

Practice Leaders Programme: Entrusting and Enabling General Practitioners to Lead Change to Improve Patient Experience

Marion Lynch, PDHSc, MSc, MSc, PgCMed Ed, PgCStComm RGN RMN
Nigel McFetridge, MB, BCh, MRCGP, DFPHM

Abstract

This program focused on practice-level service change as a means of improving patient care and developing leadership skills of 19 general practitioners (GPs) and aimed to: promote and support change in leadership thinking and practice, facilitate practice-led service improvement, support career development, support continuing professional development, and contribute to the development of extended GP specialty training. Nineteen GPs, in Milton Keynes, United Kingdom, both new and experienced, volunteered to participate. Milton Keynes was selected on the basis of it being an area of relative social deprivation and underperformance in national quality indicators. New and experienced GPs took part in bi-weekly Action Learning Sets, individual coaching, and placements with the national and local health organizations. Each participant completed a project to improve the quality of patient care. The learning sets supported the process and 11 of the GPs chose to complete a postgraduate certificate in General Practice. Evaluation consisted of analysis of development of leadership competencies recorded through Medical Leadership Competency Framework pre- and postintervention assessment, analysis of learning recorded in participants' reflective diaries, analysis of learning process recorded through participant focus groups, and analysis of learning and project outcomes recorded in project reports. Outcomes showed statistically significant increases in leadership competencies, changes in services and care, improved confidence and changed culture. GPs expressed increased confidence to "have a go" and motivation to "make a difference." This innovative narrative, complex, neuroleadership-based program continues to inform educational policy and practice, increasing leadership competencies, and to improve the quality of patient care.

Introduction

The multicase system study reported here looked at the principles and outcomes of the Practice Leaders Programme (PLP), an innovative health care quality-improvement project in general medical practice in Milton Keynes, United Kingdom (UK). This report is

an abridged version of an extended article that will appear online in 2011 at www.thepermanentejournal.org. The increasing need to lead innovation across many separate organizations in local health communities means that new thinking is required so that the involved organizations can develop a shared vision, imple-

ment change, and sustain quality improvement to improve health and health care. Through the PLP, general practitioners (GPs) improved their leadership competencies, created a culture of confidence in leading change, and gained knowledge of and experience in designing, implementing, and evaluating service improvement (Figure 1). Nineteen GP-led improvement projects during 2008-2009 affected more than 140,000 patients. In 2009-2010, the PLP continued as an educational model in Oxfordshire to address new solutions for unplanned admissions to hospitals across a population of 600,000, and it is now being used to rethink local solutions in preparation for GP-led commissioning of health care.

Background

With the shift in function, form, and funding of health services in the UK and the largest planned redesign of the National Health Service (NHS) in a generation, there is understandably some anxiety and excitement about how things can be done.

Equity and Excellence: Liberating the NHS¹ sets the direction for the new NHS. It gives those working in the community in the UK an opportunity to design, commission, and deliver new community models

Marion Lynch, PDHSc, MSc, MSc, PgCMed Ed, PgCStComm RGN RMN, is Associate General Practitioner Dean and Academic Lead at the Oxford Deanery in Oxford, England and Reader in Clinical Epidemiology and Social Medicine at Buckingham University, Buckingham, England. E-mail: email@marionlynch.com

Nigel McFetridge, MB, BCh, MRCGP, DFPHM, is a General Practitioner and Professional Development Coach at the Oxford Deanery in Oxford, England. E-mail: nigel@changedthinking.com

of health care and create new ways of working. This will require GPs, most of whom have no leadership training, to rapidly think like leaders and lead in a way such that people across different organizations share the same vision and are positively energized to achieve it voluntarily. In 2008, we recognized this, realizing that a new leadership-development approach was needed that would work for leading independent, highly intelligent, adaptive professionals working in a variety of organizations to continuously improve individual care for patients within very tight funding constraints.

The Milton Keynes PLP was set up as a pilot to explore and try out a new way of delivering leadership development. It was iterative and based on coaching and facilitation to lead a practice-based improvement project, rather than being based just on education and training. A “Plan-Do-Study-Act”²² approach was set within a core framework.

