**Quality improvement scientific symposium virtual session three: keynote presentation – Dr Martin Chadwick**

**Accessible transcript**

**Visual**

**Two video feeds appear side by side. On the left, a woman wearing glasses and a white blazer over a blue dress sits in front of a virtual background of cherry blossom trees and rushes beside a picturesque river. On the right, a man with short greying hair and wearing a blue and white patterned shirt sits in front of a virtual background of a bay side town under a bright blue sky.**

**Audio**

(Woman): A warm welcome to you, Martin. Over to you. Thank you.

**Visual**

**Martin’s video feed fills the screen.**

**Audio**

(Martin): Kia ora katoa.

Ko Mātaatua te waka.

Ko Putauaki te maunga.
Ko Whakatāne te awa.

Ko Ngāti Awa.
Te Whānau-ā-Apanui te iwi.

Ko Martin Chadwick tōku ingoa.

So, kia ora, everyone. As mentioned, my name's Martin Chadwick. I'm the chief allied health professions officer at the Ministry of Health. And I'm going to try to talk to you today around clinical leadership and the role that it has to play with regards to improving clinical care. So, just going to share my screen here.

**Visual

Martin’s video feed shrinks down and moves to the right-hand side as the slide of a presentation appears. A white border surrounds a blue background with shadowed patterns of koru and tapa cloth designs. In the top right corner of the slide is a dark blue logo with a white koru – the logo for the Ministry of Health, Manatū Hauora. The title is in black text: ‘Improving Clinical Care Requires Clinical Leadership’. Under this in smaller text: ‘Dr Martin Chadwick, Chief Allied Health Professions Officer, Ministry of Health, New Zealand.’**

**Audio**

(Martin): And so, what I want to do to begin with is to try to put this into a little bit of a context, and if I'm looking to what is my left; I'm looking at my second screen, but bear with me.

**Visual

A new slide has a title in black text: ‘Building on Evidence Based Practice’. Under this is a Venn diagram of overlapping labelled circles. The largest circle contains all the others and is labelled ‘Environment and Organisational Context’. Within this biggest circle are three smaller overlapping circles in a triangle formation. The three circles are labelled ‘Best available research evidence’, ‘Client’s popuatio’s characteristics state, needs, value and preferences’ and ‘Resources, including practitioners’ expertise’. A dotted line rings the point where the three circles intersect and is labelled ‘Decision Making’.**

**Audio**

(Martin): So what I want to do is to think a little bit about the context of – we are all relatively familiar with the concept of evidence-based practice, and evidence-based practice being that intersection of the person, their preferences, what they're looking for, their clinician and the experience and the best available evidence. Now, I want to try to take that a bit further and start to put that within the context of the environment – the organisational context and the person's environment, and within that, to start to think about evidence-based practice really being about the decision-making that occurs in the intersection of all of those points of the broader context, the person, the clinician and the best available evidence.

**Visual**
**On a new slide, a diagram made up of rows of different coloured circles. The first row is labelled ‘Intra Disciplinary Practice’. This is followed by a row of five circles each a different colour – blue, grey, light blue, green and yellow. The second row is labelled ‘Inter Disciplinary Practice’. The row of five circles has a double ended arrow between each circle. The third row is labelled ‘Multi-Disciplinary Practice’, and the row of circles are overlapping. The final row is labelled Trans Disciplinary Practice and has one elongated multi-coloured oval as opposed to a row of circles.**

 **Audio**

(Martin): And so that's probably context number one. The second is with regards to a nomenclature around how we talk about team-working, and the first is around intra-disciplinary team working, which is about working within a discipline. So my background and my remit is with regards to allied health. So, unashamedly, I'm going to talk in allied health terms. So when I talk about intra-disciplinary practice, it's about a physio working within their sphere; it's about a speech language therapist working just within their sphere, so on and so forth, as opposed to interdisciplinary practice, which is when you have work which is occurring or care which is occurring between professions. So, for example, you may have, uh, a general practitioner who then makes a referral to a physiotherapist or makes a referral to a speech language therapist. And so, the two professions are working with a very formal interaction between. The third one is multidisciplinary practice – when we start to talk about working with each other, and in the New Zealand context, I think it's very clear when you look at a rehab-type environment where you may have a ward environment, but you have the, um, medical practitioner who may be working with the nurse practitioner that is then working with the allied health team. And so, each has got their very distinctive roles, but they then come together to work together. And the last component is transdisciplinary practice,

