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NATIONAL PRESIDENT

The accidental clinical leader (and manager)

I bought my first desktop computer in 1989. Many a night was spent with a book on my lap in front of this impressive machine, with its 20 MB hard drive, learning DOS and a programme called Framework III. There was a choice between pixelated green or amber text on a black screen.

A year later when I became a registrar in paediatrics I was able to create, maintain and interrogate a basic spreadsheet. It soon became my duty to do the departmental on-call and leave rosters, from house surgeons all the way up to, and including, consultants.

In retrospect, this gave me a unique opportunity to interact with the whole department on a regular basis; at times there were some very tricky conversations and negotiations around rostering, annual leave and on call requests. When it came to choosing a registrar representative for the paediatric department, I was nominated and elected – most people already knew me due to my spreadsheet skills. From there it was a short jump to becoming a registrar representative on the University Hospital Registrar Board. This became part of my curriculum vitae. Six months into my first consultant job I was appointed Chief of Paediatrics and this was added to my CV – and so it became a self-fulfilling prophecy.

As you must realise by now, due to my ability to do a basic spreadsheet, I became an "accidental clinical leader." Without any formal training in clinical leadership, I somehow managed to wing it.

According to the 70/20/10 Model, 70% of what you learn is based on experience, 20% on feedback and coaching and 10% on formal training. There are many quotes about experience, all of them pretty disheartening and demoralising. "Experience is a good school, but the fees are high," said Heinrich Heine. And from Vern Law: "Experience is a hard teacher. She gives the test first and the lesson afterwards."

Believe me, as an accidental clinical leader I sometimes learned the hard way while my colleagues and family looked on and suffered the consequences of my learning experience.

So let us look at the 20% that consists of coaching and feedback. Not only should this occur but it should be done correctly. Practice is futile unless you actually practise the right thing in the right way. Vince Lombardi: "Practise does not make perfect. Only perfect practice makes perfect."

Experience is important but you can, and should, learn from the mistakes and ideas of others. A few years ago I stumbled across a TED talk which changed my thoughts on leadership and clinical leadership, and stimulated my appetite to read and learn more and to become less of an accidental leader. It was the now famous talk by Simon Sinek (16.5 million views on TED Talks). The catch phrase of his presentation and book is "people don't buy what you do, they buy why you do it". But something in his talk was of particular interest to me. If your 'followers' believe what you believe, they will commit wholeheartedly to your vision with their blood, sweat and tears. Martin Luther King did not get up on stage and urge people to get rid of racial inequality and outline a 10-step plan to do so. He started by describing his vision ("I have a dream"). People who had the same dream and belief trusted him and followed him as a leader.

Those who lead are able to do so because others trust that the decisions being made have the best interests of the group at heart and as a result they are prepared to work hard to achieve something bigger than themselves. Simon Sinek described the underlying principles of creating the 'active follower' – without this trust and confidence, you cannot be a leader.

So to recap, I come from a generation of "accidental clinical leaders". My journey started as a spreadsheet creator. The journey of others probably started differently. Some people would have been elected by their 'active followers', some would have been shoulder-tapped by management, and so on. However, we all have one thing in common - we mostly learned from hard-earned experience and "winged" it, and to various degrees, we are still "winging" it some, or most of the time.

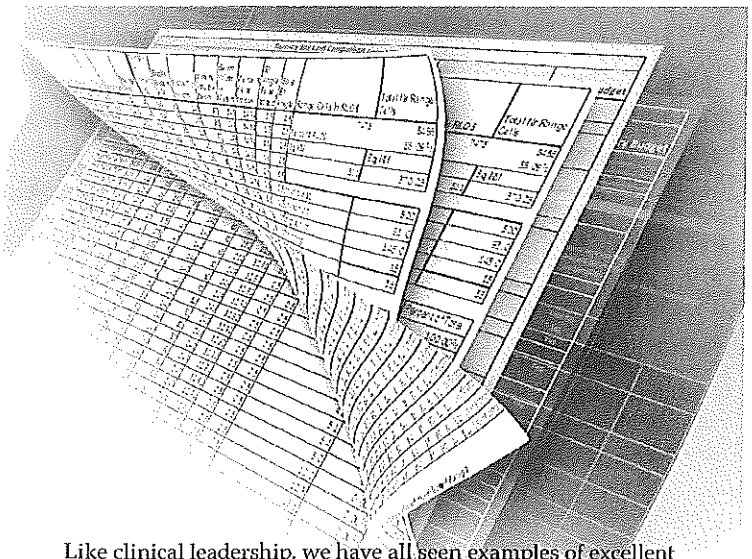
> *People already knew me due to my spreadsheet skills. From there it was a short jump to becoming a registrar.*

We have all seen examples of excellent clinical leadership but unfortunately we have also heard, seen or suffered under clinical-leadership-gone-bad.

