



Victorian Healthcare Association

Clinical Leadership in Community Health

Project Report

March 2009

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Introduction

The Community Health sector in Victoria has been actively engaged, since 2005, in developing a framework to ensure effective clinical governance for the delivery of services in the community. The work has been led by the Victorian Healthcare Association Clinical Governance Steering Committee and has involved the active collaboration of the community health sector workforce to inform the development of quality and safety elements to support a robust system of clinical governance across the CHS.

A significant area of focus has been the exploration of clinical leadership. This report provides the outcomes of the work to date in theoretical foundations for developing a model of clinical leadership, an understanding of current practice and activities of clinical leadership in community health settings and the identification of further enhancement of systems and processes to support a sustainable model which will form part of the clinical governance framework in the community health sector. The implementation of a robust process for clinical leadership in community health positions the sector for the future in a reformed health care system.

Background

The Victorian Healthcare Association Clinical Governance Steering Committee identified the need to explore the role of Clinical Leadership as part of its work on the development of a Clinical Governance Framework for Community Health Services in Victoria. Clinical Leadership was seen to be an essential element on which to establish a strong foundation for effective clinical governance in community health settings. Preliminary work undertaken within the sector and by the Steering Committee and Project Manager highlighted the need to distinguish the roles of clinical supervision and clinical leadership.

A Project Brief was developed and formed the basis of a submission to the Department of Human Services (DHS) for support with this aspect of the clinical governance work. DHS has been supportive of the work undertaken by VHA and has contributed to the deliberations of the Steering Committee. DHS subsequently provided funding for the Clinical Leadership project.

Why Clinical Leadership?

The primary objective of this project was to develop a model of clinical leadership for the Community Health sector. The intent was to undertake the project in two stages:

Stage One: Development of appropriate model/s for clinical leadership in community health; and

Stage Two: Trial of clinical leadership model /positions in community health.

The scope of this work focussed on Stage One of the project and involved exploration of the role of clinical leadership in community health settings and consideration of the interface issues across the care continuum. Initial work around credentialing and scope of practice had identified a strong relationship with having effective clinical supervision and clinical leadership to support these processes and improve quality and safety of services delivered to the community. However, the scope of this particular project was explicit in focussing on clinical leadership as opposed to clinical supervision.

Defining Clinical Leadership in the context of community based service delivery proved a challenging aspect of this project in the initial stages of project design. For the purposes of the Clinical Leadership in Community Health Project, the Committee and Project Officer adopted the Victorian Quality Council's definition:

“both a set of tasks to lead improvements in the safety and quality of healthcare, and the attributes required to successfully carry them out.”¹

As the project progressed it became evident that there was considerable variation in the definition and understanding of clinical leadership across the community health sector.

Project Overview

The design of the project methodology sought to ensure community health sector involvement to ascertain current practice. The development of the methodology was supported by a sector wide Clinical Governance Forum whereby participants provided feedback and input on the initial findings of work undertaken by the Project Officer. A Working Group was established to oversee the project and regular reports were made to the Clinical Governance Steering Committee. The project focussed on clinical leadership mechanisms within and external to organisations.

The early engagement of the sector has enabled input to the development of an appropriate model of clinical leadership for CHS settings that will provide a consistent approach to clinical leadership and a model that could be implemented effectively across the sector. This approach has the potential to drive the change management process as we continue to develop and improve clinical governance in the community health service sector.

The project methodology included:

1. A Literature Review
2. Review of current practice in the community health sector
 - a) Site visits
 - b) Focus groups

¹ Developing the clinical leadership role in clinical governance: A guide for clinicians and health services, 2005:2

3. Investigation and exploration of best practice related to clinical leadership.

1. Literature Review

An extensive literature search was undertaken of clinical supervision and clinical leadership both internationally and within Australia to provide an overview of current evidence and thinking to inform model development. Whilst the review yielded extensive work in the area of clinical supervision, this was not the case for clinical leadership. The main focus was more on generic leadership attributes and characteristics.

The Victoria Quality Council has focussed on clinical leadership in its work on clinical governance and provides a framework for clinical leadership within the health sector. Models for clinical leadership do exist within Australia and overseas, however, they are limited and were predominantly seen in the nursing profession. There was little evidence of clinical leadership development across the allied health sector.