The evidence and concepts underpinning the construction and content of the PLP are cognitive and cultural. Narrative medicine,^{3,4} neuroleadership,^{5,6} and complex adaptive systems theory⁷ provided some of the evidence base for this way of knowing, as well as the frameworks for understanding the context and environment and applying new knowledge and understanding. The new thinking was away from diagnosis-based problem solving and toward solution-focused vision, goals, and planning; away from closed, linear system thinking and toward complex adaptive system thinking; away from knowledge acquisition and toward knowledge creation and application.

Analysis of the demographics, deprivation, quality indicators, and patient satisfaction scores across the South Central Strategic Health Authority (the funding organization) highlighted specific localities in need of an educational intervention aimed at improving quality of

care and clinical leadership. Assessment of the organizational cultures of the host organizations (Primary Care Trusts) pointed to those most resistant or responsive to innovation (Cultural Web).⁸ Further investigation of communities’ needs and general practice priorities allowed the project to invite those practices most in need or ready to change to join the program.

Methods

Milton Keynes was chosen because some practices provided care in areas with significant social deprivation and some also struggled with low patient access and low patient satisfaction scores. It was thought that their patients would benefit most from the program and that working with those practices would be the best test of the program. Also, the local commissioning organization was eager to try new and innovative ideas to improve practice performance.

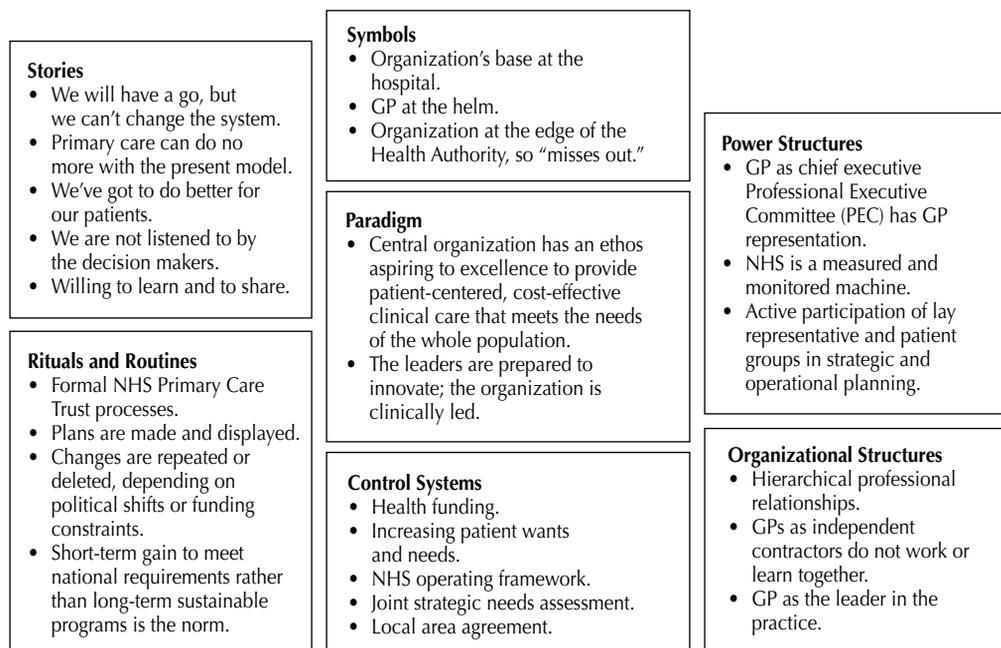


Figure 1: Components of the “Cultural Web” used to map the Practice Leaders Programme.

GP = general practitioner; NHS = National Health Service.

Intervention

Successful implementation of research into practice is influenced by three core elements: the level and nature of the evidence being used, the context or environment of the intervention, and the method of implementation. All three elements have been taken into account in the design and delivery of the PLP.

The evidence and concepts underpinning the construction and content of the PLP are cognitive and cultural. Understanding systems, patients, and mindfulness of oneself is crucial, and using narrative as a way of knowing is core to this process. Narrative medicine and neuroleadership provide some of the evidence base for this way of knowing.

The knowledge and skills needed to design and deliver the projects are both collective and individual. Complexity theory, complex adaptive systems, and health improvement models provide frameworks for understanding the context and environment and applying new knowledge and understanding.