While attending the Canadian Conference of Physician Leadership in 2011, I was exposed to a whole new world of fostering, training, supporting and recognising physician leadership. The Canadian Certified Physician Executive Program (CCPEP) was developed by the Canadian Medical Association and the Canadian Society of Physician Executives. The CCEP credential recognises physician leadership and excellence through a national, peer-generated, standards-based assessment process. Physicians awarded the CCPE have proved they have the leadership knowledge and skills needed to perform well and to direct and influence change in Canada's complex health care system.

Wow, a system that moves away from the accidental-clinical-leader-formula and changes the 70/20/10 model by increasing coaching, feedback and formal training! Physicians in clinical leadership positions no longer have to rely on experience 70% of the time. Standards are set and the Canadian certified physician executives are recognised for their qualification. In fact, it is asked for when applying for positions of leadership in the health care system.

Recently a thought hit me. If there is a generation of accidental clinical leaders, what does the managerial side of health care look like in New Zealand? What is the prevalence of accidental health managers? What training and qualifications do we accept and/or expect of a manager in health care? What does the career pathway of a health care manager look like?



Like clinical leadership, we have all seen examples of excellent managers but have all also heard, seen or suffered under management-gone-bad.

New Zealand has a health care budget of $14.5 billion. Whether we like it or not, we are also in the business of health care delivery. This business relies heavily on the skills, training, qualifications, strategy and foresight of its clinical leaders and health managers (hopefully supported by professional budgeting and business units which incorporates well trained and savvy accountants and business analysts).

The clinical leader/manager partnership should have a common purpose, or "why", which they share with their active followers. Unfortunately, and increasingly so, this common purpose and the "why" of health care delivery are pre-determined and orchestrated further and further away from the front line.

> *Those who lead are able to do so because others trust that the decisions being made have the best interests of the group at heart.*

I have total trust and a strong belief in my clinical colleagues across the whole spectrum of front line health care delivery. They work very hard on the shop floor. Their training, qualifications and performance are evaluated, re-evaluated and scrutinised on a recurring basis. They are expected to work harder, faster and safer, "at the top of their licence" and to adjust to a continuous stream of change, new initiatives and targets and at the same time do so within a relatively shrinking budget. Are they doing it with their blood, sweat and tears because they believe in the direction we are heading and because we all share a common belief..... or not?

Would it not be fair that they/we should expect a high level of training, qualification and evaluation of their/our clinical leaders and managers? Should there not be a structured training programme and recognised qualifications for clinical leaders and health managers? You might ask what the cost will be to the New Zealand health service to establish this? I ask you: "What is the cost of NOT doing it?"

It is time New Zealand's health care system invests a bit more of the $14.5 billion in supporting, fostering, coaching and formal training of clinical leaders and health managers to reduce the prevalence and degree of accidental clinical leaders and managers. This would make more sense than our current practice of spending money on high-flying external advisors who come in to our hospitals and clinical services, borrow our watches to tell us the time and then walk off with a nice slice of our budgets!

Hein Stander

West Coast efforts recognised

The hard work by ASMS West Coast Branch President Paul Holt and others has paid off with the Government's announcement it has finally signed off on the business case for funding of the Grey Hospital rebuild.

There were a lot of frustrating U-turns and dragging of heels over the business case, which caused unnecessary anxiety both for the senior doctors and other clinical staff working on the West Coast, and of course for local people wondering what health services they would end up with.

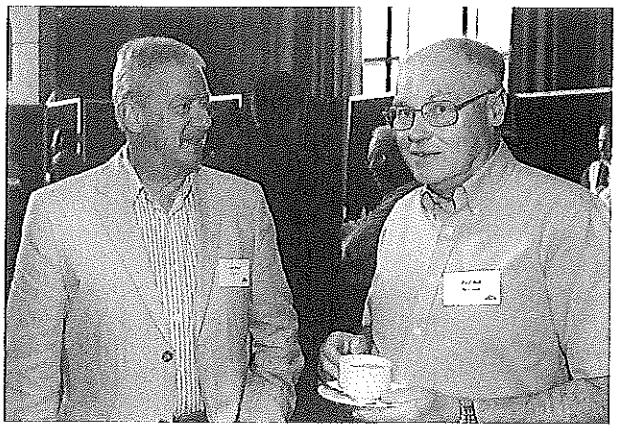
ASMS Executive Director Ian Powell praised Paul Holt's courage in speaking out against earlier attempts to reduce services on the Coast.