The literature describes concepts, readiness, environment settings, tasks and attributes that combine to create the ingredients for successful clinical leadership. Some professions (nursing) and professional bodies have undertaken work to develop an approach to clinical leadership and support its development but few "pure", well defined models exist particularly in the context of community based service delivery. As the community health sector continues to strengthen its approach to clinical governance there is an opportunity to define and develop an appropriate and sustainable model of clinical leadership that supports service delivery in community based settings and particularly for people who have complex health needs.

2. Review of current practice in community health

- a) **Site visit program** - The community health sector has been working to strengthen clinical leadership in recognition of the importance and connection to the delivery of high quality and safe services. As part of the methodology, five community health services that had incorporated clinical leadership positions into their organisational structures or were recognised for their quality and safety program, were targeted for consultation and participated in a site visit program. This comprised: a rural integrated community health service (CHS), a metropolitan primary health service, a metropolitan CHS with clinical leadership positions in place for 18 months, a metropolitan CHS with clinical leadership positions in place for 5 years and a cross sector area based program delivering community based health services in partnership with a range of acute and community health agencies.
- b) **Focus Groups** - a number of focus groups were conducted targeting: Chief Executive Officers, Community Health Program Managers and

Directors, Coordinators, Team Leaders, Clinicians, Quality Improvement & Community Services Accreditation (QICSA) Reviewers, QICSA internal contacts and Clinical supervisors. The VQC framework which articulates the four key organisational elements for effective improvement of quality health care² was utilised to guide the discussions of the focus groups. Reflection on current or future initiatives was also sought as well as the identification of specific models that support improved clinical practice. The VQC framework was useful in identifying the potential gaps in quality and safety activities at a service delivery level.



Figure 1: Diagrammatic representation of Victorian Quality Council Safety and Quality Framework (2003)

3. Investigation and exploration of best practice related to clinical leadership

The investigation of best practice involved review of structures and mechanisms that operate to improve clinical practice, offer support to clinicians in identifying best practice models, promote cross sector and collaborative working relationships and promote discipline specific professional development. This included the identification of clinical networks, advisory committees, professional organisations and tertiary sector initiatives that have been established and enact the functions lists above.

Attributes and Tasks for Effective Clinical Leadership

² Better Quality, Better Health Care (Victorian Quality Council, 2005:10)

A review of the literature and an examination of the QICSA Standards and Australian Council on Healthcare Standards (ACHS) emphasise the importance of leadership and fostering of a culture of continuous improvement to establish an effective quality program. These are essential preconditions to drive the quality and safety agenda that underpins optimum clinical governance.

The ACHS describes the attribute of leadership in this context as:

“...the ability to provide direction and cope with change. It involves establishing a vision, developing strategies for producing the changes needed to implement the vision, aligning people and motivating and inspiring people to overcome obstacles”³

Leadership at the Board and Senior Management level are required to establish a culture which encourages and rewards openness, mutual respect and teamwork as part of the safety and quality agenda. The governing body of the organisation is responsible for articulating a requirement for clinical leadership that will drive high quality clinical practice and service delivery which will be monitored through its reporting framework. As with all quality and safety activities, clinical leadership must occur at all levels of the organisation and become an intrinsic practice throughout the organisation. This will translate at a program and service delivery level through a range of mechanisms that focus on clinical practice improvements to achieve optimum outcomes for clients. Furthermore, once such a culture and practice has been established, the Board is well placed to fulfil its clinical governance responsibilities.