which is when we start to work across. And that's a talk for another day, but it's that sense of how we can work with the sense of there are things that can be shared. There are skills and tasks that don't necessarily sit with one profession. They may sit across many professions, but it doesn't take away from that which is a special and unique contribution of one profession versus another profession. And so, it's that hierarchy of team-working between intra-, inter-, multi- and trans-disciplinary.

**Visual**

**A slide is titled: ‘Lifting the lid on the black box of care’. Under this is an image containing a yellow sad emoji face with a thermometer in its mouth and an ice pack on is head. Next to this is a plus symbol and beside this is a black cube. After this is an equals symbol followed by a grinning emoji face.**

**Audio**

(Martin): But specifically today, I'm looking at improving clinical care and clinical leadership, and I want to take a very, very simplistic approach, but this will hopefully all make some kind of sense – that... Look at it that there's this black box of care that occurs, that someone presents in whatever scenario it is, and they present and they receive this black box of care, and at the end of it, they're happy, they're better. And there's that sense of what occurs within that black box of care? And that's what I want to look at today and try to lift the lid on of what occurs when you have that black box of care, and unashamedly looking at this from an allied health perspective.

**Visual**

**The slide changes to show the black cube open like a cardboard box. Four smaller black cubes appear above it with arrows pointing towards the large open black cube. These smaller boxes are labelled: OT, PT, SLT and SW.**

**Audio**

(Martin): And so, it's about saying that allied health is many professions, and so, when we start to lift the lid on that black box of care, what you may have is that you may have the component which is occupational therapy and the component which is physiotherapy and the component which is speech language therapy and social work, and it could be podiatry, and it could be anaesthetic technicians. You know, the list goes on and on. The point being that there is a multiplicity of professional groups that may be involved, rounded into that black box of care. And so, the issue that I think we need to explore is – what happens when we begin to open each individual box of care?

**Visual**

**The slide changes again as the four smaller black boxes now open.**

**Audio**

(Martin): Because when we open each individual box of care, each of these professions have got a history of their own right. They're very proud, and they should be, of what they have done, what they have achieved, and how they have built a body of knowledge over time. And so there is a sense, if you're an occupational therapist, what is it to be an occupational therapist, and what is the history of occupational therapy and what have been the key contributors to occupational therapy as a profession?

**Visual**

**A row of nine small black boxes appear above the four black boxes with arrows pointing towards the open boxes. Each of these new boxes bears the pharmacy Rx symbol.**

**Audio**

(Martin): And as you start to open each individual box, what you start to find is that there is a multiplicity of approaches and there are various gurus that sit within these various approaches that start to look at that it's this approach or it's another approach. And quite often, they don't agree necessarily as to what the right approach would be.

**Visual**

**A slide shows planet Earth sitting atop a stack of eight turtles floating in space.**

**Audio**

(Martin): And so it's a matter of that what I see as the issue here is that when you then in turn go and start to open up each individual box in turn, that you can run the risk of it becomes turtles all the way down. You know, how far down do you go to try to get an understanding of actually who's right within all of this? Because that's part of the richness of history, of shared learning – that whole gathering of evidence over time. And so it becomes problematic. Who's right within all of this? And so, when we look at improving clinical care, it's one of those that what do we choose to do? Do we choose to really go down into the micro, or is that one that we choose to rather come up and start to look more at the macro? And I think it's that latter approach that I just want to spend a little bit of time exploring today, and say, more tangibly, what can that start to look like?

