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Impacts of Health and Social Care Professionals Leadership in Publicly-Funded Health Services in Ireland

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Abstract

Purpose: This purpose of this study was to understand the impact of health and social care professional leadership across the publicly funded health services in Ireland. **Methods:** In-depth interviews were carried out with twenty-two participants. These participants included former and current health and social care professional (HSCPs) who were in positions with a leadership mandate in respect of a number of different HSCPs groups (n = 16). A small number of HSCP managers and others working with HSCP leaders (n = 6) were also included in the study. **Results/Findings:** The findings show that HSCP leadership roles have a positive impact on the institution (through supporting interdisciplinary integration; more efficient strategy service planning and integration and better governance of HSCPs), service users (by bringing a focus on what is best for the service user, improving access to resources and better aligning resources with need) and on HSCPs themselves (throug better representation of HSCPs within the institution, by ensuring HSCPs are better informed about developments, by ensuring HSCPs feel more valued and supported). It is noted, however, that these type of leadership roles can also create another layer of bureaucracy. **Conclusions:** It is concluded that HSCP leadershi roles can have positive impacts on the institution, the service user and HSCPs themselves. These impacts make an important contribution to the implementation of good quality, effective services. **Advances in Knowledge:** This study provides a unique insight into HSCP leadership in Ireland and highlights the potential of this role to effective and high-quality service development and implementation. The findings are intended to inform future strategic development in Ireland.

Introduction

In Ireland, Allied Health Professions (AHPs) are referred to as Health and Social Care Professions and this term is used to describe a range of professionals who provide an extensive array of services and interventions in diagnostic, therapeutic and social care domains across all elements of the

health services.[1] Health and Social Care Professionals (HSCPs) account for approximately 14% (16,193 posts in 2018)[2] of all positions within the Health Service Executive (HSE) in Ireland and about one quarter of the entire clinical workforce. [2] The crucial role to be played by HSCPs in implementing national policy priorities for service transformation, and improved integration of acute hospital care with primary healthcare services has been acknowledged in national policy (Department of Health 2019 *Statement of Strategy 2016–2019*[3]). Good outcomes, however, rely on effective leadership which has been defined as:

> *Being able to cultivate an environment where all employees can contribute to their maximum potential in support of the mission of the organisation.* [4] p.17

It is acknowledged that such leadership is an essential requirement for healthcare systems to manage the increasing complexities faced by healthcare services, to facilitate improved clinical care and outcomes, better clinical practice, enhanced conflict management and good governance.

HSCPs are essential members of clinical teams within the healthcare system and their role as leaders in supporting the development of future healthcare delivery has been subject to some consideration in a number of jurisdictions including New Zealand[5], Australia[6], Canada[7] and the UK.[8] In Victoria, Australia, for example, a significant movement towards a systematic approach to HSCP leadership has been underway for a number of years. There is a recognition that HSCPS have a key leadership role to play to enhance health developments and, are currently under-utilised. Critically, they must increase their involvement in planning, management and leadership and in this access to leadership development opportunities is crucial.

This type of systematic approach to HSCP leadership has also been acknowledged by the NHS Institute for Innovation and Improvement[9], in the UK, where trust boards are advised to consider looking to strengthen leadership arrangements for HSCPs (referred to as allied health professionals, or AHPs, in the UK) at board level by appointing a senior AHP to lead health policy. This is intended to ensure a strategic focus by AHPs at board level as senior roles are by their nature more strategic, focused on relationships, influencing and engagement. The Institution for Innovation and Improvement also suggests that the appointment of these roles could focus on unlocking AHP potential within a trust and harnessing the AHP workforce's potential for system redesign. Hence, the intention is to identify the AHP workforce's transformative potential, to include implementing new care pathways in order to improve quality and productivity and build workforce competence and capability to realise the benefits of HSCP leadership. In this way, senior roles can demonstrate that the professions are valued, and board business can be communicated to and from AHPs so as to deliver trust priorities. Additionally, these roles can enable talent management and succession planning, with AHPs actively engaged in trust and system-wide initiatives. This will contribute to the strategic focus on demonstrating value according to the triple NHS aim (better care for individuals, better health for the population and lower cost through improvement).