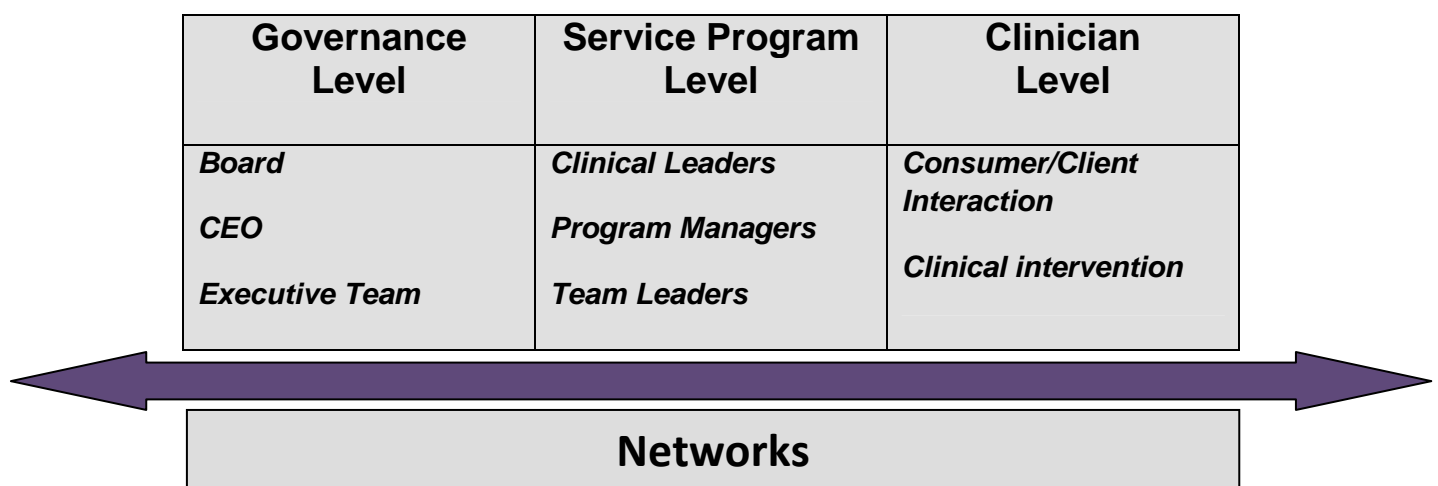


Figure 2: Representation of Clinical Leadership across an organisation

An effective quality and safety program, of which Clinical leadership is a significant component, will be supported in the organisation that can demonstrate:

³ The ACHS EQUIP 4 Guide, Part 1 – Accreditation, standards, guidelines, 2006, Sydney Australia: 261.

- Organisational structures, processes and resources to monitor, manage and improve the quality and safety of care;
- Quality and safety objectives clearly define staff roles and responsibilities;
- Technical support and information enables staff to participate in improving clinical care;
- Consumer and carer involvement in quality and safety
- A robust system of risk management
- Strategies are developed which address recognised problem areas in service delivery i.e. infection control;
- Incident/adverse event management is clear and transparent;
- Service delivery is based on the best available evidence and delivered by properly credentialed and trained staff;
- Opportunities to review compliance with standards are encouraged e.g. external reviews;
- Benchmarking activities with other organisations are undertaken;
- An organisational culture where participation and leadership is resourced, supported, recognised and rewarded.⁴

The extensive literature on leadership indicates that effective leadership relates to the practices of the leader and not a given personality. Kouzes and Posner define these practices as the leader's ability to:

- Model the way;
- Inspire a shared vision;
- Challenge the process;
- Enable others to act;
- Encourage the heart.

Furthermore, they stress the importance of credibility in the workplace and identifying the characteristics that people look for in their leaders. These will include honesty, competence, ability to be forward looking and the ability to inspire others.⁵

Individuals responsible for clinical leadership activities should possess such attributes in order to drive the safety and quality program. Such individuals will be found in various parts of the organisation and a task of management is to identify and foster development of clinicians to be part of the clinical leadership structure to support continuous improvement activities for an effective safety and quality program.

Some of the key tasks or activities that support clinical leadership are:

- Ensuring a focus at the service and program level to improve quality and safety;

⁴ Better Quality, Better Health Care, Victorian Quality Council, 2005:5

⁵ Leadership Challenge, Kouzes, J. & Posner, B. 2002.

- Current knowledge and understanding of health service policy, evidence based practice, relevant research;
- An ability to apply research and evidence based practice within the organisation for improvements in service delivery, program development and design;
- Active involvement in the formal quality and safety structures and initiatives within the organisation;
- Ensuring clinicians possess the qualifications, skills and experience for effective and safe service delivery;
- Promoting professional and skill development across the organisation;
- Providing clinical supervision as appropriate;
- Working effectively with consumers and community to inform program design and clinical treatment practice ;
- Contributing to effective information management;
- Utilising data for service planning, evaluation, clinical risk management and improvements in clinical service delivery;
- Workforce redesign; and
- Developing innovative models of care.

The involvement in external activities to support clinical leadership may include participation in clinical networks, contributing to policy and legislative development, informing system design and development, mentoring and resourcing individuals/organisations within the sector.