Dr Holt, meanwhile, says he's pleased the Government has listened to what doctors and other clinical staff have been saying about the level and type of services needed in the area.

"The feeling among people here is that the planned rebuild will adequately cater for health needs on the West Coast for the medium term," he says. "There's a strong sense of relief out in the community that we finally have some certainty.

"We do need to keep a watch on the Government's plans for Greymouth to make sure there is adequate space for consulting rooms, equipment, allied health and so on. We'll be looking at the detail of the Government's plans to make sure it's workable."

Paul Holt acknowledged the efforts of West Coast DHB Chief Executive David Meates and Programme Director Michael Frampton to get a good result for the region.



Paul Holt, right, talking to Canterbury Oral and Maxillofacial Surgeon Les Snape at last year's ASMS Annual Conference.

EXECUTIVE DIRECTOR

Drilling down on clinical leadership

The ASMS now has a much clearer picture of how each DHB is performing when it comes to providing time for non-clinical duties and distributive clinical leadership.

After two electronic surveys of DHB-employed members we have analysed the results for all of the 20 DHBs, supplemented by the insights provided by branch officers, our industrial staff and through the Joint Consultation Committees.

Our findings for each DHB are below, grouped by performance. The results must be qualified by the fact that in the first survey 63% of members said they did not have enough time for non-clinical duties to participate in 'distributive clinical leadership' activities (only 37% said they did). Overall, DHBs earned an E grade.

In the second survey only 30% of members believed their DHB was genuinely committed to 'distributive clinical leadership' in its decision-making processes, whereas 47% said it wasn't (23% didn't know).

How they performed

Pretty good ★★★

Lakes; Canterbury; West Coast

Lakes

One of the best but risks deterioration if rests on its laurels.

Ron Dunham

This Rotorua-Taupo-based DHB is the top ranked for provision of time and earned a B grade (although around one-third still did not have sufficient time). Lakes undertook a major job-sizing review a few years ago and, while probably somewhat out-of-date, did address time for non-clinical duties noticeably better than other DHBs.

It is also the second ranked DHB for its genuine commitment to clinical leadership in decision-making (and one of only two DHBs where 50% of SMOs responded in the positive). Both the chief executive and senior management (and also middle management) are also rated highly.

> *It takes a long time to build up collaborative goodwill and common purpose; it takes only a short time to lose it.*

Lakes has been helped by having a committed and effective chief medical officer for many years and his successor is continuing in similar vein. However, a word of caution is appropriate. This year there have been signs of disengagement in important processes, including leadership appointments. Distance is emerging between SMOs and senior management. The chief executive will need to ensure that these incidents don't morph into a new direction and a deterioration of what has been an effective collaborative relationship for some years.

It takes a long time to build up collaborative goodwill and common purpose; it takes only a short time to lose it.

Canterbury and West Coast

Very good but always scope for improvement.

Like Hutt Valley and Wairarapa, these two DHBs separated by the Southern Alps have the same chief executive but (unlike their northern counterparts) separate senior management structures. But culturally and performance-wise these two DHB couplets are chalk and cheese. Both ranked in the top three for their commitment to distributive clinical leadership in decision-making processes (1st for Canterbury and 3rd for West Coast); their shared chief executive is ranked 2nd and 3rd respectively); while in senior management, Canterbury is 2nd while West Coast drops relatively to 9th.

They are less impressive on the provision of time, although once again in a survey revealing widespread non-performance. West Coast was a relatively credible 5th (but still 55% without enough time) while Canterbury was 9th (above average, just, but very low by its standards and the 'top of the E graders'). This demonstrates the significance of the differences between vacancies (positions that health bosses choose to advertise) and shortages (includes those many more positions that DHBs need but are not advertised with the result being an overworked workforce). There is scope for improvement here.

Could do better but showing promise ★★

Northland; Waitemata; Counties Manukau; Waikato; Tairawhiti; Hawke's Bay; Taranaki; MidCentral; Nelson Marlborough; South Canterbury

Northland

Promising but capable of doing much better.

In respect of provision of time for distributive clinical leadership, Northland is bang in the middle, both in ranking and percentages. There is nothing impressive about this and, as with other DHBs recording a similar result, Northland receives an E grade.