In Scotland, clinical governance has been a major change initiative for facilitating quality and accountability in health care since 2002.[10 (10)] Responsibilities of AHP leaders within clinical governance have included the application of evidence to practice, risk management, audit, teamwork and engagement in the learning underpinning quality-based care.

In Ireland, similarly to elsewhere, the contribution made by HSCPs to the delivery of health and social care is not fully understood or appreciated. This may have arisen, in part at least, from the disparate nature of their education and work, which includes a very broad range of services and interventions in diagnostic, therapeutic and social care domains across all elements of the health services. The HSE notes that:

> *Despite the significant contribution that HSCPs make to delivery of health and social care their input and potential contribution is often not fully understood or appreciated. This can result in underutilisation of a very significant resource and failure to capitalise on the potential outcomes and economies that are possible(1)*[1 p. 6]

This failure to capitalise on and achieve maximum benefit from this group of professionals requires a coordinated and systematic approach to service development, leadership and implementation. One step in this approach is to understand the potential contribution of HSCPs where they occupy leadership roles.

Methodology

This section reports on the methodological approach adopted to understanding the contribution made by current and former HSCP leaders in Ireland.

Aim and objectives

This study was commissioned by the National Health & Social Care Professions Office and the overall purpose of the research was to:

> *understand the impact of health and social care professional leadership across the publicly funded health services in Ireland.*

The study took place as part of a broader quality improvement initiative which focused on developing a national strategy support HSCPs in Ireland and this is reflected in the key objectives which were to:

1. present a national and international context for HSCP leadership
2. collect primary data in relation to impact and outcomes of HSCP leadership
3. make recommendations in respect of the future of HSCP leadership, taking account of strategic developments in the health services.

Methods

A systematic, flexible and rigorous approach to the study was adopted. Key components included the following.

<u>Scoping review of literature</u>

A scoping review of the literature, based primarily on information provided by the

commissioners and a synthesis of the most relevant information, was conducted.

Primary data collection

In total, 22 individuals were interviewed for this research and both face-to-face and telephone interviews were conducted. A snowball sampling approach was adopted and this commenced with the HSCP leaders group hosted by the National Health & Social Care Professions Office. Those interviewed included:

- former HSCP leaders (*n* = 4)
- current HSCP leaders (*n* = 12)
- individuals, generally HSCP managers of individual disciplines, working in environments with HSCP leaders (*n* = 4)
- individuals to whom HSCP leaders report to (*n* = 2).

For clarity, participants who are currently or have previously worked in HSCP leadership roles are referred to throughout the findings as 'HSCP leaders'. Participants who have not worked in HSCP leadership roles are referred to throughout as 'HSCP managers' (n = 4) and these include personnel who report to HSCP leaders. Two individuals who HSCP leaders currently report to were also included.

Data were collected through audio-recorded interviews using open-ended interviewing technique which allowed flexibility with the questions, and for the participants' own story to be told. Each interview lasted between thirty and forty minutes and "member checking", summarising what had been said while using respondents' own words, took place at the end of each interview.[11] This allowed for participant validation of the data at the time of collection.

Data preparation

All of the interviews were audiotaped and transcribed. The anonymisation of the interview data involved removing all personal information (e.g. names and locations) and the assignment of pseudonyms. Where necessary, the qualitative data were edited to safeguard participants' anonymity, but it has been ensured that this has not distorted their data or changed the key messages that emerged. Two researchers (S.H., M.S.) were involved in the preparation, immersion and analysis of the data.

Data analysis

Following all interviews, notes were written up within 24 hours, which provided an opportunity to reflect on the process of the interview. Each audio file was listened to at least three times, which provided an opportunity to become familiar with the nuances and content of each interview. All audio files were transcribed, and memos were made as a means of capturing ideas, views and intuitions at all stages of the data process. Following transcription, each transcript was read through several times to get an overall sense of the data.

- The data were then imported into NVivo, where data coding took place. Open coding, where a provisional name is given to each category, was used, and a compare-and-contrast approach was adopted to form categories, establish the boundaries of the categories and assign data segments.
    - Following this, data related to each category were retrieved and a narrative around each segment was created.

