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Editorial

Releasing the potential of health services: translating clinical leadership into healthcare quality improvement

A Niroshan Siriwardena MMedSci PhD FRCGP
Visiting Professor of Primary Care, School of Health and Social Care, University of Lincoln, UK

A great deal of talk and effort is devoted to developing leadership and clinical leadership in the health service, for example through the work of the NHS Leadership Centre.[1] The policy change, which has increased the likelihood of private companies, with shareholders as well as patients to consider, contracting for NHS services means an ever-increasing variety of health service providers producing models of leadership rather than just the traditional models within the NHS. When considering leadership, there are a number of key questions that come to mind. What is leadership in the health service? Is clinical leadership different? Why and how should we support clinical leaders? How can we measure the impact of clinical leadership?

Leadership comes from a strong sense of direction effectively communicated to others. The 'vision thing' is amply demonstrated by the story of the cleaner, working at the US space programme, who, when asked what he was doing, stated that he was sending a man to the moon. The sense of direction or vision is always predicated on strong beliefs that can be felt and shared by others, and it is these values that serve to inspire others. In health services here and in other countries, where there are always opportunities to improve the quality of care,[2] such vision and values ultimately serve as a vehicle or catalyst for change leading to improvement in patient care. So, put simply, leadership vision and values become a vehicle for improvements in care, and lack of improvement demonstrates a failure of leadership.[3]

Clinical leadership is similar and yet inherently different from leadership *per se*. Chris Ham describes the inverted pyramid of power within healthcare organisations, in which it is the front-line clinician that has the greatest power to effect or to subvert change.[4] Clinical leaders have additional characteristics including credibility amongst their peers, the expertise and skills to be opinion leaders, the ability to galvanise and support their clinical teams, and the education, skills, motivation and energy to communicate with colleagues.[5] Peer-to-peer interaction can be very powerful, involving an underlying set of beliefs and language that facilitate such communication, a concept sometimes described as homophily.[6]

The ever-increasing number of courses and textbooks on leadership are reminiscent of the adage that the more treatments there are for a condition, the less likely any of them are to be effective. I would argue that the leadership texts worth reading are those that provide a real sense of leadership in action, written by people who have experience of real leadership. Rudy Giuliani's book on leadership is full of practical advice from someone who has experienced real leadership and who has an engaging story to tell.[7] His messages include study, read and learn; prepare relentlessly; organise around a purpose; make everyone accountable all of the time, develop and communicate strong beliefs; reflect then decide; under-promise and over-deliver; are as relevant to clinical leaders as they are to politicians.[7]

Although the concept of clinical leadership is well known in acute medical and primary care teams, it is difficult to understand why some teams work well and others fail, or why teams work in some situations or during certain periods of time but not others. Structures, whether hierarchical or non-hierarchical, unidisciplinary or multidisciplinary, and functions are often heterogeneous. Socially, some groups function well, whereas others create and recreate dysfunction. Leaders, followers and their individual styles are sometimes creative and other times destructive. So where should clinical leaders begin? There are critical factors to the success of quality improvement programmes including leadership and communication at executive, managerial and clinical levels, a strong organisational structure geared to improvement, information feedback using measurement expertise,[8] and mindsets often need to be changed for this to occur.[9] We must learn from the experience of others, but ultimately real clinical leadership, at whatever level of an organisation,

is learnt through doing, and derived from reflection through real experience.

Finally, how can we use clinical leadership to transform health care and how do we measure the impact of this. Over the past two years, I had the privilege of working as medical director of a large ambulance service with some exceptional colleagues and this has provided me with practical experience of leadership, 'followership' and teamworking at executive level and at clinical team level.

An important decision was taken two years ago by the board and executive team of an ambulance trust to organise clinicians into clinical teams of up to a dozen paramedics and ambulance technicians, each with a clinical team leader. There was a clear vision and focus on making sustainable improvements in patient care, for example, in terms of delivering primary care to patients,[10] and in improving the management of coronary heart disease (CHD). Investigation with electrocardiography (ECG), management with nitrates, oxygen and analgesia, and intervention with pre-hospital thrombolysis and resuscitation were intermediate measurable outcomes or key performance indicators (KPIs), based on robust research evidence, believed to be important by clinicians and patients and also required for external benchmarking. These had been implemented as guidelines for some time, but with lack of measurement in some areas (such as pain management or thrombolysis), and lack of demonstrable improvement in others.