Nineteen GPs took part, seven of whom recently qualified. The program ran from October 2008 to September 2009 and consisted of biweekly all-day learning sets, personal coaching, and general support for the design, delivery, and evaluation of quality-improvement projects in their practices. All participants were offered the opportunity to register for a higher degree with Oxford Brookes University, Oxford.

The 19 GPs were split into 3 learning sets of 6 to 8 people (one specifically for the recently qualified GPs). The participants elected to stay in the same learning sets through the program, and the content of the two learning sets for the established GPs stayed broadly similar.

The first action set was particularly important, as it was the first

time that the new approach was used and was expected to be well outside most GPs' comfort zones. The facilitator focused on building trust in the groups and on developing a willingness to try new ideas. Ground rules for behavior were established, and key barriers to success were identified, along with ways to overcome them. The ideas of a thinking environment and new listening skills were introduced through some simple exercises.⁹

Subsequent learning sets were structured loosely within an overall framework (see Sidebar: The Learning Set Framework), with typical action learning combined with a mix of theory delivered by the facilitator. Content was introduced in response to the expressed needs of the participants, often to help them move toward solutions. Participants agreed on actions for their projects during each learning set and brought the outcomes to the next set. They learned to help each other find new solutions, plan further

actions, and run the learning sets themselves. Each participant was also given access to eight telephone coaching sessions from an independent coaching company. The coaching model established personal success criteria and personal goals that were then, if wanted, integrated within the action learning sets.

Learning set content included an introduction to service-improvement models, change management, social marketing, health economics, lean thinking, leadership skills, neuroleadership, mythodrama, de Bono six hats thinking,¹⁰ presentation and communication skills, report writing, patient perspectives, Myers-Briggs Type Indicator¹¹ and team leadership, chairing groups and meetings, public involvement, NHS structures, policy development¹² and process mapping, and discussions and presentations of the individual projects.

At the end of the year, the participants described their personal journeys and project successes at a major presentation.

The Learning Set Framework

Term 1. Start the Journey

1. Understand:
 - Change in a complex and adaptive world,
 - Leadership competencies to deliver effective, personal, and safe health care for your patients,
 - The culture and context of the patient, the profession, and the practice within National Health Service priorities.
2. Identify your personal development needs.
3. Define your service-improvement project.
4. Discover a compelling vision of a future culture that motivates individuals to change behavior, then set inspired and challenging goals.
5. Plan the big steps to your goals and start the first small steps.

Term 2. Evolve, Lead, and Deliver

1. Think in new ways to make the best use of your brain—focus on solutions.
2. Develop your leadership competencies and experience transformational leadership.
3. Deliver service improvements.

Term 3. Complete the Journey, Review, and Celebrate

1. Complete and sustain the service improvement.
2. Develop your leadership competencies further.
3. Evaluate the program, cultural change, and personal competencies.
4. Share your insights and reflections.
5. Write fantastic reports; celebrate and share your achievements.

Evaluation

The data were analyzed by independent researchers to identify changes in competency in individuals and emergent themes in learning process and project outcome. This higher-order analysis identified convergent and contradicting themes. The findings have been reported as organizational reports and academic papers. The outcome measures included the following:

- Medical Leadership Competency Framework self-assessment forms completed before and after the program.¹³
- Session evaluation forms completed for each learning set.
- Service-improvement project reports and reflective accounts from participants.
- Focus-group transcripts.
- Other evidence, such as program handbooks, videos of presentations, program documentation, and correspondence.

The evaluation methods took account of narrative and stories viewed through the lens of Kirkpatrick's four levels of evaluation¹⁴ as well as quantitative data (which alone does not capture the complexities of modern health care organizations or educational interventions). The evaluation aimed to:

- Determine the nature and scope of any changes in leadership thinking and practice among participants in the context of the educational intervention.
- Record changes in the learning and continuing professional development needs of participants over the course of the educational intervention.
- Assess the scope and impact of the service-improvement projects.
- Identify supporting evidence to encourage future uptake of the program.

Data were analyzed by individual researchers independently of the program leader, facilitators, and coaches. Professional responsibility and lines of support were agreed on in relation to handling anonymous and confidential data. Content was gained from all participants, and learning contracts established roles and responsibilities. All program data were shared with the researchers, and no identifiable patient information was used in the study. No ethical approval was required for the program.