Key Findings

The review process has identified considerable activity within the community health sector related to clinical leadership. This included the existence of structures to support clinical leadership through designated clinical leadership positions, incorporation of clinical leadership activities within broader roles and a strong commitment to strengthening clinical governance through the development of clinical leadership activities across organisations. There was, however, considerable variation on the understanding or definition of clinical leadership and an overlap with activities related to clinical supervision.

The key findings from the site visits and focus groups are categorised under the VQC organisational elements. The framework provides a useful structure to guide and inform a model of clinical leadership for the CH sector.

Governance & Leadership

Demonstrated commitment to high quality and safe service delivery by the Executive Team was seen as a key driver to promote continuous improvement across the service. This influenced the culture of the organisation and enhanced the opportunity to implement changes in practice and service delivery within

clinical and management/administrative positions. Clinical leaders who are involved in planning, program evaluation and related activities have an important role to play in driving and maintaining a culture which supports quality and safety. Furthermore, structural arrangements to support quality and safety activities and representation by staff from across the organisation was seen as a critical element in driving cultural and practice change. There was strong support for the establishment of designated quality positions, however, participants highlighted the importance of quality and safety initiatives having a "bottom up" approach and that these are well linked to overall the organisational quality and safety program.

There has been substantial progress in the implementation of reporting mechanisms to Boards of Management to improve organisational clinical governance. However, the lack of reporting indicators impeded any strong analysis or benchmarking and this was identified as an area for further work.

Organisations are experiencing increasing demands in relation to compliance activities i.e. accreditation, clinical governance, risk management and reporting and this is impacting on service delivery time. Not all CHS have dedicated quality positions and participants expressed support for resource allocation to establish such positions.

There was not always a clear distinction between clinical supervision and clinical leadership. During the course of the consultation process with sector representatives it was highlighted that clinical supervision provided the opportunity for focussing on improvements to individual clinical practice whereas clinical leadership operated at a program or overall service delivery level to improve quality and safety.

The involvement of staff, across all levels of the organisation, in strategic and operational planning processes was viewed as an important aspect to promote the integration of quality and safety activities. A clinical leader being involved in such processes would ensure that an informed view of clinical activity and practice was incorporated into the process.

Many community health services have strong links with Universities through their clinical placement arrangements and this provides an opportunity to pursue research activities. A greater focus on research needs to occur especially in demonstrating the effectiveness of community based service delivery. Program managers and clinicians proposed the establishment of "Centres of Excellence" to undertake program research to identify and inform best practice in CH service delivery.

Competence and Education

Improvements in integrating professional development, evidence based/best practice and research into current practice was required. Participants noted that

research/evidence based literature often needed translation and application to a community based settings. A clinical leader could play a major role in assisting with this and could also support implementation and evaluation of practice change.

The development of processes and the availability of experienced or expert clinicians to support Program and or/Line Managers in human resource management was required particularly in the area of performance appraisals and defining the scope of practice.

The monitoring of clinical competence in community health settings was seen as a major issue and there appears to be variation in how this is managed, depending on the professional discipline and/ or program requirements. Whilst the object of the consultation was to elicit information on clinical leadership, participants highlighted issues related to clinical supervision. It was noted that the practice and frequency of clinical supervision varies depending on the discipline. For example there are fairly well articulated requirements for supervision in counselling services. However, the availability of appropriately skilled clinicians for other professional disciplines to undertake this role was problematic and is impacted by high turnover rates of experienced clinicians in the CH sector. Additionally, models for clinical supervision require different approaches depending on the size and structure of the organisation. The availability of time and adequate resources to support models of supervision was problematic.

Participants highlighted the role of professional organisations or peak bodies in terms of initial and ongoing registration and continuing professional development and that these were valuable aspects of support.

There was a perception that access to professional development and clinical information in community health settings was limited and comparisons were made with the acute sector where there appeared to be better opportunities and resourcing for such activities. There was agreement that professional development and ongoing education practice should be evaluated.

Demand management strategies can be enhanced or improved through innovative service delivery models and clinical leadership have a role to play in designing and monitoring such initiatives.

Consumer Involvement

The involvement and engagement of consumers in quality and safety aspects of the CHS requires greater understanding and development. Whilst many CHS have had a significant focus in this area and have sought to improve consumer involvement in service development, further activity and work was required.

