Leading change in anaesthesia in a multi-disciplinary setting

“It is not necessary to change -survival is not mandatory”  W Edwards Deming

We live in difficult times. After a decade of rapid growth and investment, the NHS is facing one of the most challenging periods in its existence. Financial constraints, changing patient demographics, disease burden and expectations are coalescing to threaten the current model of healthcare provision in the UK. (Kings Fund, 2012) In the UK, we are living longer, and more of us are living with complex co-morbidities (multi-morbidity) of acquired ‘lifestyle’ conditions such as obesity and diabetes mellitus. However, NHS funding has remained static whilst healthcare inflation has risen sharply with the development of expensive new drugs and technologies.

These external factors have been exacerbated by a radical structural reorganization triggered by the Health and Social Care Act and the changing future workforce. For those who are passionate about delivering high quality care for all, continuing to provide healthcare in the same way is no longer sustainable. Changes to the way we deliver healthcare are necessary throughout every aspect of the NHS, in order to meet the ‘Nicholson Challenge’: to save the estimated 20 billion pounds required to maintain and develop the standards of care at the pace seen in the last 10 years and meet the needs of a growing, sicker population.

In the face of such a bleak forecast, it would be easy to become despondent. But as well as some huge challenges, NHS has a huge resource. It is one of the largest employers in the world, with a workforce of 1.3 million people in England and Wales alone. This skilled and dedicated body of workers contains the intellectual and social capital to not only preserve but also improve care by developing the solutions and leading the subsequent changes necessitated by current circumstances.

The challenge of complexity in multidisciplinary healthcare.

The barriers to change and improvement are significant, within the NHS culture, individual’s psychology around change and the technical ability to develop and implement improvement strategies. The nature of healthcare makes this challenge even more daunting. Clinical care is highly complex and requires the input of a range of professional skills in all but the simplest cases. This is mirrored by the complexity of managing and leading these processes to ensure that good quality and efficiency are maintained. For these reasons, it is imperative that any improvement planning is multidisciplinary. In a complex system, any intervention has the potential to affect a great many practitioners and processes. The risks of unintended consequences are high. Many initiatives aimed at improving care may have a deleterious impact on patients if not planned and executed with potential wider effects in mind. This can be mitigated by good collaboration and communication across disciplines when planning and conducting changes for improvement. There is a growing body of evidence that quality improvement efforts conducted within multi disciplinary groups are more successful (summarized by Vincent et al, 2011). This may be due to the wider range of skills and perspectives brought into planning, and the fact that the multidisciplinary team is more likely to contain the varied interpersonal skills needed to successfully negotiate any planned change.

Much of the published work on improvement science emphasizes the importance of analysing processes from all conceivable angles before diagnosing problems and recommending the solutions. This is the norm in industrial and business improvement initiatives. For example, in Lean improvement philosophy, the traits of hands-on “production-line” experience and knowledge are highly valued (Womack, 1991). They emphasize that leadership should be distributed within the team, rather than the preserve of individuals with special qualities in positions of authority. Lean principles guide leaders to seek out facts from the source and create consensus (genchi genbutsu). Team leaders
working to the Lean philosophy do not need to have unique traits that make them leaders: rather, they should be skilled in utilising the talents of the whole team to solve problems.

For an industry so dependent on multidisciplinary working for good clinical care, healthcare has been slow to pick up multidisciplinary working as part of organizational change. Doctors’ improvement efforts have largely been based on clinical research or audit: driving improvement by measuring processes or outcomes against a predetermined standard, rather than focusing on innovations aimed at changing the whole organizational system or process. Currently, it is non-clinical managers who lead many organization-wide improvement and efficiency initiatives, and improvement methodology is only recently receiving any coverage in postgraduate and undergraduate medical education. However, front line clinical involvement in improvement work is hugely beneficial. It ensures quality and safety lie at the core of improvements, and early engagement with those likely to be implementing any changes ensures new practices are more likely to be widely adopted and sustained (Hamilton, 2008).

Why anaesthetists? The skill and knowledge to lead

Within the complex and varied healthcare environment, anaesthesia is in a strong position to share knowledge and develop the specialty to lead this change. There is a desire amongst the specialty for anaesthetists to take a leading role in developing medical strategy and exert a greater influence on patient care within a wider system, as evidenced by a recent editorial proposing the expansion of the anaesthetist’s role, beyond the traditional domain of the operating theatre, to develop as ‘peri-operative physicians’ (Grocott, 2012). Leadership is a natural part of the anaesthetic role, as is supporting a team leader in a ‘followership’ role. Anaesthetists show dexterity in leading, following and collaborating in clinical practice, in the operating theatre or critical care clinical environment. Expanding these clinical skills to adopt a leading role in organizational improvement is an effective way to increase the influence of the specialty and beneficial to share these skills within the wider healthcare system.

Anaesthetists have always worked as part of a team: the primacy of safety in anaesthesia’s clinical culture, leadership skills and multidisciplinary working are ingrained in daily anaesthetic routine and were a part of training long before many other specialties adopted these fundamental concepts, (Gaba, 2000). Anaesthetists work collaboratively in multidisciplinary groups within hospitals, as well as regional and national clinical, research and audit networks. Beyond the surgical or critical care patient pathways, anaesthetists have technical and non-technical multidisciplinary leadership skills to be excellent leaders of change throughout the hospital.