Results

The pre- and postprogram Medical Leadership Competency Framework 11 self-assessment demonstrated a statistical significant improvement in scores at the end of the program for 79 of the 80 items. This indicated that participants' perceptions of their abilities in these competencies had improved (generally from 3 ["I need to improve this"] to 2 ["I do this satisfactorily"] or 1 ["I do this well"]). Of the 79 scores, 78 demonstrated significance at the $p > 0.01$ level (ie, highly statistically significant).

Themes from the Findings Evidence

- "Challenged my ideas and made me think in different ways."
- "Made me believe in what I am doing."
- "Learned why we all think differently."
- "I appreciate the link between neuroscience and leadership."

As participants progressed with the program and the delivery of their service-improvement projects, their reflective accounts changed, showing recorded knowledge gradually being transferred into practice, linking with Kirkpatrick's fourth level of knowledge.¹⁴

The service-improvement projects provided the vehicle for participants to put theory into practice and apply the knowledge gained while working in a supported environment. The success of this approach encouraged all participants to feel confident in leading and implementing further improvement projects in their current and future roles.

There was a realization among some participants that although they might previously have been eager to introduce changes into their practices, they were now able to see why attempts had been either unsuccessful or not well received. As a result of the program, participants noted a greater understanding of how to approach service improvement and change in a way more likely to engender success.

Context

- "Taught me how to get things done."
- "Many small but significant changes."

All participants reported having shared knowledge and skills acquired as a result of the program, with practice colleagues. This resulted in a cascade of learning beyond that of the immediate participants.

Facilitation

- "Time to learn about ourselves."
- "We own our improvements."
- "Solution focussed will now be my way forward."

Participants commented on how they had benefited from being able to draw on the knowledge and experience of those leading the program. Similarly, once trust had been established, participants valued the support that their peers provided in each of the learning sets. The sets were viewed as a safe environment in which to experiment, discuss new ideas, and request help in addressing problems. The expressed value of individual

telephone coaching was mixed, with established GPs appearing to appreciate this component more than the newly qualified GPs.

Leadership

- “Permission to have a go.”
- “We now have a can-do culture.”
- “We now have less hierarchy.”

At the beginning of the program, participants were asked for their views on leaders and leadership. Although able to express their opinions on good leadership, several were concerned that they would not be able to become leaders themselves, feeling that leadership was innate. Their reflective accounts note that by the end of the program all participants had gained confidence and felt sure of their own ability to lead and to sustain service-improvement work.

Learning Process

Participants were initially apprehensive about delivering their projects. However, there was an early acceptance that a service-improvement project was an appropriate way to put knowledge and skills into practice. By the end of the program, the reflective accounts indicated that the projects were one of the highlights of the program. The initial apprehension had turned to feelings of immense personal and professional achievement, a real sense of a successful journey. New aspects of the projects emerged and the pace picked up as participants brought new solution-focused skills, new concepts, and new ways of thinking to each step they took. The learning sets provided a space where participants could bring problems and the group would work together to solve them and to find a solution. The sessions that introduced the model for improvement,² Myers-Briggs Type Indicator,¹¹ and neuroleadership⁶ were noted as be-

ing particularly helpful in relation to the projects. The projects also helped participants to acknowledge that as clinicians they can lead change and be more directly involved in the rollout of new services. It also widened their view of partnership and the need to learn with others as well as work with them:

“I think that it would have been better if we could have learned with non-GP colleagues who are also trying to improve the quality of care.”

Coming to the program at later stages in their careers meant that the experienced GPs were ready to learn and motivated to engage with the subject matter in a different way than were their newly qualified colleagues, who were still looking for the “right” answer. The newly qualified GPs observed that the program had given them the confidence to think about settling into a practice and actively contributing to the development of the practice, thereby improving services for patients from the start:

“We would like to set up our own practice together, the New Family Practice.”

However, the PLP had made the newly qualified GPs more aware of the need to take a long-term view of their career development and to consider this when applying for either salaried or partnership posts:

“A practice would have to be willing to support me as a future leader, not just treat me as a working GP.”

Established GPs noted that the new GPs gained a knowledge and skills base that had usually taken the established GPs more than 10 years to develop. This is a swifter movement from novice to expert than traditional learning experiences allow.