Clinical team leaders were engaged to review records of patients with suspected myocardial infarction, audit CHD indicators, feed these back in real time to the clinical audit office, and provide individual feedback to members of their teams if clinical performance fell short of the ideal. Education was provided by team leaders supported by clinical education specialists when gaps were identified (e.g. ECG acquisition and interpretation or thrombolysis skills), either at team level or across the service. Teams were benchmarked using confidence charts (see Figure 1) and improvements measured using statistical process control techniques (see Figures 2 and 3).[11–13] This development produced an organisational change focused on quality improvement,[14] and was an iterative rather than linear process, as Harvey-Jones described in his experiences with ICI.[15]

The result has been a measurable improvement in clinical outcomes, for example an increase in ECG acquisition rates due to a training programme for ambulance technicians (see Figure 2). There has also been a doubling in thrombolysis rates (see Figure 3) as a result of education and training, peer support, roadshows involving opinion leaders, and system changes including an instruction to thrombolyse whatever the proximity to an acute unit, an improvement which, if sustained, should have the effect of saving a great many lives. This increase took place in an organisation which maintained financial balance during the 15 years of its existence. In this limited example I was privileged to see leadership in action, with managers and clinical leaders working effectively together to bring about real improvements in care and outcomes through education, training and involvement

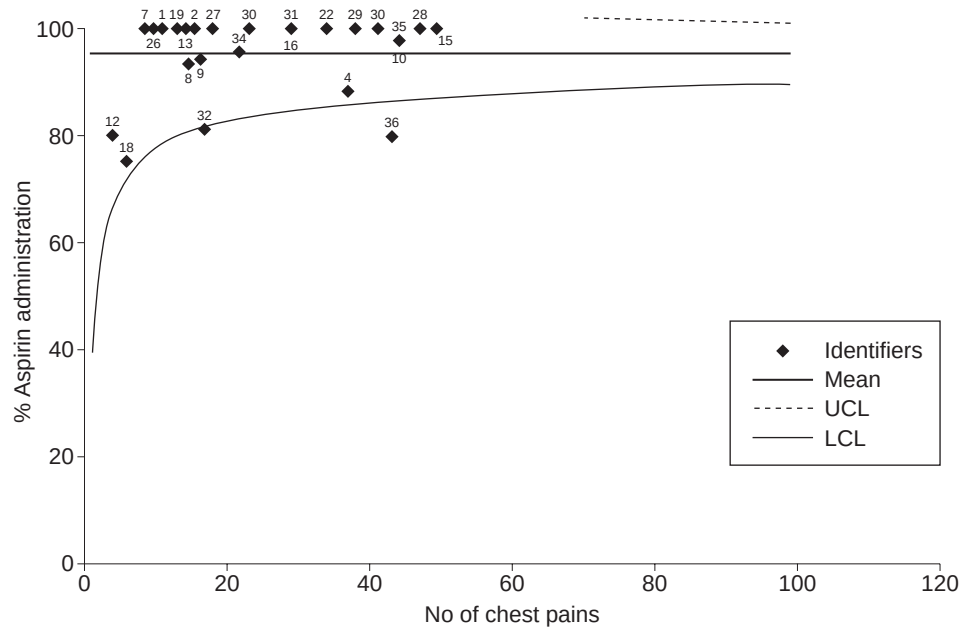

Figure 1 Confidence chart showing rate (%) of administration of aspirin to patients with suspected myocardial infarction. Results for different teams are shown; team 36 is an outlier, requiring further assessment and support. UCL, upper confidence limit; LCL, lower confidence limit