Consumer information and feedback was used at a strategic level but how it is translated to clinical service delivery was less certain. There was a clear need

for improved processes to incorporate client/consumer feedback into program and service delivery areas. Clinicians expressed the view that they lacked the skills to illicit information from consumers related to program and service development and needed assistance in this area.

Clinicians expressed a strong desire to develop engagement strategies and illicit meaningful feedback related to clinical service delivery to maximise input from consumers to inform program and service development.

There was also a need to facilitate community engagement and to consider involvement/discussion with particular age demographics i.e. aged, youth and children to inform service and program development. Participants noted this required particular skills and clinicians and managers would need support to undertake this type of activity.

Information Management

The absence of well defined minimum data sets, clinical indicators and the ability to collect consistent data has been problematic in CHS and the sector more broadly. This has been a significant constraint in improving the quality and safety of clinical services.

The breadth and spread of service delivery in the community health sector required extensive data collection to meet funding requirements and the variation within the data sets resulted in limited opportunity to correlate data or look at information in an integrated way.

Better utilisation and application of data for service planning was highlighted as a gap for CHS. Some of the factors impacting on this included: the complexity of design processes for information collection, inconsistency in how information is collected and a lack of expertise in interpreting the information. This was also an issue in analysing data appropriately to provide feedback to clinicians to improve clinical practice. It was felt that a clinical leader, because of their clinical knowledge, could play a major role in interpreting and applying data for service planning, clinical service delivery and service evaluation. Clinicians needed training and support in data management and analysis.

Furthermore, clinicians expressed the need for assistance with designing and implementing appropriate tools to assess the effectiveness of their treatment interventions.

Whilst some organisations have implemented service review and evaluation processes and undertaken benchmarking exercises with other CHS, there are difficulties with comparative analysis of data which was seen to be the result of differences in data collection processes across agencies.

View of current clinical leadership positions

Some organisations in the CH sector have developed specific roles where clinical leadership is the primary function. They are referred to as Senior Clinician, Clinical Leader, Senior Practitioner, Coordinator, Team Leader. The EFT allocation varied from one – 3 day per week positions and up to full time roles. Clinical leaders are involved in a broad range of activities with the major focus on clinical activities. They play a major role in leading changes around quality and safety across organisations and a review of Position Descriptions found a broad representation of activities as described in the four dimensions of the VQC clinical leadership framework.

Where there were established clinical leadership positions the following benefits were noted:

- Improved communication across the organisation. This was particularly evident in multi-disciplinary teams and therefore influenced clinical practice;
- Greater understanding of practitioners role in service delivery and the emerging interface issues across the care continuum;
- Provision of staff support to undertake their role and feeling valued as part of the service delivery team and assistance in addressing administrative and line management issues;
- Promoting innovation and driving “bottom up” practice change.

In the absence of clear and well defined models of Clinical Leadership positions, the development and scope of clinical leadership roles appears to have been influenced by the qualities of people appointed to them, the organisational culture and the impetus for their establishment. These roles have been somewhat evolutionary and no formal evaluation has been undertaken. This is an area for future focus and the findings of the evaluation could inform the framework and structure for such positions across the sector.

Future Challenges/Issues for resolution

The interview process identified some gaps and areas for improvement to support clinical leadership roles in the community health sector:

- Establishing clear lines of accountability and reporting for clinical leadership roles and functions – such roles often form a component of a person’s broader role within the organisation. In order to optimise quality and safety improvement activities a strong link should exist with structures and systems driving quality and safety within the organisation.
- Allocation of resources to support clinical leadership responsibilities was necessary. This entailed time to work with staff and establish internal and external relationships to maximise the value of the role through tapping

into current trends and evidence based practice, current research and developing peer support networks.

Exploration of best practice in Clinical Leadership

Clinical leadership has been a developing concept in the Australian healthcare sector and has been shaped and supported by internal and external structures, tasks and roles. A number of external structures have been created specifically to support clinical leadership in the acute health care sector and some other structures incorporate that function as part of a broader brief. The community health sector has become involved in a number of these aspects as it has moved to strengthen clinical governance practice.

