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Clinical Leadership and the Challenge of Change

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Key Points

• Having clinicians involved in management improves outcomes for patients and saves money.
• Partnerships between clinicians, professional organisations and managers has allowed spread of innovation at scale in Ireland.
• Clinicians and managers are together the stewards of healthcare.
• “what’s well-made endures, and shines on”.

Healthcare is one of the most hazardous industries in the world. A series of large studies and numerous high profile stories of harm and unnecessary death in the services we provide have shown that whilst modern medical advances have been remarkable, hospitals are often unsafe places for patients and staff alike.

It has been recognised for many years that having clinicians involved in managing our healthcare services results in improved efficiencies, effectiveness and improved outcomes for patients. The Kings Fund (2014) in the United Kingdom reported recently that organisations with engaged staff deliver better patient experiences, have fewer errors, lower infection and mortality rates, stronger financial management, higher staff morale and motivation, reduced stress levels and less absenteeism.

Internationally our healthcare systems are currently experiencing unprecedented challenges with constrained budgets, organisational restructuring, hospital centric models of care, workforce challenges and ever increasing demands on our healthcare services as a result of changing demographics (increase in the number of older persons) and chronic diseases (with co-morbidities).

Despite these challenges there are real opportunities to improve services for patients and staff through a partnership approach with clinicians, managers and of course, patients. In many areas we know the right thing to do, but we repeatedly see how difficult it is to do the right thing. Take for example hand washing. In the mid- 1800s, Dr Ignaz Semmelweis was the first healthcare professional to demonstrate experimentally that hand washing could prevent infections. Did the healthcare establishment embrace his discovery and implement hand washing as a mandatory component of healthcare? It most certainly did not. About 5 years later he died in a public asylum at the age of 47 having been shunned and discredited by his colleagues.

So why is it so difficult to do the right thing? This question has been the subject of significant study for many years. Many techniques, models and theories have been developed over the years and mini industries have been established in the area of quality improvement. There are clearly risks with not implementing a proven methodology. However, there are also risks with seeking to implement different methodologies that can cause confusion among the very people you wish to implement the change. The million dollar question (often literally) now is ‘which model or theory works best?’ After the initial enthusiasm of trying something new, can the initial improvement be sustained independent of the initial champion? Unfortunately very often the answer is no.

As a pragmatist, I believe that there are a few simple steps that should be taken. Firstly, identify the aim of the project (often more difficult than it sounds); secondly ensure there is a mechanism of measurement (“In God we trust, everyone else must bring data”: quote attributed to Deming) thirdly, use a standardised project management process and lastly, have an implementation plan that has been agreed with all key stakeholders.

In Ireland, we have been seeking to tackle this issue in a novel way. The National Clinical Programmes were initiated in 2010 under the leadership of Dr. Barry White, who was succeeded by me in 2012.

The aim of the programmes is to improve and standardise patient care regardless of geography, by bringing together clinical disciplines and enabling them to share innovative evidence-based solutions in the interest of better patient care.

Clinical leadership is at the core of the National Clinical Programmes. The experience of other health systems around the world has been that the involvement of clinicians in designing and leading improvements in patient care is essential. The core objectives of all the clinical programmes are to improve:

• The quality of care;

• Access to all services;

• Value for money and for the patient.

There are over 30 National Clinical Programmes tasked with improving specific areas within the health service. This is achieved by designing and specifying standardised models of care, guidelines, pathways and associated strategies for the delivery of clinical care. Examples include clinical programmes in Acute Medicine, Acute Surgery, Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Emergency Medicine, Critical Care, Chronic Heart Disease, Stroke and many more.

Each of the Programmes has a Clinical Lead, a multidisciplinary Working Group (including patient representatives) and a Clinical Advisory Group. The value of having a wide range of clinicians involved is twofold. Firstly, it is likely that the proposed solutions will be more robust, and secondly will be accepted by colleagues at implementation.

These groups are further enhanced by additional collaboration and consultation with a range of significant stakeholders across the healthcare system.

Some of the achievements attributable to the National Clinical Programmes to date include:

• Reduction in average Length of Stay of medical patients from 8.5 days in 2010 to 6.9 days in 2013

• Increased surgical volume by 9.6% (2010 to 2012)

• Reduced surgical bed day usage by 9.1%. (2010 to 2012)

• The national stroke thrombolysis rate has increased from 3.3% in 2008 to 9.5% in 2012, one of the highest reported in developed countries.

• Access to national neonatal bidirectional inter-facility transfer and retrieval extended to a 24 hour seven day week service as set out in the National Clinical Programme for Transport Medicine Model of Care.

• Asthma clinical practice guidelines developed including Emergency Adult Asthma Guidelines and Emergency Paediatric Asthma Guidelines with a National Education programme now operational in primary and secondary care for asthma.

• Primary Percutaneous Coronary Intervention centers in operation nationally for patients experiencing acute coronary syndrome as set out in the Model of Care.

• 12 COPD Outreach Clinics fully operational, providing an “Early Supported Discharge” programme by a COPD Outreach multidisciplinary team for certain patients with Acute Exacerbations of COPD, that would otherwise require acute inpatient care.

• Identification of ‘Preferred Drugs’ with the potential to save €19m per annum by getting prescribers to change their prescribing patterns.

• A national model of care to deliver Continuous Subcutaneous Insulin Infusion therapy to children with type 1 diabetes under 5 years of age has been developed and implemented.

• 24 Musculoskeletal Advanced Practice Physiotherapists (6 per Health Service Executive region) in post which has resulted in over 18,000 referrals removed from Orthopaedic and Rheumatology outpatient waiting lists nationally in 2013 The learning over the past three years of the clinical programmes has emphasised the essential need to:

• Maintain and enhance clinical leadership;

• Develop clinical pathways that are truly patient-centred, and seamlessly cross organisational and professional boundaries;

• Align programme design with service priorities;

• Enhance evidence-base and per formance and outcome measurement;

• Ensure structured and consistent implementation;

• Align with key enabling functions such as finance, human resources and information & communication technology.

Since their foundation, the National Clinical Programmes have been one of the most significant positive developments in the Irish Health Service. Their success is due to the close collaboration between the Health Service Executive (HSE) and the Medical Colleges, working in partnership with patients, nursing and health and social care professionals. The Programmes have changed and continue to change how care is delivered using evidence-based approaches to system reform.

According to Ronda Hughes (in Patient Safety and Quality: An Evidence-Based Handbook for Nurses: Vol. 3) quality improvement requires five essential elements for success: fostering and sustaining a culture of change and safety, developing and clarifying an understanding of the problem, involving key stakeholders, testing change strategies, continuous monitoring of performance and reporting of findings to sustain the change. The Clinical Programmes contain all of these essential elements.

Conclusion

As clinicians and managers, finding ways to work together is fundamental to the provision of high quality patient care. We must learn to trust one another and appreciate the richness of skills and perceptions both parties bring to the partnership. Together, we are the stewards of healthcare and together, we have a shared responsibility to make it easy to do the right thing. I am very grateful to the many clinicians and managers who have had the courage to be involved in such a large change initiative. We have also been fortunate to have had ministerial and departmental support for our work. The benefit of having eager hearts and minds is clear and it is with a belief in the endless possibilities of change and a better future that we proceed in our endeavour.

As the poet John O’Donnell says so eloquently in his poem, *The Lucas Planet No. 33* (in memory of the poet Seamus Heaney) “The consolation that what’s well-made endures, and shines on”.

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