

Quality improvement in action

Fostering clinical engagement and medical leadership and aligning cultural values: an evaluation of a general practice specialty trainee integrated training placement in a primary care trust

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ABSTRACT

Objectives To report on the extent to which a general practice specialty trainee integrated training placement (ITP) developed the leadership skills and knowledge of general practice specialty trainees (GPSTRs) and on the potential of the ITP to improve clinical engagement.

Design A case study method was used in a Kent primary care trust (PCT). Sources of data included face-to-face and telephone interviews (three GPSTRs, three PCT clinical supervisors, three general practitioner (GP) clinical supervisors and three Deanery/PCT managers), reflective diaries, documentary sources and observation. Interview data were transcribed and analysed using the constant comparative method.

Results All respondents were positive about the value and success of the ITP in developing the leadership skills of the GPSTRs covering three dimensions: leadership of self, leadership of teams

and leadership of organisations within systems. The ITP had enabled GP trainees to understand the context for change, to develop skills to set the direction for change and to collect and apply evidence to decision making. The ITP was described as an effective means of breaking down cultural barriers between general practice and the PCT and as having the potential for improving clinical engagement.

Conclusions The ITP provided a model to enable the effective exchange of knowledge and understanding of differing cultures between GPSTRs, general practice and the PCT. It provided a sound basis for effective, dispersed clinical engagement and leadership.

Keywords: clinical engagement, evaluation, leadership, organisational culture

How this fits in with quality in primary care

What do we know?

Quality and productivity have been placed at the heart of the NHS reforms and clinical leadership is seen as a key driver to ensure they become reality. In the context of these reforms, the role of the GP as a leader of innovation and improvement in care would need to be strengthened. Traditionally, medical education has not prepared clinicians for this type of role.

What does this paper add?

This paper reports the evaluation of an integrated training placement (ITP) in which GPSTRs spending two days a week in a PCT demonstrated effective leadership skills and knowledge, thereby strengthening the role of the GP as a leader and improving clinical engagement.

Introduction

Quality and productivity have been placed at the heart of NHS reforms and clinical leadership is seen as a key driver to making these a reality. The role of the GP as a leader of innovation and improvement, based on the needs of local communities, is expected to be strengthened.¹ The clinician is envisaged as acting as practitioner, partner and leader as health care is delivered by teams that include clinicians alongside management and support staff.²

Research evidence shows that significant change in clinical domains can be achieved with the cooperation and support of clinicians.^{3,4} However, placing GPs centre stage as leaders of innovation will require more than just clinical engagement and there has been an ongoing debate about the need to improve clinical leadership knowledge and skills through education and training.^{5,6}

Improving leadership training is important but Hays⁵ suggests that it is essential to be clear about the model of leadership that is promoted. Although engagement in formal organisational leadership roles is a symbolic mechanism for improvement of care, the complex subcultures in healthcare organisations and the role of informal leaders are also important.⁷ Within healthcare systems 'leadership roles are not defined in hierarchical management of reporting lines, but as overseeing components within a complex of related sub-systems forming the wider healthcare business'.⁸

Thus, if leadership is about the process of influencing and effecting change through the action of others then the range of individuals who might be considered leaders needs to be extended beyond those in formal leadership positions.⁷ Individual health professionals should share a leadership role to achieve change at the front line.⁵ Hays advocates a shared, democratic leadership model for primary care.⁵ Key attributes would include: understanding the business and core values of primary care; a clear vision of the future and effective communication.⁵ Effective leadership has three dimensions – leadership of self, leadership of others and leadership of organisations.⁹

There have been calls for medical education to increase its emphasis on leadership skills to ensure that the aims of Lord Darzi's review of the health service¹ are achieved. Traditionally, medical training has been of limited value in preparing doctors to take on leadership roles to bring about change in the system of care as they were taught to advance their skills and knowledge in order to treat individual patients within the healthcare system.^{10,11} Additionally, there has been variability in coverage of leadership training in postgraduate education across the UK.⁶ To improve this situation the NHS Institute for

Innovation and Improvement has been leading the development of the Medical Leadership Competency Framework (MLCF)¹² which defines the leadership competencies to be taught in undergraduate and postgraduate programmes for medical students, doctors and dental surgeons. The application of the MLCF differs according to the career stage of the doctor and the type of role they fulfil and widespread acceptance of the MLCF is now resulting in the integration of leadership and management competencies into all undergraduate and postgraduate curricula.¹³ However, it will take some time before the benefits of this are fully realised.

