadership

Clinical directors should have leadership attributes that involve and empower all staff to work towards a shared vision of improved patient care

Minimum specification for Operational Framework

Leadership attributes of CDs should be developed by courses, coaching and mentoring where necessary
The organisation should visibly support clinical leadership and in all clinical disciplines; from Lead CD to the lead of the micro-system

Front line ownership methodology should be available to promote distributed leadership

The culture of the organisation reflects the effectiveness of its leaders and should be measured

AUTHORITY

The clinical directorates were set up to be based on a co-leadership model with clear accountability. The original guiding principles document recognised that the role of the executive clinical director and/or clinical director is dependent on the exercise of authority, both moral and actual (6). Moral authority should derive from the leadership characteristics of the individual clinical director i.e. perceived capability, professional respect, trust, communication skills, ability to build relationships; quality of decision-making etc. The loss of moral authority would seriously, and potentially fatally, undermine the ability of the clinical director to fulfil the role. Actual authority was to be derived both from the contractual nature of the role, which assigns executive authority to the clinical director, and from the influence the clinical director could bring to bear on the allocation of resources within the directorate.

The feedback gathered from Hospital group visits and electronic surveys conducted by the National Clinical Director Programme suggests that Clinical Directors have insufficient authority over the directorate resources; both human and financial. Only 22% of survey respondents to a survey in 2015 claimed they were budget holders and none have a line management role over non medical staff in their directorate. This finding occurs despite the statement in the 2012 Clinical Director Job Description; *“the Clinical Director will be responsible for, and will have authority over, all medical services including resources for same (budget, staffing etc).”*

Principle 3, Authority

Moral authority- Clinical Directors to be appointed on the basis of their integrity and Leadership ability

Actual authority- as outlined in the job description 2012; *“the clinical director will be responsible for, and will have authority over, all medical services including the resources for same (budget, staffing etc.)”*

Minimum Specifications for Operational Framework

HSE to implement the job description to allow budget transfer to the directorate and realign non medical staff to have a reporting relationship to the Clinical Director for discharge of clinical duties and provision of clinical service

Transfer the budget to the directorates utilising a robust financial management system

Redeploy existing financial staff to work in directorates

Ensure that Business Managers supporting the Clinical Director have appropriate financial and managerial training

Ensure that there are systems for reliable, accurate and timely budget reports to the Clinical Directorate Team

Ensure that controls and assurances remain in place as the CEO remains ultimately accountable for the budget with approximately 80% control residing with the CD

ACCOUNTABILITY

Doctors are accountable to many people and regulators within healthcare, including their patients, employers, professional bodies (such as the IMC) and to the courts. Clinical Directors are willing to undertake the responsibility and accountability that is inherent in the terms of the post, and explicitly

stated in their job description, however the majority of CDs feel that they are not afforded sufficient authority to match the accountability to which they are held.

The Clinical director is accountable for their own clinical practice and also for his or her decisions on allocating resources (where they have been afforded the authority to do so).

The Medical council Guide to Professional Conduct and Ethics refers to doctors in management roles in two areas-

“24 Healthcare Resources

24.2 You have a duty to assist in the efficient and effective use of healthcare resources and to give advice on their appropriate allocation. You should balance your duty to do your best for each individual patient with the wider need to use finite healthcare resources efficiently and responsibly. Such awareness should inform decision-making in your clinical practice”

“63 Doctors in Management Roles

Your primary objective is the health, safety and care of patients, even if your role does not involve providing clinical care for individual patients. You may still be accountable to the Medical Council for your conduct.”

The HSE introduced an Accountability Framework in 2015 that sets out the means by which the HSE and in particular the National Divisions, Hospital Groups and Community Healthcare Organisations, are held to account for their performance. The performance indicators against which divisional performance is monitored are set out in the Balanced Scorecards grouped under:

- . Access
- . Quality
- . Finance
- . People

The framework sets out the accountability of 5 levels from the Minister of Health to the individual hospital CEOs. This framework was introduced to hold managerial staff (clinical and non-clinical) to account in terms of specific areas of healthcare assessed at Performance Management meetings and fills the gap that currently exists in the absence of Hospital Group Boards. Ultimately, the Hospital or Hospital Group Board of Trustees should fulfil this function by having oversight of financial and clinical services.

Principle 4, Accountability

“Liability to give an account of and answer for discharge of duties or conduct”

Clinical Directors are accountable to

- Patients
- Employer
- External regulatory bodies
- Medical Council
- The courts
- The media
- Elected politicians

Minimum Specifications for an Operational Framework

Structure to support accountability should include focussed review of clinical and financial performance within the directorate with support from appropriately trained personnel including data analysts and accountants

Participation at Performance Management meetings with the Acute Hospital division transitioning to review of directorate, hospital and group performance by the Group Board of Trustees

CLARITY OF ROLE AND REPORTING RELATIONSHIPS

Clear accountability and reporting relationships for all staff within a hospital or hospital group or CHO is central to good governance and to an effective clinical directorate model. Clinical Directors and healthcare professionals at all levels within a directorate both in hospitals and CHOs must know their responsibilities, level of authority and who they are accountable to (8).