Examples of external structures include:

- 1. Clinical Networks** – multidisciplinary groups working on a collegiate basis to provide leadership and strategic planning for clinical service development across the continuum of care. They have emerged to facilitate improved client/patient outcomes and promote clinician engagement in health service planning, design and delivery. They foster communication and collaboration. Such networks vary in type and focus, but primarily provide a structure for effective working relationships within and between different organisations and individuals.⁶

Clinical networks in Victoria responding to identified priorities include: Cardiac Services, Renal Health, Maternity & Newborn, Stroke Services, Paediatric Service Development, Emergency Care Improvement & Innovation, Acquired Brain Injury/Alcohol and other Drug Clinician Consultant Network.

- 2. Professional organisations** – a number of discipline specific professional organisations provide support to clinician and include OT Australia, Australian Physiotherapy Association, Australian Nursing Federation and associated Special Interest Groups, The Bouverie Centre and Psychiatric Disability Services of Victoria (VICSERV).

These organisations undertake a number of strategies to support members which includes professional support, training, research, policy development and advocacy.

- 3. Tertiary sector** – Formal clinical partnership models have been developed to foster collaborative working arrangements and research opportunities. These include Clinical Partnership, Deakin University, School of Nursing, Faculty of Health, Medicine, Nursing and Behavioural Sciences, Royal District Nursing Service Institute of Community Health.

⁶ Government of South Australia, Department of Health, *Statewide Clinical Networks*, 2007.

Alliances also operate between the community health and tertiary sector with regard to clinical placements for undergraduates and research projects which intersect with aspects of clinical leadership.

- 4. Cross sector Liaison** – a range of cross sector working structures operate to improve clinical practice and service delivery. Some examples include: Hospital Admission Risk Program (intra and inter organisational), Peninsula Diabetes Professionals, Eastern Regional Counselling Network (check title), to name a few.

Two examples of external structures that may be appropriate models to support clinical leadership in community health settings are:

- **Australian Primary Care Collaboratives** – assist GPs and primary health care providers to work together to improve patient clinical outcomes, reduce lifestyle risk factors, promote good health for people with chronic and complex health issues and promote a culture of quality improvement in primary health care.
- **Clinical Leadership Council – Dental Health Services Victoria** – has been established to improve clinical practice in public oral health agencies through a number of strategies including promoting research, developing clinical guidelines and provision of professional development and education sessions.

Discussion

The community health sector within Victoria has been proactive in developing structures and processes to support high quality, effective service delivery. As the sector has grown and matured it has responded to the requirement for improvements in quality and safety processes to support the diverse range of clinical practice delivered in community based settings. There has been a particular emphasis on clinical leadership, however, the current practice has been evolutionary in its development, responding to local circumstances and need and is not well defined or uniform across the sector. Whilst there have been significant advancements in clinical governance and clinical leadership at a governance level what the project has highlighted is substantial gaps at a service delivery level due to a lack of system development and resource capacity.

The project has highlighted the variance in understanding of what clinical leadership means and initial work should focus on establishing a consistent definition and framework across the sector. This will provide a foundation for collaborative approaches to model development that can be adapted to accommodate the variation in community health settings across Victoria. Additionally, a shared understanding of the essential elements for clinical leadership will enable the sector to benchmark future quality and safety

improvement initiatives in this area. A list of tasks relevant to clinical leadership in community health settings is included in Appendix 1.

A proposed definition of clinical leadership for the community health sector:

“Clinical leadership in Community Health is the process of developing a culture and leading a set of tasks to continually improve the quality and safety of service delivery to consumers. Effective clinical leadership involves individuals with the appropriate skills and attributes, at all levels of an organisation, focussing on multidisciplinary/interdisciplinary service delivery.”

Effective clinical governance requires participation and leadership at every organisational level of the CHS and clinical leadership activities should be integrated into existing leadership roles across the organisation. A key learning from the project is the need to develop clinical leadership at a program and service delivery level. Every endeavour should be made to ensure that those with clinical leadership responsibilities are involved in the safety and quality program and have input into the development and implementation of initiatives. This will strengthen the quality and safety program and ensure that clinical leadership is embedded into program and organisational activities to improve program/service outcomes.

As the community health sector continues to be engaged in the delivery of services for people with multiple and complex needs, which requires cross sector interaction, further systems development will need to occur. Clinical leadership will form an intrinsic part of promoting interdisciplinary service delivery to strengthen the continuum of care for people with complex needs. Such models of care should be developed both within the CHS and with external service providers involved in the care of clients.