Therefore, to support the development of potential clinical leaders amongst those currently undergoing training, the Kent, Surrey and Sussex (KSS) Deanery in collaboration with one PCT in Kent established an ITP in which GPSTRs spent two days a week in the PCT for four months and led on a project for health improvement. The aims of the ITP were to enable GPSTRs to:

- gain a better understanding of strategic and contextual issues which affect the commissioning, design and delivery of health care to meet the needs of their population including service redesign, commissioning and the public health agenda (i.e. the business of PCTs).
- develop leadership, management and partnership skills.

Three GPSTRs were purposively selected from the cohort of GP trainees based on their expression of interest in participating and the willingness of their host general practice placement to release them. They were allocated a clinical supervisor from specially selected and trained senior staff within the PCT (the PCT supervisor) in addition to a clinical supervisor and a GP educational supervisor within the general practice in which they were based during the period of the ITP.

In the ITP the GPSTRs spent one day in a peer learning set facilitated by a GP programme director and attended PCT meetings and other events. On the second day they worked on individual predetermined projects. These aspects of the ITP were underpinned by a competency tool mapped to the GP curriculum and the MLCF.¹² The project work involved assessing and distilling evidence, engaging and communicating with a wide range of stakeholders and demonstrating leadership.

The curriculum elements, learning outcomes and assessment of the ITP were set by the KSS Deanery and administered by the PCT supervisors and there was a steering group to oversee its implementation.

This paper draws on the findings from the evaluation of the effectiveness, acceptability and appropriateness of the ITP. It focuses on the extent to which leadership skills and knowledge were developed.

Methods

A case study method was used – a case study is an empirical inquiry that investigates a contemporary phenomenon within its real life context, particularly when the boundaries between phenomenon and context are not clearly evident.¹⁴ Sources of data included face-to-face and telephone interviews, reflective diaries and observation. Documentary sources included steering group minutes, training schedules, project reports and assessment documents.

Participants and procedure

Nine of the 12 key participants were interviewed on two occasions – six weeks after the commencement and at the end of the ITP. The remainder were interviewed at the end of the ITP. Interviews took between 40 and 60 minutes and were tape-recorded.

GP specialty trainees

Face-to-face interviews were conducted with the GPSTRs. In their initial interviews they were asked about their expectations of the ITP, current understanding of PCTs, their learning experience and how they were demonstrating meeting the core competencies. In the final interview they were asked about how the ITP had worked, whether it had added value, their leadership and management skills and what changes could be made to the placement to make it more effective. In addition they were asked to complete a reflective diary to record situations where they felt they learned something new about the context of care, or engaged with other health professionals or PCT staff to benefit their practice.

PCT/deanery staff

Interviews were conducted with two deanery staff who were integral to running the programme, three PCT supervisors and one PCT manager. They were interviewed six weeks into the ITP (face to face) and again at the end of the ITP (telephone interview). They were asked about the extent to which they felt able to carry out their roles, facilitate learning and engage with PCT work, whether the ITP had added value, how the scheme was progressing, the skills and knowledge acquired by the GPSTRs and what problems they had encountered.

GP supervisors

The GP supervisors were interviewed by telephone at the end of the ITP and asked about their roles, the value of the ITP, the skills and knowledge gained by the trainees and whether the trainees were able to add value to general practice.

Data analysis

Tapes were transcribed verbatim and were analysed using the constant comparative method to identify categories of data, concepts and relations between variables. The data from all sources identified above were then synthesised to provide an overall picture of the effectiveness, acceptability and appropriateness of the ITP and to provide guidance on how the scheme could be rolled out and adopted within other PCTs.

Results

All respondents were positive about the value and success of the ITP and evidence indicated that the GPSTRs had met their core curriculum competencies at the level expected. The skills acquired included problem solving, time management, project management, setting objectives, setting milestones, conducting needs assessments, collecting evidence, networking, communication and delegation.