Credibility of the findings

On completion of the preliminary data analysis described above and identification of key categories, an iterative process took place between personnel from the National Health & Social Care Professions Office (M.S., J.R.) and the research team (S.H., M.S.). The purpose of this engagement was to provide an external check on the inquiry process and to refine working hypotheses about the meaning of different categories. This allowed for the emergence of key themes.

On completion of the thematic identification, an engagement in the form of a group meeting took place with participants in the research, personnel from the National Health & Social Care Professions Office and the lead researcher (S.H.). This provided for a direct test of findings and interpretations with the human sources as well as facilitating fairness of representation within the narrative. These processes ensured each contributor was involved in the co-construction of the understanding of HSCP leadership presented in this paper.

Identification of recommendations

Proposed recommendations were derived from the scoping review of the literature and the primary data collection process. These proposed recommendations were discussed and agreed in an iterative process with the National HSCP Office.

Ethical issues

The HSE Research Ethical Committee (REC) is the main research and ethics committee in Ireland to protect potential participants in health service risks research and to promote high ethical standards in research for health. The REC criteria summaries activities that do not require research and ethics committee review and approval. These include research utilising existing publicly available documents or data, observational studies in public places in which the identity of the participant remains anonymous, case study of one patient with the proviso that written informed consent has been obtained from the relevant study subject/participant, quality assurance studies, clinical audits and service evaluations [(12)].

As this research study was focused on a service evaluation to support a broader quality assurance development, HSE approval was not required. The researchers, however, adhered to sound ethical procedures throughout guided by the Social Research Association [(13)]. In the context of this study, this included the protection of the study participants through safeguarding their dignity, rights, safety and wellbeing throughout the process. Specific ethical issues considered and addressed throughout the project were in areas of confidentiality, anonymity and data protection. Only the minimum amount of personal data required was sought, and personal data were not used for any purpose other than that specified at the time of collection. Written informed consent was sought for all participants taking part in interviews. All data were anonymised and all research outputs were checked carefully to ensure that no individual is identifiable. In addition, all appropriate steps were taken to ensure both the quantitative and the qualitative data were held in a secure way. This included the removal of direct identifiers, the use of pseudonyms and the use of technical means to break the link between data and identifiable individuals.

Both system and physical security safeguards were put in place to ensure the data are protected.

In addition, oversight of the implementation of this study took place through the National Office for Health and Social Care Professionals. This was predominately to assure the principles of fidelity (being faithful to agreements and promises of the research aim and objectives) and veracity (referring to telling the truth in recognition of the participant's right to be treated autonomously and fully informed). [14]

Accuracy and validity of the findings

Validity and accuracy in any research are affected by a number of factors, including the appropriateness of the focus, the approach and methods, the availability of data, and the capacity of the data to support valid findings. [15] This study collected new data using qualitative methods, and best practices were adhered to. These data came from face-to-face and telephone interviews with individuals and all necessary steps were taken to explore the nature and substance of the issues emerging. These practices lend credibility to the findings. The accuracy and validity of the findings were strengthened by the inclusion of former, current and non-HSCP leaders and this allowed for stakeholder triangulation. This enabled the consistency of the findings to be tested.

Limitations

This research took place over a relatively short time period with a small number of individuals. It is noted, however, that there are only a small number of HSCP leadership posts in place in Ireland and, consequently, those involved may account for a relatively large number of those in such posts. As with all research of this nature, the data represent the views of key stakeholders, and these may not necessarily accord with the views of all stakeholders.

Findings

The findings from this research focus on the impact of HSCP leadership posts on the institution, the patient or service user, and HSCPs themselves.

Impact of HSCP leader posts on the institution

Many comments were made that highlighted positive impacts of having an HSCP leadership post in place. These included: 'we find the post valuable', 'it contributes a lot', 'it's facilitated significant service development', 'it's provided a focus for the health and social care professional group and 'I think it's a valuable role for me, and for the group'.

Three specific impacts were identified in respect of the HSCP leadership role on the institution and these were:

- Supporting interdisciplinary integration
- Ensuring more efficient strategic service planning and delivery
- Providing better governance of HSCPs

A more detailed consideration of these three impacts is now presented.