Clarity and recognition of the role of the clinical director as the clinical and executive leader within the directorate must be widely communicated in the organisation. In addition, all multidisciplinary team members must be clear on their role as part of the directorate team and their role in providing leadership in their own specific area of competence (9).

Principle 5, Clarity of Role and Reporting Relationships

Each person working in a large organisation and within small teams needs to clearly know their own role and to whom they report. Without clarity of individual role and reporting relationships; there is room for ambiguity

Minimum Specifications for an Operational Framework

Job descriptions of staff providing a clinical service should be reviewed and aligned to the clinical director model

There should be a reporting relationship of medical and non-medical staff to the clinical director on clinical issues and on issues on quality of patient care (over time it is expected that each member of staff in the directorate will have a reporting relationship through their line manager to the clinical director- *(CD Job description 2012)*)

COMMUNICATION AND INFORMATION

Effective open communication mechanisms facilitate the efficient working of clinical directorates, the engagement of colleagues and the development of trust among the team and the wider organisation. The lines of communication should be vertical to ensure effective transfer of information between executive management and frontline staff through the directorate. Communication should also be horizontal to ensure continuity of care and integration of services across directorates within an organisation. Horizontal communication should include the clinical care programmes and the Community Health Organisations to allow for improvement in care pathways, access and the development of integrated patient care.

Communication of information ideally occurs at face to face meetings, to allow the front line staff who advocate for the patient to be heard in a clinical context. Data reports, both clinical and financial, should be timely and contain reliable, relevant information. The clinical directorate should be supported by data analysts to interpret data from clinical teams and construct meaningful, understandable outputs for the executive.

Communication within the hospital group and to the community must be well supported by current IT technology to allow networking across sites.

Principle 6, Communication and Information

There should be well developed communication

Vertically from the frontline staff and patient, through the directorate to the executive and board and back

Horizontally between directorates for patient flow and integration

Horizontally between directorates at hospital group and CHO level

Outwards between directorates and Clinical Care programmes and CHOs

Minimum specification for an operational Framework

IT support – availability of personnel and technology for the directorate

Data analytical support to all directorates

A schedule of regular face to face meetings with staff at clinical front line, other directorates and lead clinical directorate level

A schedule of reports or meetings between clinical care programmes and directorates

A schedule of reports or meetings between CHO and directorates

COMMITMENT TO QUALITY IMPROVEMENT

The purpose of the Clinical Directorate model is to improve outcomes for patients within available resources. The Clinical Director and their team must show commitment to quality improvement and ideally have some knowledge of, training in or access to, QI methodology (including principles of LEAN). Training on QI may or may not be formal, but a commitment to continuous improvement of the quality of care delivered within the directorate should be a core principle and represent the majority of the work of the directorate. An audit schedule should capture improvements.

Principle 7, Commitment to Quality Improvement

The clinical directorate team should be fully committed to QI and have training in or support for implementing and sustaining quality improvement initiatives

Minimum Specifications for an Operational Framework

Access to funded QI and or LEAN training for the Clinical directorate team (i.e. through a recognised post graduate body or accredited course)

Organisational support for QI initiatives

Support for QI initiatives from the Quality department where this exists

Schedule of Audit for outcomes, with reports to executive or QPS committee where this exists

ACCESS TO EDUCATION AND TRAINING

The introduction of the clinical directorate model necessitated some alteration of role for some healthcare staff. Staff who were fully trained and competent in certain areas may now be working in areas in which they are not formally trained and may feel under-skilled.

Healthcare professionals often report feeling ill-prepared and isolated in leadership and managerial roles. To fully realise the potential benefits of clinicians in leadership roles, training and education must be offered including on generic leadership skills and for specific areas such as risk management, complaints management, systems analysis review, open disclosure and quality improvement methodology. It must be recognised however that clinical directors do not need to be qualified in areas such as financial management; they should be robustly supported by qualified financial and managerial personnel in these areas. Access to training and education applies to all members of the clinical directorate team. Annual review of staff at performance achievement could help to identify gaps in competency that could be remedied by training. A suite of core competencies and minimum training requirements should be developed for clinical directors and their teams.

Broader education of the value of leadership at an early stage in undergraduate clinical training will result in a generation of clinicians who view clinical leadership as valuable and ultimately result in a network of clinicians who understand and support the need for such roles.

Principle 8, Training and Education

All members of the clinical directorate team should be appropriately trained to a minimum acceptable standard

Minimum Specifications for an Operational Framework

All members of the directorate team should have access to funded training and education in appropriate areas (to include but not be limited to- open disclosure, systems analysis review, handling complaints, managing conflict, basic budget principles).

Clinical Directorate Team members should complete an annual assessment or performance achievement process against a list of core competencies.

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