Participation and Engagement by Design: Maximising the Return on Investment of a Medical and Clinical Leadership and Quality Improvement Programme

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INTRODUCTION

Medical Leadership is seen as a key factor to improve the quality of care for patients, improve patient safety and result in efficient hospitals (Dickenson and Ham, 2008; Clark, 2012; Clark and Nath, 2014). Doctors require 'hybrid leadership' as this term describes those with a professional background who combine this role with leadership responsibilities (Spehar et al, 2014; Fulop, 2012). A Clinical Leadership programme was commissioned from the Centre for Leadership, Sheffield Hallam University by one of the identified Sir Bruce Keogh (2013) 'failing hospitals' in June 2014. Thirty eight (38) Clinical leads were identified by the Medical Director as being in an appropriate role to benefit from the programme. While thirty one (31) completed the programme and ten 10 (32%) submitted quality improvement projects at the end of the programme in March 2015. An analysis of 5 of these reports utilising the Return on Investment methodology (Phillips and Phillips, 2006) and with the use of specific process and outcome metrics, identified a Return on Investment for the hospital trust of 566%.

OBJECTIVES

A Social Constructionist approach (Jha, 2012) facilitated a relationship to develop an understanding of 'sense making' between the Academic and senior medical leader to co-design, co-create and deliver a Clinical Leadership programme that was relevant, useful and appropriate and that in turn would result in their engagement and participation. A participatory research methodology, guided the overall approach. All Clinical Leads were offered a 1:1 interview to explore their current role, strengths, areas for further development and factors that enthuse and motivate as well as barriers to engagement with a leadership programme. At this meeting Clinical Leads were asked to identify what motivates and excites them in their role as Clinical Lead and how what motivates them in this role could lead to their focus on a Quality Improvement project for the leadership programme. The Clinical Leads were asked if they would complete two leadership diagnostic questionnaires and gave permission for their Quality Improvement project data to be accessed by the University team to help them in data analysis of base line measures and follow up. The project was registered with Sheffield Hallam University Research ethics committee.

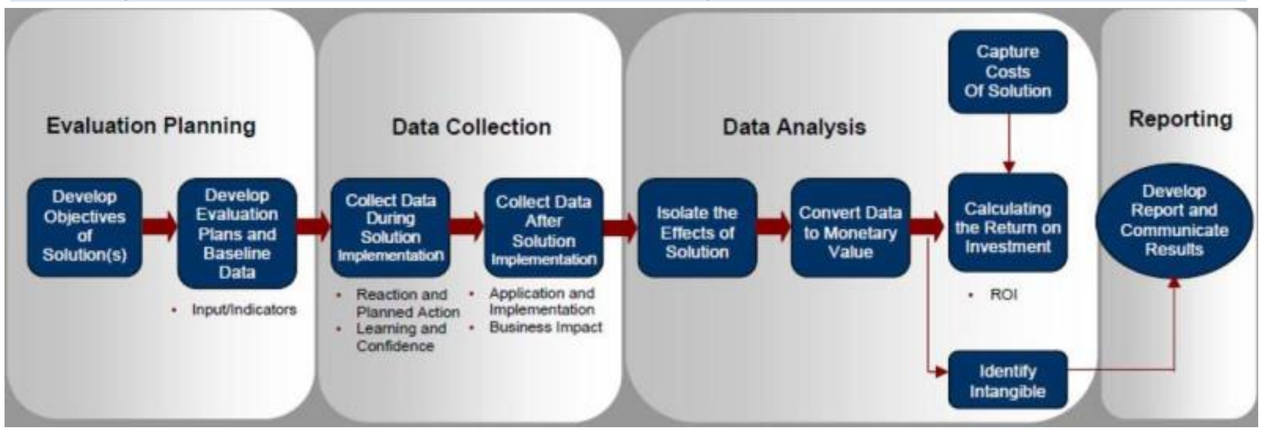

Table 1: Six types of data (Phillips and Phillips, 2006)

SIX TYPES OF DATA (Phillips and Phillips, 2006)	SIX TYPES OF DATA (Applies to the NLAG Clinical Leadership Development Programme 2014 -15)
1. Reaction – usually questionnaire or survey and aims to identify customer satisfaction	1. Reaction – informal processes to gather feedback in multiple ways through participant emails, HR Lead, MD and Associate Medical Director
2. What participants have learnt from the programme	2. Action Learning Sets to encourage reflection on learning, reflection within quality improvement reports and reflection within 'front of the group' presentations
3. Measure application and implementation	3. Use of skills in the writing of quality improvement projects, reflection on learning from leadership diagnostics
4. Measure business impact – the actual business impact from the programme – • Output • Quality • Costs time • Patient / Customer • Satisfaction	4. The return on investment and measures of performance – an analysis of which quality improvement projects evidence: increased productivity (outputs) increased quality savings in time increases in patient satisfaction
5. A cost profile in terms of direct and indirect costs expressed as a benefit / cost ratio	5. A content analysis of quality improvement reports ROI(%) = Net Programme Benefit / Programme Costs
6. Intangible benefits are defined as implementation and business measures benefits that are not converted to monetary value	6. A content analysis of quality improvement reports

CONCLUSIONS

Ten (10) Clinical leads have submitted Quality Improvement reports with five (5) providing sufficient metrics and evidence for a Return on Investment calculation to be made. Case Study 1:Reduced DNA with text messages by 63% in a 3 month period, this would represent a return of £256,695 over the first year. Case Study 2 identified excessive use of acute general hospital bed by neuro rehabilitation patients while awaiting a panel decision for a rehab bed. By changing the process a saving of £58,250 can be made in 2015. Case Study 3: identified incorrect coding for hospital surgical procedures saving £413,000. Case Study 4 Laboratory errors were addressed through a change in the process saving the time of one WTE consultant, this consultant had previously attended a QI programme but no previous leadership programme: we discounted the 50% of the savings made to her previous learning resulting in £40,000 saved. Finally in Case Study 5 a review of a business model showed an under-capacity to deliver all commissioned work and left a deficit of £2,064 but with increased demand of 22%. The cost of the Leadership Programme (including consultant hours to attend) was £136,000, providing a return of £770,009 which is a Return on Investment of 566%.

REFERENCES

Clark, J. (2012), "Medical Leadership and engagement: no longer an optional extra" *Journal of Health Organization and management.* Vol 26 (4), pp. 437 - 443; Clark J and Nath V (2014) "Medical Engagement: A journey not an event" *The Kings Fund, London*
Dickinson, H. and Ham, C. (2008), *"Engaging Doctors in Leadership: Review of the Literature,"* Coventry, NHS Institute for Innovation and Improvement; Fulup, L (2012) Leadership, Clinician managers and a thing called "hybridity" *Journal of Health Organisation and Management* 26(5) 578-604; Jha A K (2012) Epistemological and pedagogical Concerns of Constructionism; Relating to the Educational Practices *Creative Education* Vol.3 (2) 171-178 ; Keogh B (2013) *Review into the quality of care and treatment provided by 14 hospital trusts in England ; Overview report;*
Phillips, J and Phillips, P (2006) 'Return on Investment Measures Success' *Industrial Management*
Spehar, I, Frich, J C and Kjekshus, L E (2014) 'Clinicians in Management: a qualitative study of managers' use of influence strategies in hospitals *BMC Health Services Research* 14:251

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