<u>Supporting interdisciplinary integration</u>

Many HSCP leaders recognised the need for a more coordinated approach to the delivery of HSCP services, with one person noting that 'it is not good for patients for there to be all this silo working'. Several participants in the research highlighted a

core focus of their leadership role as breaking down barriers between different HSCP disciplines to allow for greater interdisciplinary working. One HSCP leader said:

> *So I just see my role as trying to bring the [service] together and strengthen it as a group rather than as individual departments. Because I think it's very easy for us to stick in our department.*

Another HSCP leader noted that 'integration is the middle name' of the role and that, by its nature:

> *It helps break down boundaries and allows for a primary focus on patients, as opposed to patients' services, or operations.*

Examples were given of the HSCP leadership activities involved in integration, including:

- facilitating regular meetings between HSCP managers from different disciplines
- playing a leadership role in a coordinating group where the HSCP leader meets with directors of other services (e.g. nursing, medicine) to 'coordinate the clinical input and the clinical service'
- reviewing various policies, such as record keeping, to come up with a common system across the HSCP disciplines under the leader's remit
- developing a clinical workplace that is 'aligned to the organisation's strategic plan', and setting and reporting on key performance indicators that align with the plan
- working together to coordinate the clinical inputs to individual service managers' structures
- making changes within the structure to integrate them so that the services becomes 'smoother' for both the patients/users and clinicians.

Provides a collective voice

Some HSCP leaders drew attention to being able to provide the 'single coordinated voice from the group'. It was claimed that, by doing so, they had changed the way in which the HSCPs were seen within the institution. One HSCP said:

> *They're seen as an entity, whereas before it was always physio, OT [occupational therapy] and the others. I now go to meetings and say this is a nursing thing, this is a therapy thing… So I think at an organisational level, there is definitely, and I think particularly in a smaller organisation, there is definitely benefit in having the disciplines of health and social care working together for common goals.*

<u>Ensuring more efficient strategic service planning and delivery</u>

The second impact arising in respect of the institution focused on the need for HSCP involvement in strategic developments taking place. Several interviewees highlighted the importance of having an HSCP voice 'at the top table' when strategic plans are being developed for clinical services and of being able to bring forward that voice. One individual noted that:

Being at the table again gives you the opportunity to unpick the current service and look to a new model that is based on the needs of the people rather than the service being provided.

Another HSCP leader highlighted the importance of a clinical voice in driving efficiency, saying:

You can see that there comes a point where the efficiencies are really difficult to achieve because they're only possible through clinical change. That is where your clinical leadership comes in. Your knowledge of the clinical world and your knowledge of what is possible clinically, your clinical relationships, the trust in you as a leader coming to a clinical group to ask them to consider a change or [ask] what change can they recommend.

In terms of new developments, it was highlighted that an HSCP leader can have a better understanding of what HSCPs' requirements are likely to be [than an individual who is not a HSCP] and of the need to plan for them strategically. One individual, speaking about institutions where this post is not in place, said:

I see individuals saying, 'We're not represented, we're not this, we're not that, we're underdeveloped as a collective profession.'

<u>Providing better governance of HSCPs</u>

The third area of impact for the institution relates to the governance of HSCPs. It was highlighted that the HSCP leadership role allows for greater oversight of the HSCPs and it was noted that there is 'a lot more oversight, which is great', when there is an HSCP leader in place. One HSCP manager noted that prior to the role being in place:

A lot of the time it was just kind of 'leave them well enough alone', do you know what I mean? S/he [the non- HSCP leader] would have had oversight as to what I'm doing but s/he wouldn't really have known what I'm doing day to day.

Another HSCP leader highlighted the importance of having a structure around continuous professional development (CPD) and supervision, noting that this was facilitated through the HSCP leader role:

I'd be very much into [the HSCP personnel] here having their CPD meetings regularly and having professional supervision, all of the rest.

It was also suggested that having an HSCP leadership role has led to improvements in knowledge, with one person saying:

The sharing of knowledge, the... Whatever it is, whether there was conferences or presentations or CPD, you know, for all of us, you know, so it would be that s/he would do things like that as well.

In summary, HSCP leadership posts have three specific impacts on the HSCP leader's institution. These are supporting interdisciplinary integration, ensuring more efficient strategic

service planning and delivery and providing better governance of HSCPs.