The DHB's performance is slightly worse on commitment to distributive clinical leadership in its decision-making processes. This is reflected in the rating of the chief executive's commitment although, as a relatively new appointment and with a positive attitude toward SMO engagement, this may improve over time. This ranking may also be skewed by a high proportion of 'don't

knows'. The rating is also similar for senior management. It does appear that members have rated management more harshly than our branch officers and national staff. Our dealings with human resources (HR) to resolve issues have also been positive.

Waitemata

Good potential but risk of encroaching top-down culture.

Waitemata came in 7th for providing sufficient non-clinical time but this has to be qualified by the fact 58% of respondents said that it didn't, earning it a D grade.

The DHB and the chief executive dropped very slightly in the rankings for their commitment to distributive clinical leadership. Of particular concern is the low ranking (14th) for the commitment of senior management, and middle management has also been found wanting. The ASMS has experienced some alarming conduct in the handling of reviews. There are elements of a top-down culture that need to be nipped in the bud before they become more extensive. The chief executive risks his relative popularity reducing if he does not take ownership of this challenge.

Counties Manukau

Good history but mixed performance. Good foundations to do much better.

This DHB received a mixed result, despite having a proud history of innovation. Its provision of time is graded by its senior medical staff as an E. On the other hand, it is ranked 7th for its commitment to distributive clinical leadership, ahead of its two neighbouring DHBs in metropolitan Auckland.

Its chief executive gets a low ranking on commitment to distributive clinical leadership but this has to be qualified by the fact that he is assessed more favourably than most of his counterparts in the 'no extent' category (7th equal best if the ranking was based on this category) and also this question attracted the highest proportion of 'don't know' responses (along with Capital & Coast). He may be a 'victim' of being seen as 'too big picture' and not operationally focused enough.

He has work to do but has good foundations to build on, including a likeable personality. On the positive side he has taken the initiative at our Joint Consultation Committee, asking for a list of SMO 'gripes' that need to be fixed and has responded positively to our request for a list of issues that he would like SMO help for. The commitment of both senior and middle management are ranked a little above the national average.

Waikato

Should be and could be doing a lot better.

Relatively speaking, Waikato is one of the better performing DHBs in respect of providing sufficient non-clinical time, ranked 6th with a D grade. But, on the other hand, the DHB's overall commitment to distributive clinical leadership is disappointing (only 23% thought it was genuinely committed). The chief executive's ranking was disappointing although over half of the respondents had a favourable view, his rating in the 'no extent' category was positively better, and one-third of the responses were 'don't know'. Both senior and middle management take a hammering, however. Some of this might be tainted by an approach from their from their employment relations unit which is seen by staff and unions as hard line.

Tairawhiti

Jim Green

Has done reasonably well but at risk of downward slide.

This Gisborne-East Coast-based smaller DHB is a good indication of national DHB failure. It is ranked well by members for providing time for non-clinical duties for distributive clinical leadership – 2nd behind Lakes – but again perspective is required with 60% answering 'yes' and 40% 'no'. When 40% of members in the second best ranked DHB respond in the negative to what is an essential requirement, it is difficult to think of a more powerful national message of DHB failure (how good really is second best, being a C+).

Senior medical staff are split right down the middle when ranking Tairawhiti's commitment to distributive clinical leadership in its decision-making process, with 37% saying it is genuinely committed and 37% saying it isn't. This mediocre result leaves the DHB ranked 6th.

The chief executive's commitment is ranked above average but senior management's plummets to 15th (possibly skewed by a high proportion of 'don't knows'). There are also recent signs of growing disenchantment among SMOs on the DHB's commitment, including among those in formal clinical leadership positions who feel unsupported. Management will need to work hard to ensure these signs don't become a trend.

Hawke's Bay

Improving overall; impressive senior management.

This DHB came out very poorly in the Robin Gauld (Otago University) 2010 clinical leadership survey of ASMS members, although the questions were different. This poor performance continues with its 19th out of 20 ranking, with just 26% of members agreeing that Hawke's Bay provided enough time to participate in distributive clinical leadership (74% saying they didn't).

Hawke's Bay does move up to middle of the pack for overall DHB commitment to distributive clinical leadership in its decision-making processes. There is a substantial improvement in rating (4th) for the chief executive's performance compared with the Gauld survey. That is despite a reputation for micro-management, especially in respect of targets. More impressive is the high rating for senior management (1st); largely attributable to Hawke's Bay's well performing chief operating officer.

Taranaki

Tony Foulkes

Mixed but good foundations; chief executive needs to be more visible.