**Visual**

**A new slide is titled: ‘Clinical Leadership in Improving Clinical Care.’ Under this is a flowchart of text boxes. The first box reads: What does good look like? An arrow from this box leads to the next which reads: Are we doing it? An arrow points to the next box: If not, what do we need to change to do it? An arrow points down to the next box: If we are doing it, what do we need to do to ensure we can continue? An arrow points left to the next box: Think of outcomes at a system level eg, length of stay, re-admissions, avoidable admissions. An arrow points to the last box: What then is the right level of resource to deliver ‘good’ for the best outcomes? Under this flowchart is the emojis equation image from the previous slide.**

**Audio**

(Martin): And very, very simply it’s how do we enact clinical leadership when it comes to improving clinical care? And it's beginning to ask some of the hard questions, because, again, there is a history that sits behind all of us in what we do in providing care day to day. But there is that sense, if you think about the environment in which you sit, is to ask the first hard question, which is – what does good look like? So, if you're working in a rehabilitation environment, and in my past history, this was a process that we went through at Bay of Plenty. You know, what does good look like when we looked at rehabilitation? Can we define – can we adequately define what good is? And then the next question is – actually, are we doing it? And so, in this particular instance within the Bay of Plenty, working with a very skilled, very talented team there, providing rehabilitation – it was that sense of, OK. So, you have each individual profession each providing, you know, very, very good care. But actually, can you define what good is? In this particular instance, where we came to was that sense of saying, 'OK. So, in a rehab environment, 'if someone comes into our facilities as status post-CVA, that there is a sense of that we know that good 'looks like having an evaluation within the first 24 to 48 hours.' Now, the evidence says that that's when you're going to have the most view as to what the potential neuroplasticity is and you get a sense of, actually, what is the rehabilitation potential of the individual? And then that lays the groundwork as to what the model of care needs to look like, what the plan of care needs to look like, what you need to be aiming towards for the individual. So, there was an ability to take a snippet and start to say that this is what good looks like. But then, the next component of that is the really simple question of saying, 'Well, are we doing it?' So, if you can define good, then the next question is – are you actually doing it? And in this particular instance, what came back was the answer was actually no, that we weren't doing it to the level that we wanted to, that there was the ability to find that good look, like that evaluation occurring within the first 24, 48 hours, but when we actually looked at it and measured it, to begin with, it was only occurring about 20 percent to 30 percent of the time. Now, understand very consciously I'm not trying to say that it needs to be approach A, B, C, or D, or following whichever is the guru that sits within the various professional groups, but rather taking much more of a macro view to say that, 'OK, so what are the key components that you can, hand on heart, say that this is what good looks like?' And actually start to measure that – that, actually, are you doing good? And I come back to the example that the answer was not as frequently as we desire to. So, therefore, we're not providing the care that we desire to provide for the people that are relying on us. So that led to some changes. It led to a look at the systems and the processes that we use, and it led to changes. And so, those changes could be measured, and, in turn, we're able to see an increase that what was 20 percent to 30 percent became 50 percent, 60 percent and hopefully continue to improve. But it was about asking that very tangible question of, 'What do we need to do differently?' And within that, it's about how we start to think much more at a systems level, because when I think about my role within the ministry, within allied health, it is to have that remit to work with the really broad grouping which is allied health. And it's not for me to say what is right or wrong with regards to various clinical approaches, but it is to be able to ask those questions of, 'Actually, can you define what good looks like for you within your clinical setting, and are you doing that?' And then to even ask the bigger questions again and saying that, if you make changes, then are we able to understand what difference that has made, but very much at a systems level? So, if you think about provision of health systems or health services, can we actually capture that and say that, because we make these changes, what has that meant for length of stay? Have we seen a change within the length of stay? What does it mean for readmit rates? Have we seen an improvement, hopefully, of your seven-day or your 28-day readmit rates? What are some of those higher system-levels measures that we can begin to look at? Because you cannot necessarily say that there's going to be causality, but you can say that there is going to be a correlation – that if you have started to do good that you can define and measure, that hopefully what you start to see is an improvement in some of those system-level outcomes. Again, you can't hand on heart say it's because of what you've changed, but you can say that there's a correlation to the changes that you've made and the outcomes that are starting to come about.