Most important, however, was the opportunity that the ITP provided to develop leadership and management skills. The GPSTRs reported observing effective leadership and management in action:

‘We’ve been watching leadership in action in various forms and we’ve been able to notice how people work as good leaders ... and the different types of leadership.’
GPSTR

‘I could see the way management works and that they have goals and aims and I never knew that management have a cycle or perhaps revisit what they have done and see how their aims come about or how they measure the outcome.’
GPSTR

The presence of role models within the PCT was vital to trainees’ learning and they reported gaining an understanding of how good leaders hold a vision of the future and motivate people to adopt that vision:

‘They should be able to produce a vision which others can follow ... and be able to see that vision and to see it all the way through, and develop teamwork or a virtual team, and go through the process and be able to deliver. One person that was really impressive was someone who chaired a meeting with about at least 30 people around the table, and the thing that really impressed me about him was – because obviously each member came with their own ideas, with their agenda, and he would listen to them just sitting there quietly, listening to them and then he’d reproduce it in a way that everybody would understand where that person was coming from ... and he did it throughout the meeting that was about 3/3.5 hours or so, and I think that was something – the endurance, body language and the consistency was there.’ GPSTR

There was consensus that the ITP enabled the GPSTRs to observe leadership in action and it enabled them to begin to develop the skills needed to become effective leaders. Three dimensions of their leadership skills and knowledge development were examined: leadership of self, leadership of others and leadership of organisations within systems (see Table 1).

Leading self

This dimension included the personal qualities of self-awareness, self-management and self-development. The following illustrates that GPSTRs felt they had developed self-awareness and the potential for self-development:

'I think I have identified the strengths that I am able to drive things forward ... I need to get more experience in different fields to see how I can develop various other styles of leadership and work in different circumstances.'
GPSTR

'They have sort of initiated us into the sort of leadership roles. I would say in terms of where we are, we're still at the infancy level, our undergraduate level. Yes we have done the ropes, the tricks of the trade, but we have to develop them.'
GPSTR

GPSTRs reported that the ITP had provided the opportunity and insight for them to become leaders, to recognise different styles of leadership and know when to apply them and to move forward in developing their own leadership.

Leading others/teams

This dimension included developing networks and working within teams to bring about change. These skills were developed through the individual project work:

'As a doctor we are not really involved in building our own teams and working with other people towards achieving a

Table 1 How Medical Leadership Competency Framework attributes were acquired

| Competency attributes | How developed in the ITP |
|--|---|
| Personal qualities | |
| Self-awareness | Role models, participation in meetings, own project, observation |
| Self-management | Own project, chairing meetings, role models |
| Self-development | Learning sets, own project, chairing meetings |
| Acting with integrity | Learning sets, own project |
| Working with others | |
| Developing networks | Own project, meeting PCT staff |
| Building and maintaining relationships | Own project, attendance at meetings |
| Encouraging contribution | Learning sets, own project |
| Working within teams | Own projects, learning sets, tutorials |
| Setting direction | |
| Identifying the context for change | Attendance at commissioning and high level meetings, own project, documents |
| Applying knowledge and evidence | Own projects, contribution to meetings, tutorials |
| Own projects | |
| Making decisions | Own projects, tutorials, observation and providing feedback |
| Evaluating impact | On PCT leaders |
| Managing services | |
| Planning | Learning sets, presentations, own project |
| Managing resources | Own project |
| Managing people | Own project |
| Managing performance | Not applicable |
| Improving services | |
| Ensuring patient safety | Within GP practice |
| Critically evaluating | Own project |
| Encouraging innovation | Own project |
| Facilitating transformation | Own project – limited in scale at this stage |

certain vision. But when I did my project I was ... able to identify key people in the PCT who would be able to help me with my project and I was able to initiate that stage of building my own team and able to use their skills and expertise ... to work towards my project. I had to, you know, push them or drive them towards my goal.' GPSTR

'He has learned ... negotiation, how to build a team.' Clinical supervisor

It was evident that the GPSTRs had demonstrated a vision and were able to persuade team members to support and deliver their vision. Work carried out on two of the three projects has led to changes in practice and the work was highly valued by the PCT.

Leadership of organisations within wider healthcare systems

This dimension of effective leadership involved identifying the context of change, setting the direction, applying knowledge and evidence and making decisions. Thus, a sound understanding of the business and core values of the organisation or area which is to be led would be needed. At the commencement of the ITP the GPSTRs reported having little understanding of the work or values of PCTs:

'I was afraid of PCTs in a way that I didn't know about the PCT and how does it work ... the PCT in my view was an alien who was trying to influence the GP practice all the time.' GPSTR

Following the ITP all respondents reported a marked increase in the GPSTRs knowledge about the workings of the PCT, practice-based commissioning, the commissioning cycle, world-class commissioning, wider health policy and the implications of these for patient care:

