Effecting a national implementation project through distributed leadership in the West Midlands: rising to the spread challenge

James Gillies,1 Victoria A Hodgetts Morton,2 Simone Jasim,1 Caroline Fox,3 Penny Broggio,4 Thillagavathie Pillay5,6

ABSTRACT
We describe the utility and impact of a distributed leadership model to implement a National Health Service (NHS) England Academic Health Sciences national quality improvement programme, in the West Midlands. This model was adopted to address the inherent difficulties of implementing change in practice in a large geographical region with a diverse population of health service personnel. We report on the inclusion of a senior trainee as part of the implementation team, supported by a multidisciplinary clinical consultant team, with equal agency in decision making, acting as mentors and activators in the background.

INTRODUCTION
The problem
In December 2018, the West Midlands Academic Health Science Network (WMAHSN) was tasked with the spread of a quality improvement programme, Preventing Cerebral Palsy in Preterm babies (PReCePT) for the region, as part of the National Academic Health Science Network thrust to deliver this innovation to the country at scale and pace.1 PReCePT focused on increasing uptake of magnesium sulphate (MgSO4) administration to mothers in established preterm labour <30 weeks gestation, to reduce the risks of cerebral palsy in their preterm babies.2 The WMAHSN was the last network to engage in this national implementation work. The region had the worst 2017 baseline uptake of MgSO4 at this stage (58.6%); targets of 85% were set by the national programme.2

The leadership model employed by the national PReCePT programme included a single clinical lead per region providing oversight, support and guidance to nominated trust-based obstetric and neonatal PReCePT team leads. These team leads then cascaded information within their respective organisations with progress fed back to the regional and national PReCePT team.

For the West Midlands, this single clinical model posed significant challenges: first, the region stretches over 90 miles South to North and East to West covering 5000 square miles and encompassed 14 obstetric and 14 neonatal units, in 13 hospital trusts. Time constraints dictated by geographical size and number of providers made face to face discussions and support, if led by a single individual, less likely to succeed. Second, the obstetric and neonatal services varied in the clinical exposure (number of cases) in dealing with preterm pregnancies eligible for this intervention (246–296 weeks). These ranged from just 1 eligible case per year at maternity services linked to 4 special care baby neonatal units (caring for the bigger baby, less ill), to 80 eligible cases per year in those maternity services linked to 5 neonatal intensive care units (NICU) (caring for the sickest and most premature of babies), and 5 local neonatal units (LNU) (intermediate capabilities for neonatal care). This together with a diverse experienced workforce meant that different levels of support for implantation of change would be required.

Rationale and aim
These challenges were acknowledged and reflections on learning from the Health Foundation,4 highlighting that successful spread of innovation in the National Health Service (NHS) needs to focus on the needs of those adopting the innovation and their context and not the innovation itself. To not do so would risk the pace and results from spread of innovation to the West Midlands achieving the expected national targets. To overcome these challenges, a novel team structure was developed, modelled around distributed leadership in effecting the spread challenge.
The distributed leadership model used
We focused on distributed leadership as a collection of leadership approaches including collaborative, coordinated, shared working without a hierarchical body ‘in charge’. There are many variations in terms, but the most appropriate for our purposes is a description by Bennett et al who proposed that distributed leadership is based on three characteristics: (a) people making a concreitive effort to work together to pool initiative, expertise and influence; (b) that leadership can include people at all levels in an organisation and (c) difference of expertise, perspectives and capabilities are harnessed to forge trust and reciprocal influence.

We reflected on Currie and Lockett’s perspectives of Gronn’s dimensions of concreitive action and conjoint agency, for distributed leadership in NHS practice. While Gronn’s model represents a ‘pure’ application of distributed leadership, most NHS practice involves transformational leadership which tends towards a heroic autocratic approach with little concreitive action or conjoint agency. We understood that the extent to which these dimensions interact is influenced by the organisational and policy context and this then determines different conceptions of distributed leadership in practice.