**Visual**

**A slide is titled: ‘Leadership Enacted.’ This slide has two versions of the emoji faces diagram. The first is labelled Presentation 1 and shows the sick emoji plus the open black box equals the grinning emoji. Above the open black box is four cubes with arrows pointing towards it. The first box is medium sized and is labelled OT. The second box is the smallest and is labelled PT. The next box is slightly bigger and is labelled SLT, and the last box labelled SW is the largest. The second diagram is called Presentation 2. In this version, the OT box is the smallest, the PT box is the largest, the SLT box has gone, and the SW box is of medium size.**

**Audio**

(Martin): And so, within that, the vision, I guess, of saying, 'So, what does leadership enacted look like?' And it's understanding that people present to our facilities for a whole raft of reasons, and leadership looks like that understanding that it's not cookie-cutter, that it's not a sense of, 'We need to do the same every single time,' and to think about it in a transdisciplinary way, that it's not a matter of saying that we need to ensure that every single profession is represented all of the time. But actually, there's the ability to say that, for certain presentations, that, actually, social work is going to be the most important group that is going to have to interact with the individual within their context, within their circumstance. It may be that physiotherapy is going to have very little to do with that presentation, but then you may have a different type of presentation, and, actually, it is physiotherapy which is going to be the lead in that one. They're going to need to work with their occupational therapy colleagues and with their social work colleagues, but they may be the profession that takes the lead within that. And it's being comfortable that it is the ability to work with your colleagues and the desire to see that you're going to deliver the best outcome because you've gone through that process saying, 'Actually, what does good look like within this context? Have you measured what is good? Are you doing it or not in the first instance? If you are, tickety-boo. Awesome. If not, what do you need to change? What is the leadership that you need to provide in this type of a scenario to say that, actually, we are not providing good care to the people who are coming to see us in the first instance. Therefore, if we want to provide good care, we need to change something. We need to change something, but we need to keep on measuring to ensure that any change that we've done has actually led

to a difference, that we are now enacting better care as to how we've defined it because of the changes that we've made.

**Visual**

**A new slide has an image of a thin stick balanced on top of a round stone. The stick has three similar looking stones balanced on it -- one stone balanced on one end and two stones balanced one atop the other on the other end. A quote in blue text appears under the image: ‘Professional expertise and values are powerful inhibitors of innovation because of the vested mindset they create is the status quo. However, expertise is essential to improvisation…’ Anderson and McDaniel (2000).**

**Audio**

(Martin): And so, I end with this one quote, which I have kept for years, because I think it just really, for me, personifies the tension that we have to deal with, and it reads that... And so therein kind of lies the rub – the paradox, if you will. It's about acknowledging that we each bring a very defined expertise and a history and the desire to do the very best. But it's about bringing that to the table, if you will, but not holding on to it too, too tightly because you don't want to then try to protect that at the expense of saying, 'Actually, how do we need to innovate? How do we need to change? How do we challenge what we currently do if we're not doing good by the patient, by the person that we see in the first instance?’ So, how do we use our skill set with that whole sense that, if we want to improve, improvement is change, but what are we going to change and how are we going to know if that change has made an improvement? Which comes back to that point, again, of what is good. Can you define good? Can you measure good? And then where are you? And so, that's the vision that I want to put out there. I think when we start to think about how can we enact clinical leadership, it's keeping ourselves really grounded at the end of it all that we're all here for the people that we serve and to be able to challenge ourselves and to say that, actually, can we define with confidence what good is, and can we go ahead and actually start to measure that? And if we're not delivering good, that means we have to change, but change it in a way to ensure that you're actually delivering what you wanted to deliver in the first place.

**Visual**

**A slide with a teal background is titled: ‘Thank you… Q&A.’ Inside a white circle is a quote in black text: ‘Leaders think and talk about the solutions. Followers think and talk about their problems.’ Brian Tracy. Next to this is a list of contact details. Martin Chadwick. Martin.Chadwick@health.govt.nz +64 21 220 3044. The Twitter logo, then @CAHPONZ**

**Audio**

(Martin): And so, that's me. Leaders think and talk about the solutions. Followers think and talk about the problems. This is about leadership, and it's about trying to think about the solutions. So, my contact details are there – my email, my phone and my Twitter account. So, very, very keen to hear your thoughts and/or questions after the presentation.