Taranaki is perplexing, with mixed results, and based on the ASMS's interactions we were surprised with the disappointing rankings. On the positive side (relatively) it is ranked 4th for provision of time to participate in distributive clinical leadership activities, although again this has to be qualified similar to Tairawhiti above – what is good about the national picture when 4th out of 20 earns a D grade?

The ranking of the DHB's commitment to distributive clinical leadership in decision-making processes is below average while the chief executive's ranking is at the bottom. The latter is surprising because he appears to be genuinely liked and there are no signs of antagonism towards him. His style, however, is very 'below the radar' with less visibility than his counterparts in other DHBs. In part this may due to a long absence resulting from being the victim of a nasty traffic accident and also skewed by the highest number of 'don't knows'.

On the other hand, senior management ranks well (5th).

MidCentral

Middling but potential to do a lot better.

This Manawatu-Horowhenua based DHB is middle ranking in the provision of time but ranked much higher (5th) on its commitment to distributive leadership in decision-making processes. It is at the back of the middle pack in respect of the chief executive's commitment (despite a 'salt of the earth' engaging personality) and up a bit for senior management. The ASMS's experience is that this is a DHB that benefits considerably from the calibre of its chief medical officer and HR general manager.

Nelson Marlborough

Mixed, with potential.

This 'top of the south' DHB ranks well, relative to others, on the provision of time (3rd) but still with 46% responding in the negative its overall commitment to distributive clinical leadership plummets to a poor 15th, tempered by about one-third 'don't knows'. The chief executive's commitment is ranked average. His senior management team is ranked higher at 4th, although there is little difference when percentages are compared.

South Canterbury

Promising, but fixable problem to sort out.

The first of the two surveys is bad news for this DHB with a ranking of 18th and up to 70% of surveyed members saying they don't have enough time for distributive clinical leadership. On the other hand, there was a mixed result for South Canterbury's commitment to distributive clinical leadership – ranked in the top five in terms of positive respondents but with 50% of them believing their DHB was not genuinely committed.

Thereafter it gets interesting, rather like a tale of two managements. The (new) chief executive gets a very high rating on commitment (3rd and the only chief executive who no SMO answered in the 'no extent' option; even the impressive Canterbury and West Coast had 3% and 11% respectively for this response). In marked contrast, senior management came a poor 12th in the combined 'great' and 'some extent' category; 50% of respondents said senior management's commitment was 'to no extent', the highest level of all 20 DHBs. There is a challenge here for the chief executive to work through.

Need to really lift their game ★

Bay of Plenty; Whanganui; Capital & Coast

Bay of Plenty

Bordering on being in serious difficulties but some recent changes in senior management offers opportunities for improvement.

Bay of Plenty performs better than most DHBs on provision of time for clinical leadership activities (although it still receives a D grade). But it has serious problems in its overall genuine commitment to distributive clinical leadership in decision-making processes, with just 16% believing it was committed (17th). The chief executive's ranking was underwhelming - but for senior management it was disastrous (20th out of 20).

This is a DHB in difficulty, although recent changes in both senior management and clinical leadership in areas where there were serious problems may provide a stronger foundation for moving forward. But the DHB will have to listen to the messages. HR practices over fair process in some individual cases have been sub-optimal.

Whanganui

Signs of both improvement and regression.

Like Hawke's Bay, Whanganui was a poor performer in the 2010 Gauld survey and this continues. It received the lowest ranking for commitment to providing time to participate in distributive leadership positions (79% responded in the negative).

Relative to other DHBs, Whanganui is in the middle bunch on commitment to distributive clinical leadership in its decision-making processes (still with 54% saying no, however). The chief executive's and senior management's ranking is a little higher. Whanganui has improved somewhat since the Gauld survey but this is from a low base. There are, however, some worrying signs of hard-line attitudes emerging.

Capital & Coast

Debbie Chin

Should be doing a lot better; could go either upward or downward.

As one of New Zealand's largest DHBs including tertiary services, Capital & Coast's ranking is disappointing, beginning with below average on what is already a poor national assessment of provision of sufficient time and also for the DHB's overall commitment to distributive clinical leadership in its decision-making processes.

Its chief executive ranking is second lowest although this has to be qualified by the fact that as a recent interim appointment she is not well known among many senior medical staff. The result may also be tempered by the high number of 'don't know' respondents. Senior management ranks better in the surveys, but the results are not startling.

The possums in these DHBs need to get out of the headlights.