For the NHS, over the last decade, ‘distributed leadership’ has been promoted to deliver change across health systems. The essence of this leadership in the NHS can be seen within the NHS Leadership Academy’s Leadership Model, Developing People—Improving Care and the NHS Change Model. However, the practical reality is that NHS policy context is largely transactional in nature, promoting a heroic autocratic approach to leadership. This heavily influences the extent to which conjoint agency and concreitive action can be enacted when distributed leadership approaches are being adopted. In the context of the PReCePT implementation project, it was felt that taking a single person approach to clinical leadership would not address the regional challenges of meeting the needs of those adopting the innovation and their context. The distributed leadership model planned, and subsequently adopted by this project, was heavily influenced by Gronn’s description and what Currie and Locket refer to as ‘pure’ distributed leadership. Centred on the needs of the innovation adopters, it was intentionally designed through concreitive action to enact the three characteristics of conjoint agency. The model embraced a participatory philosophy of commitment to empowerment through sharing of knowledge, planning, acting, monitoring and reflecting, to address the spread challenge.

METHOD
1. The four stages in the development of the model, its impact on quarterly uptake rates for the region for the period of implementation (April 2019–March 2020), additional output and our collective reflections that this facilitated is described. All obstetric and neonatal units participated in the regional implementation programme.
2. The WMAHSN conducted an end of project evaluation that included a request for stakeholders to complete a questionnaire. Seven questions were designed to understand how regional project leadership was experienced by key trust-based individuals in a way that was participatory and meet their needs. The key findings of this evaluation are described in this paper.

RESULTS
Developing the intervention (distributed leadership model)
1. The initial call out: when approached by the WMAHSN to be the delivery vehicle to implement the quality improvement project in the region, a regional call out was sent by the WMAHSN for a volunteer to take on a funded role of the single regional clinical lead. Despite this, all trusts having local multidisciplinary PReCePT teams in place, this call was not answered.
2. A distributed leadership model for the West Midlands project was conceived and promoted: in attempting to understand the reasons for the call out not being answered, a 1:1 discussion was held with a senior neonatologist in the region. The challenges outlined above were acknowledged, reviewed by the WMAHSN project lead and a team approach with a distributed leadership across the discipline of obstetrics and neonatology promoted. WMAHSN funding for two programmed activities per month per candidate was approved.
3. A second call out for regional clinical team leads for the West Midlands was made after the review, and now answered.
4. Realigning with the national implementation programme: the WMAHSN project fell back in line with the recording and reporting structure for the national PReCePT programme.

Structure of the distributed leadership model used
This comprised four clinicians: (a) a consultant neonatologist from an NICU and an LNU, (b) a consultant obstetrician with an interest in preterm birth prevention and (c) an obstetric senior trainee with an interest in quality improvement and preterm birth prevention (figure 1). They were supported by a WMAHSN project manager and project lead.

Roles within the regional lead clinical team
The trainee was nominated as the lead figure for the clinical lead team to represent the region at national meetings. The distributed leadership approach encouraged a team model based on reciprocal influence and reflection. This ensured that the trainee was mentored by three senior clinicians with diverse clinical experience to guide this project, allowing the trainee to flourish. At the same time, the trainee and team influenced their senior colleagues and they, one-another. The senior consultants acted as joint activators to and with the trainee who together synchronised their actions as to ensure delivery
of the regional clinical lead duties across the region. Each clinician took on responsibility for close communication with 3–4 obstetric and neonatal services in order to facilitate better relationship building through familiarity with individuals and teams within their own organisational context.

**Impact of the regional lead clinical team**

**Overall uptake rates**

There was a substantial and sustained increase in the regional administration rate of MgSO₄ from the 2017 benchmark of 58.6%² to 85.5% for the period April 2019 to March 2020 when the project was delivered. During that period, the administration rates each quarter were: Q1 81.8%, Q2 80.9%, Q3 87.1% and Q4 85.5%. Quarter 4 administration rates dropped slightly due to the impact of COVID-19 on staffing and birthing behaviour during March 2020, this continued in to Q1 2020–2021. These reflect figures consistently close to or above the suggested national target set by the national neonatal audit programme, of 85%.³ The full data from this work are likely to be reported for the PReCePT programme, elsewhere.²

**Regional collaborative guideline**

The team cohesively worked towards the development and implementation of the first West Midlands regional combined obstetric and neonatal (ie, perinatal) guidelines. ‘West Midlands Guideline for the Administration of Magnesium Sulphate to Women in Preterm Labour for Fetal Neuroprotection’ published 6 July 2020.