The King’s Fund has written extensively on clinical leadership, and has strongly advocated that leadership should be developed ‘from the board to the ward’. They recommend that front line clinical staff should drive improvement and organizational leadership, based on a ‘distributed’ leadership style, (Kings Fund, 2011). In this model, individuals lead and follow; depending on the skills required and leadership of the team may change hands many times. People need not be designated as leaders by any formal title, but adopt the role as the situation dictates often in quite informal ways.

‘NHS needs people to think of themselves as leaders not because they are personally exceptional, senior or inspirational to others, but because they can see what needs doing and can work with others to do it.’ (The Kings Fund, 2011)

This leadership style is collaborative and crosses boundaries, ‘post heroic’, quiet engaging leadership rather than the charismatic leader or hero figure of old. These descriptions are strikingly similar to the model of team leadership practiced by many in anaesthesia and taught prominently in anaesthesia ‘human factors’ training. Anaesthetic clinical team leadership changes depending on the situation and the team leader collaborates with his team to optimize their individual talents and viewpoints, in order to maximize safety. This can be seen in collaboration with surgeons, obstetricians, emergency
physicians, nurses, OPDs or midwives amongst others.

**The future of clinical improvement and leadership: collaboration beyond traditional boundaries**

Having accepted the rationale for multidisciplinary collaboration in quality improvement initiatives, and highlighted the useful transferrable clinical skills in anaesthesia, what additions can be made to build and improve on quality improvement strategies moving forward?

More recent initiatives to teach improvement skills to doctors as well as more established leadership and team training in anaesthesia will help embed the skills necessary to provide leadership at every level ‘from board to ward’ and provide a shared understanding of the skills necessary for leading improvement in a complex system. Quality improvement skills and practice have an increased prominence in anaesthesia training and the number of quality improvement publications is increasing in anaesthetic journals (Farrell, 2012). Beyond embedding leadership skills and knowledge of improvement science in clinicians, the improvement team could be greatly improved by broadening its constitution and redefining what we mean by “multidisciplinary”. The team can reach beyond traditional professional boundaries, and encourage collaboration with clinical colleagues from nursing, therapies and other associated health professionals.

NHS managers should also be included in this ‘improvement team’, for the unique perspective and skills they possess. Whilst clinical leadership is essential, this should be in the context of a partnership with managers, rather than as a replacement for NHS managers. Managers bring technical know how of improvement science and project management, as well as an important perspective on financial planning, allowing improvement to provide ‘value’ as well as higher quality care. Several schemes exist to promote such alliances, such as London’s Imperial Healthcare ‘Paired Learning’ and NHS North West’s ‘Leading Together’. These schemes and others like them have shown that breaking down traditional barriers and facilitating manager-clinician collaboration effectively utilizes the skills and attributes of both groups. Investing in these relationships results in stronger working relationships, more sustainable outcomes from quality improvement schemes and has even been shown to reduce external consultancy costs. (Kings Fund, 2011)

**Patient centred care: engagement and participation in change**

We can take the ‘multidisciplinary improvement team’ definition even further, to include the most important ‘stakeholder’ in the healthcare system: the patient. Patient experience has gained rightful importance in healthcare, becoming part of the core definition of ‘quality care’. However, patients can provide expertise beyond comments on improving experience. Industrial improvement science teaches that we should rigorously pursue customer (for us, patient) ‘value’ in planning: processes that provide little value to the patient are the cause of wasted time and money and sources of potential harm that add nothing to improving health, for example conducting blood tests pre operatively because that is ‘routine’ but not clinically necessary. In order to truly understand what provides value, we need to consider improvements from the patient’s perspective.

There have already been significant efforts to increase public awareness of anaesthesia as a science, in Britain and beyond, as exemplified by the success of public engagement in developing the popular Science Museum ‘Pain Less’ exhibition, (Morley, 2012).

Engaging with patients on service planning is also receiving increasing attention, with significant benefits realized by this new collaboration. We are moving from designing services for patients to designing services with patients, a process called ‘co-design’ or ‘co-production’. The benefits include improved safety, outcomes and quality of care, as well as high levels of staff and patient engagement in improvement initiatives, (Health Foundation, 2010). The NHS Institute of Innovation has promoted this approach in the “Experience Based Design’ scheme which has successfully transformed a range
of acute and community services to provide better value and quality healthcare (NHS Institute of Innovation and Improvement, 2009)

Anaesthetists collaborating with the public on improvement initiatives would give patients increased exposure to what anaesthetists do, and give improvement efforts the benefit of the important patient perspective, a mutually beneficial partnership.

Whilst the challenges facing healthcare are significant, we already have many of the potential solutions to hand. Many of these are contained within the skill set of anaesthetists. Anaesthetists work in and lead teams on a daily basis, and many within the specialty are already well versed in many of the strategies used to facilitate improvement and change. By broadening the involvement of anaesthetists outside of our traditional practice, collaborating with groups within and beyond the medical profession, and promoting a culture of quality improvement, anaesthesia as a specialty can lead the quality improvement agenda in the same way that it led the safety agenda in the past.

Word count: 2004

References

Transforming the delivery of health and social care. The case for fundamental change. The Kings Fund, 2012

Multidisciplinary centres for safety and Quality. C. Vincent, P. Batalden, P and F. Davidoff. BMJ Qual Saf 2011; 20 (Suppl 1); i73-i78


The future of leadership and management in the NHS. No more heroes. Kings Fund, 2011


How do you get Clinicians involved in quality improvement? The Health Foundation, 2010

The ebd approach: Concepts and Case studies. NHS Institute of Innovation and Improvement, 2009