Like Hutt Valley and Wairarapa, Capital & Coast has been blindsided by a politically overhyped sub-regional service integration programme that is suffering through lack of purpose and direction, and an overabundance of confusion.

The possums in all three DHBs need to get out of the headlights.

There is some potential within Capital & Coast senior management, along with a responsive chief medical officer, but they need to line up their dots better. An important test will be how the DHB handles a review process for its laboratory service when, to date, it has managed to give confusing signals and is showing every sign of going down a destabilising path.

In serious difficulties

Auckland; Wairarapa; Hutt Valley; Southern

Auckland

Serious difficulties with a major leadership culture change required.

This DHB is in serious difficulty, with the emergence of a top-down micro-management culture. Auckland received a poor E grade for provision of time for clinical leadership (as do most DHBs, of course). The DHB's commitment overall and the chief executive's commitment, in particular, are judged poorly (16th and 17th respectively). This permeates down to both senior and middle management.

If ADHB is going to turn around, a major cultural change from its leadership is required.

The only 'shining light' is the respected and competent chief medical officer but she risks being dragged down in the mire.

Wairarapa and Hutt Valley

In serious difficulty; remedial action required.

These are separate DHBs, each with their own board but sharing both the same chief executive and senior management structure (this has proved to be an unwise politically driven decision). Both DHBs are in serious trouble.

They are ranked poorly on the provision of time (16th and 17th respectively), DHB commitment (20th and 19th), chief executive commitment (slightly below average in Wairarapa and 18th in Hutt Valley), and senior management commitment (respectable above average in Wairarapa but 19th in Hutt Valley). Some of this is due to ill-considered top-down restructuring but some is clearly due to a combination of poor leadership culture and performance. Remedial action is required. On the positive side, there have been recent informal indications that senior management at least is trying to take ownership of the problem and converting it into a challenge. But the recently announced resignation of the Chief Operating Officer is a setback.

Southern


Carole Heatly

In serious difficulties; needs to focus more on culture than structure.

Southern (the top-down merged Otago and Southland new DHB) inherited serious difficulties, part of which was revealed in a National Health Board report on systemic issues at Dunedin Hospital. These predated but were inherited by the current chief executive. This is a DHB in serious trouble, not helped by the chief executive mistakenly focusing on structural rather than cultural change, and failing to use the opportunity available to her as a new chief executive to completely rejig her senior management team.

For provision of sufficient time, the DHB ranked 15th (69% negative response). For its commitment to distributive leadership, Southern's overall ranking was very low (18th, with 68% believing there was no commitment at all). There is a sign of hope with the chief executive rated 12th but her senior management was a lowly 16th. The chief executive has an engaging personality but she needs to focus on culture and management performance if this situation is to be turned around. It is not too late but does require a new blood transfusion.

This is a DHB in serious trouble, not helped by a chief executive mistakenly focusing on structural rather than cultural change.

Ian Powell

The role of clinical leadership in eHealth

Graeme Osborne, Director of the National Health IT Board, National Health Board, Ministry of Health.

Health is a knowledge and information-based sector. The priority for the leaders of our health system must be to create an environment for the dissemination of knowledge through quality improvements and the measurement of performance.

In the 21st century, this means promoting the use of technology to drive innovation.

Yet not all our leaders have the understanding, experience and vision required to achieve this goal.

Many hospital specialists will have experienced times when poor leadership has prevented information systems from being used to improve workflow, bring efficiencies or support a better and safer integrated health care model.

> *How can we lift the sector's performance and work together to create digitally savvy health care organisations?*

Young clinicians coming into the sector are often frustrated by their leaders' inability to recognise the potential of information systems to improve patient outcomes.

The question for us all is how we can lift the sector's performance and work together to create digitally savvy health care organisations.

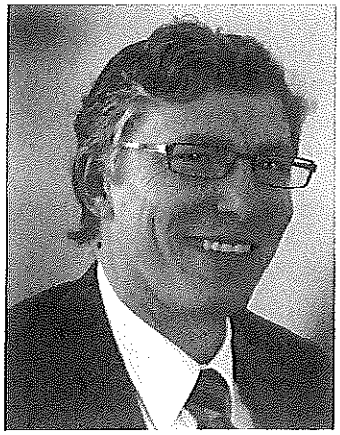
The importance of quality

Quality is the critical driver of a resilient, adaptable and safe health system. Key stakeholders, clinicians and consumers must be part of the co-design process.

The National Health IT Board's primary role is to provide leadership across the health and disability sector to support an improved health information model and future health care delivery models. However, everything we do is driven by quality improvement methods and the New Zealand Triple Aim.