Throughout this project it became evident that “a one size fits all” model would not meet the needs of the sector or be easily implemented. A major challenge for developing clinical leadership in the CH sector is developing expertise across multi dimensional service areas given the often limited critical mass of clinical expertise in a particular discipline. Community Health services vary in size, capacity and clinical service mix and may not have the quantum of experience within their organisation to support clinical leadership activities. To this end there is merit in concentrating on capacity building to support activities/functions/tasks identified for clinical leadership. This could be achieved in a number of ways and through internal and external strategies. For example an area based or catchment approach whereby several agencies worked in partnership to provide clinical leadership and support to local services could be developed. This would involve utilising existing expertise but sharing that across a catchment. Additionally, utilisation and involvement in statewide structures such as HARP and EIICD networks should form part of external support.

Where designated clinical leadership positions are established in organisations they require definition of the role, clear expectations and outcomes to be achieved and adequate resourcing to ensure they are sustainable. In the case of incorporating clinical leadership functions into an existing clinical or management role then it would be necessary to be explicit about the time allocation for these tasks/activities. Such positions should have a strong interface with existing quality positions to ensure strong linkages and consistency in organisational quality and risk management activities. Given the variation in size and capacity of community health organisations the model will have some variation in its construct.

Furthermore, whatever model is adopted it requires support by the executive leadership of the organisation. Senior managers would have an opportunity to drive strategic and operational planning based on improved understanding of quantitative and qualitative clinical information which would be supported by the clinical leader or well defined clinical leadership activities. A strong focus on improvements in data management, developing appropriate evaluation tools, undertaking benchmarking and identifying opportunities for collaborative research activities will assist organisations in more effective planning.

The project has also identified a need to support the skills development of clinicians undertaking clinical leadership activities. Generic training in leadership as well as targeted training opportunities in areas such as data management and effective data utilisation, research, supervision, consumer/community engagement and change management will assist staff to undertake these roles. Internal and external mentoring from experienced managers and leaders should form part of the process.

As with most community based organisations, the community health sector operates with fairly defined budgets and there are competing priorities around infrastructure and organisational support activities. Whilst current unit prices have built in allocations for quality activities these are now severely stretched due to increasing compliance and regulatory requirements. Consideration should be given to resourcing clinical leadership activities/roles into the future.

External support structures are an important mechanism to strengthen clinical leadership which results in improved clinical practice and client outcomes. Structures such as clinical networks, patient collaboratives, partnerships with the tertiary education sector are already being utilised by the CH sector and providing a valuable resource to assist with improvements to quality and safety activities. These should continue to form part of the structures that assist with implementing effective clinical leadership practice, however, there is also merit in exploring potential mechanisms and structures that would promote and further develop clinical leadership in the community health/primary care sector and would support the multi-disciplinary and inter-disciplinary nature of service delivery. Such structures/mechanisms could play a pivotal role in the further

development of multi-disciplinary and inter-disciplinary care models, promoting practice change and establishing suitable accountability frameworks for cross discipline and cross sector service models. Components of such a structure could include Communities of Practice and web based support (virtual communities of practice).⁷ Such a model would be an effective means of promoting clinical leadership in area based or rural context. Given the shift to community based service delivery for people with chronic and complex health conditions there is a need to ensure effective clinical governance across the care continuum.

The establishment of an external structure would provide a forum for:

- Highlighting clinical challenges and emerging issues and how these might be addressed;
- Showcasing best practice;
- Informing the development of clinical competencies and areas for improvement;
- Development of new service models;
- Acting as a resource base for organisations especially those that have limited internal resource structures; and
- Mentoring organisations and clinicians.

The current focus on the reform of the Australian health care system and the importance of strengthening the role of the primary health care sector provide a context for the community health sector to consider potential alliances and partnerships for the future.

The knowledge gained through the project has provided an opportunity to develop an audit tool for the community health sector to undertake a self assessment of their current approach to clinical leadership and assist them with identifying gaps. The design of the tool is consistent with VQC key elements (Governance and Leadership, Competence and Education, Consumer Involvement and Information Management). A list of key activities and attributes has been incorporated within each of these elements to reflect best practice for clinical leadership which will provide a foundation for CHS to build their capacity in this area. The audit tool will inform the pilot and what external structure for clinical leadership might be required.