**Audit of missed cases with regional impact**

Through regional audit, the team were able to scrutinise reasons for poor uptake of MgSO₄. Trust-specific learning points, missed opportunities for administration of MgSO₄ and identification of a practical regional time frame for administration of MgSO₄ were possible through audit. These have informed the regional guideline.

**Did the delivery of the programme meet the needs of the local PReCePT teams?**

In table 1, responses from stakeholders within individual trusts highlighted that the leadership approach was
The result of the critique of challenges posed in the West Midlands was the implementation of a clinical team of four, of diverse experience, functioning within the context of a collaborative of shared working. This resulted in the implementation of a clinical team of Midwifery based stakeholders, assuming individual responsibility in such a widely variant geographical area may have been considered too challenging by individual healthcare workers, especially, as the brief was to improve our existing rates of 

Assuming individual responsibility in such a widely variant geographical area may have been considered too challenging by individual healthcare workers, especially, as the brief was to improve our existing rates of MgSO₄ uptake from 58.6% to over 85%. The decision making around the team that coalesced thereafter took into account this potential reason for the poor initial response. In so doing a distributed leadership model evolved. In this model, all four team members worked alongside each other as part of the collective, enabling distribution of the workload between the team. This allowed the four members of the team to engage with different teams on the ground concurrently, in a more focused manner. Each of the team engaged with their units, and this was fairly independent of who was assigned as the spokesperson for the team. The team itself was not hierarchical. The junior trainee was supported and mentored through this process, and awarded the opportunity of representing work undertaken in the region, on a national level. The group felt that this was important in the trainee’s growth and development. In planning and adopting this participatory model based on reflection, mentoring and activation, the group worked together cohesively to display the characteristics of distributed leadership described.  

While the uptake for MgSO₄ in the region may represent the effect of the ‘last wave’ of implementation, we believe its success was also due to a distributed leadership model.
Through scrutiny of all levels of questions posed by teams on the ground (adopters) because there were four heads instead of one, and audit of missed opportunities with delineation of a regional practical time scale for administration of MgSO₄, the responses focused on the needs of the adopters as they themselves highlighted during evaluation. In our opinion, this distributed leadership approach contributed to improved uptake of the programme in hospitals that were struggling. The model potentially removed barriers found in a hierarchical system by giving ownership to the programme to teams on the ground. By using four individuals, we overcame the vast geographical and expertise diversity, especially for smaller units that did not see as many cases as their bigger counterparts.

The value of this model translated into leads being present but not overbearing, enabling trust-based adopters to modify PReCePT based on site context-specified challenges. A commitment to participation, shared leadership responsibilities and reciprocal influence ensured that top-down transactional performance was not a feature of the project. The clinical leads were able to feed off the experiences of each other in accepting that individual units had their distinct style, and that the pace of change was not going to be consistent for all units. This measured stance enabled a better understanding of the participatory philosophy this project so clearly displayed. Future implementation strategies for the NHS, especially in the context of cross-discipline work, such as between obstetrics and neonatal services are likely to benefit from more consistent utility of this and other distributed leadership models.

A limitation of this descriptive work is that the methods applied to the capture and analysis of qualitative data reflecting the adopter perspectives was developed to meet project management needs, at a time when the implementation phase was ongoing nationally. It is a consideration for future implementation work by the WMAHSN to plan for more in-depth external evaluation of leadership methods applied.

The spread of an innovation does not in itself guarantee an improvement in outcomes if project focus is placed on monitoring the pace and scale of the adoption. Indeed, the very act of ‘spreading an innovation’ is a risk to adoption that requires recognition and mitigation through a focus on the adopters not the innovation. Here we describe a distributed leadership model that may be the way forward for NHS future perinatal quality improvement projects, given the complex cross-discipline interactions. Our experience suggests that at least for the West Midlands, this can be successful.

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ORCID iD Thillagavathie Pillay http://orcid.org/0000-0002-4159-3282

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