Impact of HSCP leadership on the patient or service user

Three impacts were identified in respect of the patient or service user and these were bringing a focus on what is best for the service user, improving access to resources and being better able to align resources with need. These are now considered in more detail.

Bringing a focus on what is best for the service user

One HSCP leader drew attention to their strong professional view that service users need to be at the centre of everything and the fact that this permeated their interactions with HSCP managers in respect of planning and implementation saying:

> *I get people to focus on what's the best for the service user. … And if we can, I just keep reminding people, so what's the best for the service user? How can we keep the service user at the centre of that? And once people keep a focus on that, it kind of shifts their thinking. Because sometimes you can get very caught up in goals and outcomes… So it is about trying to keep that, okay, so how's this going to balance with the service user?*

A number of HSCP leaders highlighted their role in facilitating a coordinated response to proposed new developments. One HSCP lead noted that the role was about coordinating new services, or those that needed to be enhanced; in this context, this person noted:

> *Because I [was] at the table with [my HSCP] hat on and I also knew what was happening with individual services, I [was] able to identify a solution to the problem.*

This was reiterated by a HSCP leader, who noted that:

> *I think it's woven into the DNA [of the HSCP role] and [you have] the experience of working in a lot of different settings with all kinds of different interdisciplinary colleagues, from all kinds of different backgrounds. It's just… you've kind of been through the wars of what works and what doesn't work.*

<u>Improving access to resources</u>

A number of HSCPs highlighted their role in reviewing existing services to ensure the needs of their service users were met. One HSCP lead noted that they can advocate for service users by identifying gaps in current service provision by individual disciplines within the context of the overall group of HSCPs. A number of HSCPs highlighted the ability to transfer their problem-solving skills as clinicians to discussions on the broader strategic position and the importance of being able to use these skills to identify better solutions for patients and service users. One former HSCP lead said:

> *I suppose the skills that I developed there [as a clinician] transferred [into the leadership role], at a higher level and*

working through, I suppose, larger problems as such and maybe more system issues.

One HSCP leader gave the following example

Say you have resource issues that are having an actual impact on a particular service, you are able to get that flagged to the people who matter, who can do something about it. Whereas if you're not at the table... HSCP issues are not mentioned because we're not at the table when they're discussing them.

Being better able to align resources with need

One HSCP manager gave an example of a situation where there had been an increase in the number of patients who required additional resources; this person had brought the situation to the attention of the HSCP leader. Following clarifications, the HSCP leader was in a position to 'bring this to the executive team and say, "Okay, we have an issue here, we need to recruit [name of discipline] for this."'

Others gave examples of additional resources that were needed to ensure service users received the services they needed. Again, another HSCP manager drew attention to the real impact that having a HSCP leader made in terms of their work, saying:

Yeah, in very real terms we would have had more cover in terms of agency [workers] for absences. You know a role like [name of discipline], which I was trying to get [i.e. get the post created] for years, didn't happen and now has happened. So they're very tangible examples I suppose.

This was reiterated by another HSCP manager, who said:

Certainly it gives much more visibility and much more, I suppose power is probably the wrong word, but we're more seen, we seem to be getting more in terms of resources [and] our issues are highlighted at a higher level.

In summary, HSCP leadership has three specific impacts on the service user and these are bringing a focus on what is best for the service user, improving access to resources and being better able to align resources with need.

Impact of HSCP leadership on HSCPs

The final impact identified relates to the impact of HSCP leadership on HSCPs themselves and the following areas were identified:

- HSCPs are better represented within the institution
- HSCPs are better informed about developments
- HSCPs feel more valued and supported and
- HSCP leaders can create another layer of bureaucracy.

These issues are now presented.