The project has identified key tasks and attributes that underpin effective clinical leadership as well as external structures that enhance and support clinical leadership. A pilot project, established in a medium to large CHS, would support the development of clinical leadership roles and would provide a strong evidence base to determine its efficacy. Additionally, a collaborative catchment based

⁷ Safer Healthcare Now, Canada
<http://www.saferhealthcarenow.ca/Default.aspx?folderId=124>

service model could be trialled to support smaller CHS where it is more feasible to share clinical leadership expertise and build capacity across a given area.

The Clinical Leadership in Community Health Project has enabled an examination of current practice and an exploration of a suitable model for the community health sector. It is now opportune to articulate a feasible model of clinical leadership and how that might be supported and implemented. The recommendations provide some first steps to assist the community health sector in strengthening its approach to clinical leadership and considering longer term actions that will assist with improving their clinical governance framework.

Recommendations

Recommendation 1

That Community Health Services undertake an audit of current clinical leadership activities within their organisations to inform the pilot and future initiatives to support clinical leadership in the organisation and across the sector.

Recommendation 2

A pilot project be established for a 12 month period to trial two models of clinical leadership:

- in a medium to large CHS which also supports the development of clinical leadership roles;
- a collaborative catchment based service model to support smaller CHS located in a rural setting.

Recommendation 3

Exploration of a suitable structure or mechanism for the promotion and development of clinical leadership for the community/primary health care system.

Recommendation 4

That Community Health Services build internal capacity by identifying professional development opportunities to develop the skill base of staff to undertake clinical leadership activities.

Recommendation 5

That Community Health Services establish external linkages for evaluation and research activities.

Appendix 1

TASKS FOR CLINICAL LEADERSHIP IN COMMUNITY HEALTH

The following table summarises the main tasks required for effective clinical leadership in community health. Tasks have been grouped into those that are seen as requiring action in the first instance followed by those that could be addressed at a later date.

Governance and Leadership
<p><u>In the first instance:</u></p> <p>Planning and Evaluation</p> <ul style="list-style-type: none">• Interpretation and integration of quantitative and qualitative clinical information into strategic, operational and program planning and evaluation• Analysis of demographic and population health data for service delivery planning processes• Analysis of evidence based information to inform service delivery improvements <p>Quality and Safety</p> <ul style="list-style-type: none">• Influencing the development, monitoring, reporting and operation of quality systems at a program level• Ensuring clinical risks are identified and managed as part of the organisations overall risk management processes <p><u>For consideration:</u></p> <p>Organisational Policy and Procedures</p> <ul style="list-style-type: none">• Providing clinically specific input into the development, implementation and review of policy, procedures and related documents <p>Position Descriptions</p> <ul style="list-style-type: none">• Providing advice on the development of clinical roles and responsibilities and competencies <p>Legal Compliance</p>

- Ensuring that clinical activities are compliant with legal requirements across program areas

Competence and Education

In the first instance:

Service Models

- Facilitate the development and application of appropriate models of care
- Actively encouraging innovation in clinical practice

Workforce Development

- Facilitate workforce redesign to meet the needs of the client population
- Provide appropriate supervision and support to student placements

Evidenced Based Practice

- Integrate relevant research into clinical service delivery
- Developing research activities relevant to service delivery
- Coordinate effective interagency/sector liaison to promote service development
- Benchmark clinical service delivery

Credentialling and Scope of Practice

- Providing input into systems to ensure clinicians are appropriately credentialled and their scope of practice is defined

For consideration:

Professional development

- Providing input into professional development activities across disciplines and programs

Improving clinical practice

- Ensuring clinical supervision policy and procedures are effective and meet organisation standards and service needs

Performance Appraisal

- Providing input into performance appraisals

Consumer Involvement

In the first instance:

Consumer Outcomes

- Application and analysis of appropriate consumer outcomes measures

Consumer Participation

- Facilitate appropriate and effective engagement of consumers, carers and members of the community in service/program planning and evaluation

For consideration:

Consumer/ Carer/Community Information

- Supporting effective mechanisms for communicating with the community

Information Management

In the first instance:

Data Management

- Support the use of information management systems at a program level
- Development and analysis of clinically relevant data
- Facilitate the implementation and analysis of clinical indicators to lead practice improvement

For consideration:

Clinical Documentation

- Promoting best practice in clinical documentation and client information management practices

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