It's tempting for health care organisations to believe they require specialist information technology systems to suit their individual needs. But having all 20 DHBs developing their own systems to meet a common need is both inefficient and a poor use of resources.

A better approach is to have one or two DHBs or other health care organisations that are furthest up the maturity curve to work on a common problem and share their innovations with others. Remaining organisations can be 'fast followers'.



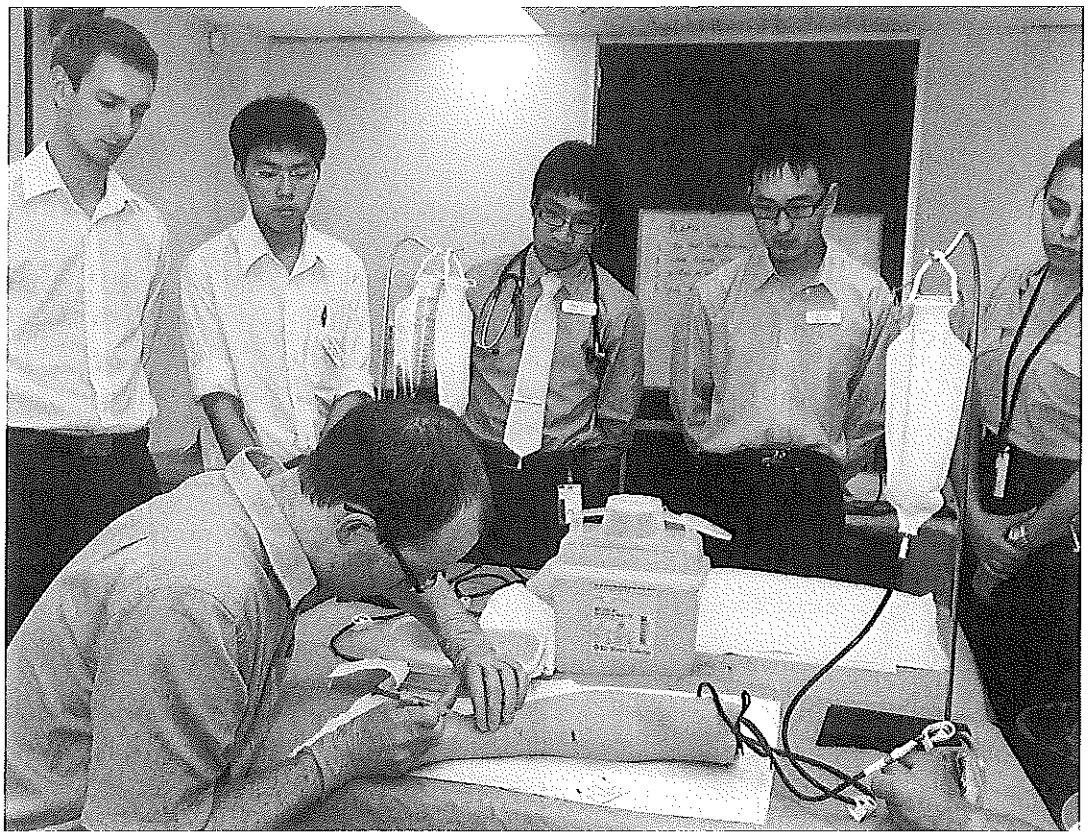
Graeme Osborne

eHealth in practice

One example of how this works in practice is the University of Auckland's VIEW research group's collaboration with Counties Manukau DHB, Midland DHBs and Middlemore Hospital's Department of Cardiology to develop a web-based electronic support programme called Acute PREDICT.