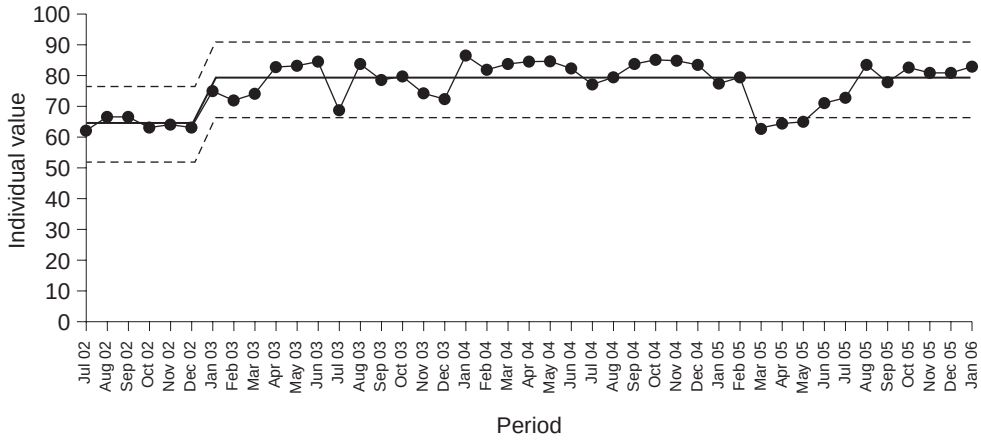

Figure 2 Statistical process control chart showing the percentage of patients with suspected myocardial infarction who had an ECG taken (from 2002 to 2006)

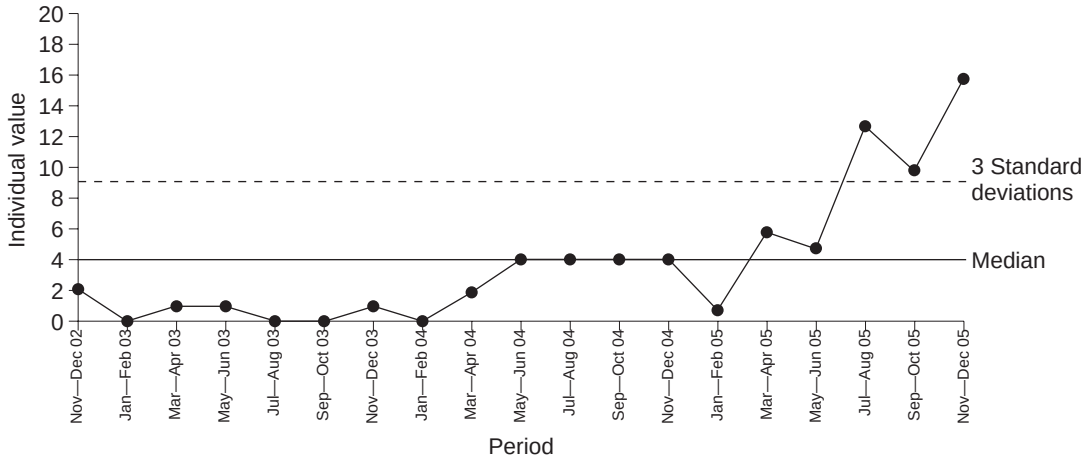

Figure 3 Statistical process control chart showing the number of prehospital thrombolyses carried out every two months (from 2002 to 2005)

of clinicians. Clinical teams led by clinicians, close to the patient and point of care, and supported by the organisation were critical to success.[16]

It remains to be seen whether and to what extent the creeping involvement of private companies moves the emphasis, vision and values of health services from clinical outcomes to financial profitability. Despite this concern, there will undoubtedly be a strong and ongoing requirement for leadership at all levels and in all parts of the health service with the need for managerial and clinical teams to demonstrate their effectiveness and maintain a clear vision to improve the quality of care based on strong values of clinical effectiveness and patient care.[17]

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CONFLICTS OF INTEREST

The author was Co-Medical Director at Lincolnshire Ambulance and Health Transport NHS Trust from August 2003 to June 2005 and is now Associate Medical Director of East Midlands Ambulance Service with responsibility for clinical education, audit and research.

ADDRESS FOR CORRESPONDENCE

Professor A Niroshan Siriwardena, Visiting Professor of Primary Care, School of Health and Social Care, University of Lincoln, Lincoln LN6 7BG, UK. Tel: +44 (0)1522 886939; fax: +44 (0)1522 837058; email: nsiriwardena@lincoln.ac.uk