HSCPs are better represented within the institution

Many HSCPs reported that they were much better represented within the institution, in terms of being able to bring forward issues arising, as a result of having an HSCP leader. One HSCP manager said:

> *Issues that matter to us get discussed. We have the opportunity to get issues that matter to us discussed at the top table.*

One HSCP manager spoke about the leader being able to achieve better understandings within the institution about what individual professions do. This was highlighted by an HSCP manager, who noted that:

> *We have definitely seen the benefit of [having a HSCP leader], like I say, when it comes to celebrating things as well, that you're able to get the issues out there, or at least have the opportunity to have them raised to a much higher level and escalated where required.*

A HSCP noted:

> *It's definitely a very powerful and beneficial role for us, especially when you're a smaller department… so very often you're the forgotten one. You know, that way. Or you're not considered to be important because there's not three or four tables of you in the canteen. So to have access to [the] senior management team, when you are a small department, is great. And long may the role continue.*

<u>HSCPs are better informed about developments</u>

It was noted that having an HSCP leader in place as part of the executive management team results in better information for HSCP managers and workers. One individual noted:

> *S/he also hears things that we need to know that don't necessarily get told. So, there's an element of being able to plan because [name of person] has heard this is going to happen, so then we're prepared for what's coming down the line.*

One HSCP leader noted that they are engaged in a two-way process 'around what's going on and where we're going, where our activity is, where our performance is, all of that'. This HSCP leader went on to say:

> *I'm kind of like a conduit of information. As an executive, as a member of the executive management team, I very much see my role as in contributing to that joint decision making around where things are going… and I'm also giving... back information to the health and social profession group – it's a two-way process.*

<u>HSCPs feel more valued and supported</u>

Feeling supported and valued is an important element of retention of personnel within health services. HSCPs suggested that they are not a visible group within the overall health services, and a number of different reasons were put forward for this. First, it was suggested that within the HSCP family,

individual professional groups are small and, consequently, they are not visible. Second, it was suggested that HSCPs are not considered essential within healthcare; one reason put forward was that their roles are not (usually) in place 24 hours a day, 365 days a year and therefore they are not seen as key players. One HSCP leader highlighted the lack of weekend services by HSCPs and consequently the perception that they are not needed at a strategic level.

Having an HSCP leader in place, however, was welcomed and HSCP managers reported feeling more valued as a result. It was noted by one HSCP manager that because the HSCP leader has more time, 'it is better for us in the longer term... I suppose we've more support'. This individual went on to say:

> *It's easier to actually arrange to meet with these people. They have more time than if it was somebody higher up, you know – they're not going to... you're just one of the ... I don't want to say the minions but you know what I mean. You're just one of the... one of many people they're managing, you know?*

Another individual who worked with an HSCP leader spoke about recognising that the professional needs of HSCPs were not being met within the institution. This person noted that HSCPs needed 'time, supervision, service development assistance and personal development assistance', and it was recognition of this that had led to the appointment of an HSCP lead.

<u>HSCPs report feeling more valued</u>

There were many comments about perceptions of the role and about the value and importance of HSCPs within the system. It was suggested that in many situations, these personnel are not valued sufficiently and consequently find it difficult to get resources. One individual, speaking about HSCP managers, said:

> *They're absolutely burnt out with pointless [requests], there's no point, they never get staff… they've been looking for stuff for years [and they don't get it]… I've tried and tried, they just... I have to go a different way…. There's no point.*

It was also highlighted that having someone in the position of HSCP leader has made 'a huge difference to how I feel we've been valued and that our opinions are asked for'. This participant went on to say that they were now 'included in everything', from being asked their opinions about strategy to sitting in on committee meetings. This was reiterated by a HSCP manager who worked with a HSCP leader; the manager said:

> *The work is valued more, yeah, and it makes us realise that maybe we're better than we thought we were.*

Additionally, getting feedback about the service, including the value of it, was identified as having an impact on the extent to which individual managers felt supported:

Another indirect impact for me anyway would be get[ting] better feedback about what your own service and where it sits, and the value of it, if that makes any sense. … You have [a] better understanding of your role, and better feedback on your role and the value of it in the bigger picture.

HSCP leaders can create another layer of bureaucracy

A small number of HSCP managers, however, spoke about the introduction of the role as having created another layer of bureaucracy, with one person noting that 'prior to the [creation of the] post [of] lead HSCP, I would have reported directly to a higher level'. Another HSCP gave an example of where, prior to the post coming into place, the process for getting a staff member replaced could be dealt with more quickly because of having direct access to the individual with the authority to make the decision. This was explained as follows:

If I had a vacancy or if I had an issue, I could go straight to… my line manager at the time, and I could get it resolved ASAP. So now I have to go through [name of HSCP leader], who in turn then goes to [name of previous line manager], because I know s/he can't make those decisions directly so it can delay things.