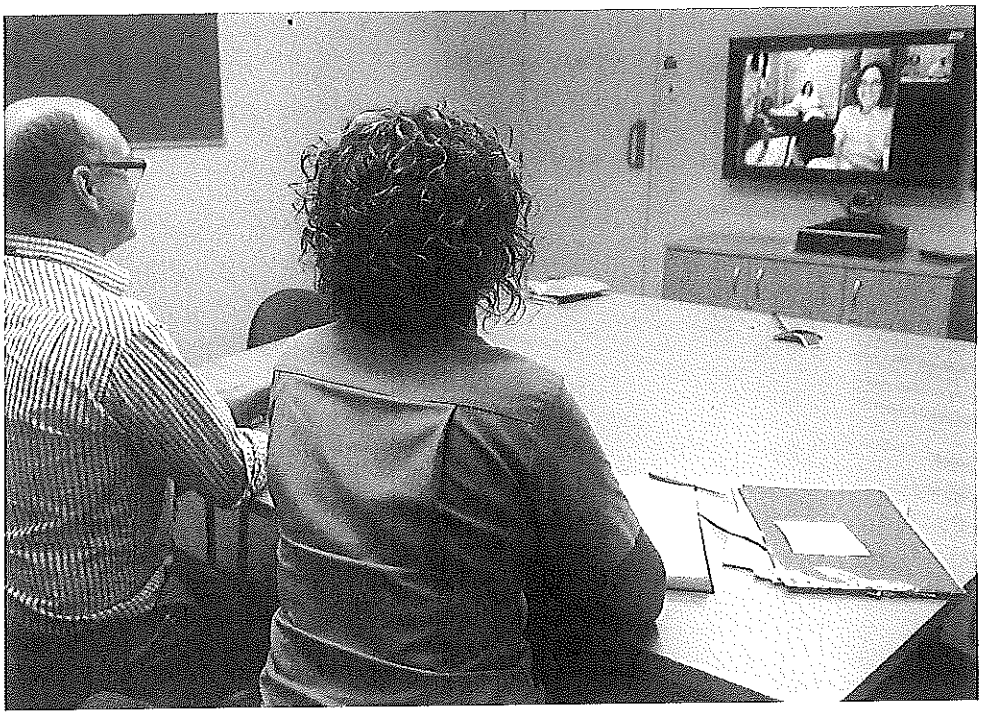
This programme was introduced into Auckland metropolitan hospitals and all Midland DHBs' hospitals before being expanded to include all patients admitted to New Zealand hospitals with Acute Coronary Syndrome (ACS).

The information is stored in the All New Zealand Acute Coronary Syndrome – Quality Improvement (ANZACS-QI) database, which is based on an international standard. The database is used to better predict patients' risk of heart disease and stroke, and to identify possible treatment improvements.



In addition to deciding who should lead the development of solutions to common problems, another important success factor is to ensure we consistently capture quality outcomes data.

Many senior doctors and dentists will be familiar with the *Atlas of Healthcare Variation*, which shows variation in the health care received by people in different geographic areas. The New Zealand Atlas aims not to make judgements but to stimulate debate on health care inequalities.



A new perspective on IT

Quality outcomes data is essential if we are to uncover the unwarranted variations in health care. And yet in New Zealand it's all too common for chief information officers to report to chief financial officers, and to be treated as if their work was nothing more than part of back-office operations.

> *We are facing several trends that will have a great impact on health care.*

Strong leaders are challenging this view. At Canterbury DHB, for example, Chief Medical Officer Dr Nigel Millar has the Chief Information Officer (CIO) report to him because he and his executive colleagues recognise that robust information is vital to the quality of the care delivered to the community.

And at Counties Manukau DHB, Professor Jonathan Gray was appointed by the Chief Executive to address the urgent need for transformational change in the way health care was designed and delivered for South Auckland communities.

A significant step was the launch of Ko Awatea as an educational centre where people were encouraged to meet, share ideas, carry out research and access the latest information on health care quality improvement.

How do we lead our organisations to deliver high-quality outcomes for patients? The answer is by measuring what we do. If it can't be measured, it can't be managed.

Clinicians as architects

Clinicians – working in partnership with consumers – need to be architects of the health system, and should accept the need to measure the impact they have at both a population level and at an individual level.

For example, are our intervention rates correct? Do we have the information systems we need to deliver services? Will our health system be sustainable with the changing dynamics of population demand?

Everything we do should be within the context of a quality model – high quality care for the people, by the people.

We are facing several trends that will have a great impact on health care. These trends include rising consumer expectations, an aging population, and rapid advances in science and biology that will increasingly allow personalisation of the health system.

In the future, empowered consumers will do their own research, use monitoring equipment and have access to personalised medications to maintain their own health and wellbeing. Health professionals will need to respond as part of the consumer's team.

How will the leaders of today adapt to this trend?

> *Health care professionals must take a lead in designing and building systems of care.*

I'm reminded of a keynote address given by Professor Sir Muir Gray to the Asia Pacific Forum on Quality Improvement in Health Care in Auckland in 2012.

Sir Muir, director of the National Knowledge Service and Chief Knowledge Officer to Britain's National Health Service, identified three forces driving a revolution in health care: citizens, knowledge and technology.

Health care professionals must take a lead in designing and building systems of care to support this revolution, said Sir Muir. "If you do not imagine and plan and build the future, someone else will."

Graeme Osborne