'He (GPSTR) has acquired the language (of the PCT). He knows what they are talking about, he knows how they function, he is not intimidated by the meetings and the language ... he knows the structure, the people.' Clinical supervisor

The ITP enabled GPSTRs to recognise the need to align their perspectives with those of the PCT to ensure clinical engagement and improve care for their patients:

'We have learned a lot about the way the PCT works ... we are the GPs of the future and we will be the ones who will be interacting with the PCT. Now if I'm able to understand where the PCT is coming from and what their whole point of view is I might be able to integrate our own thought processes better with them so that in the end, the end-product is the same and our aim is to deliver the best possible care to our patients, and it will be better if we work as partners and not as somebody completely detached from each other, and I think this is what this has done.' GPSTR

'I think from now working in the PCT I know that when I work as a GP in the community I can see what the vision of the ... PCT itself is because I've been to many of the meetings and I've seen what the overall goals are, so I know their five-year plans and I know their two-year plans and I can derive things from there because in my mind when I am working with patients I will be able to see what are the gaps so I can map those in my mind and I can approach the PCT or I can feed back to the PCT that this is what is perhaps needed and what is not needed.' GPSTR.

Supervisors also reported cultural barriers and organisational silos being broken down. For example, a clinical supervisor reported a much improved perception and understanding of the PCT:

'I have gained from it in meeting some of the people at the PCT, getting to know just where the PCT is and getting some idea of what goes on there, networking with other GPs ... I would be far more likely, having gone through this, to put myself forward, maybe, for a leadership role than I would have before.' Clinical supervisor

Whilst for the PCT supervisors the ITP improved their understanding of clinicians:

'It's brought a benefit in understanding colleagues who are doctors and have that doctor training, medical training. It has helped in understanding why some clinical engagement is really difficult.' PCT supervisor

Thus, the ITP had facilitated GPSTRs understanding of the context for change, development of skills to set the direction for change and application of evidence to decision making, placing them in a stronger position to lead innovation and improvement in patient care with a meaningful engagement with the PCT.

Discussion

Improving the health of the population by delivering effective health care is dependent on the support and active engagement of clinicians in their practitioner activities and also in their managerial and leadership roles. Indeed, Clark argues that to be a competent clinician requires doctors to be able to manage themselves and their time, work within a team, understand when to lead and when to follow and to influence effectively by knowing how the system within which they work functions.¹⁵ However, Dickinson and Ham argue that individual values and perceptions, team and microsystem cultures and wider systemic factors must be aligned to produce effective engagement in medical leadership.⁷ PCTs manage primary care services but levels of GP clinical leadership and engagement are variable and recognised as difficult to achieve.¹⁶ Understanding of each other's values and practices is

limited by the fact that they work within 'semi-detached silos'.⁴

The findings from the evaluation of the PCT-based ITP suggest that the ITP addressed a number of potential barriers to GP clinical engagement and to creating potential clinical leaders:

- It provided a model to enable the effective exchange of knowledge and understanding of differing cultures between GPSTRs, the wider general practice and the PCT.
- It provided a sound basis for developing effective, dispersed clinical engagement, the role of GPs in improving the quality of patient care and the knowledge and skills base to bring about change.
- It provided the opportunity for GPSTRs to practice leadership skills in context and to consolidate any medical leadership skills that will be acquired as part of their undergraduate or postgraduate training.

The ITP was a highly successful, novel pilot programme which enabled GPSTRs to gain leadership skills and knowledge in three dimensions of leadership. It also enabled GPSTRs to see the potential for aligning PCT and general practice values for the benefit of patients. If rolled out, so that the majority of GPSTRs spend time within a PCT, it should consolidate other approaches to developing GPs as leaders of innovation and improvement in health care thus effectively meeting the needs of their communities. However, as this was a new type of placement it was expected that there would be a number of lessons to be learned which would help in the process of improving and mainstreaming it. The main difficulties identified related to the swine flu epidemic, which diverted the attention of the PCT supervisors; this would be addressed in future by training more supervisors. PCT supervisors were initially unfamiliar with the assessment tools used for GPSTRs and would have benefited from prior observation of an assessment being undertaken. The need for more structured meetings between the GP, education and PCT supervisors was also identified. Suggestions for improving the learning experience of the GPSTRs included providing them with the opportunity to shadow PCT leaders and to undertake work which would enable them to manage resources.

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PEER REVIEW

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CONFLICTS OF INTEREST

None.

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