This individual went on to say, however:

You can say, as well, that [name of person] now represents me at the executive... Well, s/he is at the executive meetings and stuff like that, so that takes that workload away from me… So it goes both ways, to be honest.

In summary, HSCP leadership has three specific impacts on HSCPs: they are being better represented, being better informed about developments, and feeling more valued and supported. It was also highlighted, however, that depending on how this role is enacted, it can create another layer of bureaucracy.

Discussion and conclusion

This report presents the findings from a qualitative study with 22 participants who had experience of HSCP leadership positions in the Republic of Ireland. The findings, based on the views of participants in the study and examples they provided, identify a number of positive impacts of HSCP leadership positions. At an organisational level, the role was reported to support interdisciplinary integration, lead to more efficient strategic service planning and delivery, and bring about improved governance of HSCPs. For service users, the role was viewed as bringing a clear focus on what is best for the service user, improving access to resources for service users and resulting in a better alignment of resources with need. Finally, positive impacts were reported for HSCPs themselves. These impacts were identified as better representation of HSCPs within the institution, keeping HSCPs more informed in relation to developments taking place, and perceptions of HSCPs being more valued and supported within the institution.

The findings from this research are in line with the literature on the impact of good leadership on the delivery of health services. Effective leadership at all levels of care has been identified as a requirement to improve the delivery of healthcare services, enhance clinical teamwork and improve safety[11]. Good leadership has also been identified as an essential requirement for high-quality healthcare and is necessary for healthcare systems to manage the increasing complexities faced by healthcare services and to sustain change [(16)]. The findings in relation to efficient strategic service planning are particularly important in that context. Other benefits arising from strong leadership identified in the literature relate to enhanced conflict management and shared governance. [(17)] In this study, improvements in governance for HSCPs were identified.

In the Irish context, barriers identified by McCarthy and Lavery[(18)] to best-practice service delivery in their study on HSCPs included the development of new consultant-led services without added HSCP resources, a lack of meaningful consultation on service planning and on budgets, and challenges in recruitment processes, responding to HSE directives and hospital discharge policies. The findings from this research suggest that these barriers can be overcome, and examples given by participants in the research identified a number of ways in which this can take place. The role of HSCP leaders in identifying changes to existing and new services, for example, was identified in this study as a positive impact of having an HSCP leader in place. These changes may require a reassignment of resources from one discipline to another at a strategic level, and such actions are key to good leadership. In providing a mechanism through which interdisciplinary developments can take place, HSCP leaders can ensure appropriate allocation of resources within the HSCP family and allow for a reconfiguration of services where required.

In this study, HSCP leadership roles were also reported to support service integration and interprofessional working, the absence of which can be a limiting factor in health service reform. This, again, is coherent with the literature, where enhanced clinical teamwork and clinical outcomes have been identified as arising from effective leadership [(19)]. Clear leadership roles within healthcare teams are reportedly associated with aligned team objectives, better support for innovation, higher participation and a greater commitment to excellence [(9)].

Finally, in the course of this study, only a small number of defined HSCP leadership roles were identified (relative to the numbers of leadership roles in other professions, including nursing, midwifery and medicine). There is research evidence from the Australian context[(20)] demonstrating that executive HSCP leadership roles enable allied health leaders to use their influence in institutional planning and decision making. The findings from this study support this and suggest that in a situation where one sixth of the Irish Health Service Executive workforce have only limited representation in a small number of locations at

senior executive level there are negative consequences for the organisations, patients and service users and for HSCPs themselves.

Key message: HSCPs leadership has a positive impact at organisational, service and HSCP levels and mechanisms to support the development and implementation of these roles need to be considered as a matter of urgency. The findings from this study are being used as a basis to progress actions to address HSCP leadership issues and challenges within the Irish health system. Already they have informed a national objective in the annual service plan for the health services which supports an overall national priority in relation to strengthening clinical leadership. In addition, a high-level action plan and new strategic framework for HSCPs, based on the findings of the study and recommendations of the associated report along with other elements of the quality initiative, is currently under development. This plan will be monitored as part of its implementation.

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