Learning Outcomes

All participants had a greater understanding of the following:

- The importance of prior research for fully understanding the nature of the project being undertaken.
- The necessity of collecting data to provide an evidence base to be able to subsequently discern and measure change.
- Greater self-awareness.
- Increased confidence.
- Recognition of the importance of engendering team support for successful service improvement and how this might be achieved.
- Excitement regarding the improvement of patient services.
- An eagerness to achieve greater patient involvement in future practice changes.

Service-Improvement

Project Outcomes

“I am now involving patients much more.”

“Happiest admin team I have seen in 20 years.”

The service-improvement projects chosen by the GPs were very varied and practice specific. There was a wide range of development between the practices, so some projects that might seem very small to a highly developed practice needed huge cultural shifts to achieve in others. The projects could be grouped by:

Access: Improving patients’ access to different services offered by the practice through physical redesign of the office to make room for more consultation space, off-site medical record archiving, improved education for patients regarding available services through newsletters and other forms of communication, introduction of Web-based online booking and check-in, appointment reminders via text messages, online repeat prescribing.

Quality of care: redesign of services from the patient’s perspective; formation of new patient-rep-

representative groups; development of health-promotion material and information packs; redesign of chronic-disease management systems, especially diabetes and kidney disease management; setup of a new obesity treatment service.

Practice performance: becoming a training practice, introduction of internal performance management for physicians, expanding the breadth of the role of practices' nurses, establishing a nurse-led minor injury treatment service, reorganization of practice administration to allow more time for staff-patient contact, increasing investment in staff training across the practice.

Conclusion and Recommendations

Improvement in the quality of patient care is a complex undertaking, and its evaluation can produce substantial amounts of quantitative and qualitative information. Quality improvement has a social nature, has a focus on changing performance, is context dependent, is a complex and nonlinear process, and features adaptation and reflection. The PLP has provided an innovative way of meeting the learning and development needs of both newly qualified and established GPs. It has proved itself highly effective in supporting participants to implement service improvement that engages patient care and positively affects patient care. It is rare for educational programs to be able to demonstrate this direct link between educational processes and outcomes. The program is particularly suited to leading innovation in distributed-care systems.

We recommend that the model:

- Be adapted across medical education and inform quality- and safety-assurance programs (General

Medical Services 2010, the contract under which UK GPs work).

- Be continuously adapted to promote professional development toward person-centered, community-based, professionally led quality improvements in health care.
- Be used by teams such as clinical leader networks, commissioning groups, and clinicians to change thinking and thus promote radical, innovative solutions.

A year after the educational intervention, its impact and sustainability is evident. The participants in Milton Keynes continue to lead local change, using the skills and networks formed during the program. Feedback from one GP summarizes the impact:

"I now know that I have the skills to lead change and improve care and the confidence to get my voice heard."

The program ran again in 2009-2010, bringing a multisector group together to find solutions to unscheduled care across a health community. Positive outcomes of these projects and increased leadership competencies have secured funding for a third year to move forward the implementation of new models of care in the UK. In times of severe budgetary restraint, UK funding for educational interventions will normally be agreed on only for programs that demonstrate evidence of impact on quality of care and professional competence. The PLP does both.

The PLP represents a radical departure from traditional "chalk and talk" leadership training, which often focuses on studying leadership, toward providing a creative space for participants to think about and experience thinking like leaders and then build that new thinking onto their existing mental maps. The combination of action learning sets with individual one-on-one coach-

ing allows people to think about their thinking in a way that meets both their needs as a group as well as their needs as individuals.

The PLP thus provided an innovative way of meeting the learning and development needs of both newly qualified and established GPs. It proved itself highly effective in supporting participants to implement service improvement. Our view of leadership, based on "the ability to transform performance by improving thinking,"⁵⁵ is also a good description of coaching and facilitation. As the participants improved their thinking during the program, they realized that the approach worked. This encouraged them to confidently try out their new learning with others. The program also drew on the developing field of neuroleadership, defined as "an emerging field of study focused on bringing neuroscientific knowledge into the areas of leadership development, management training, change management, education, consulting, and coaching."⁵⁶ The neuroleadership approach to understanding leadership proved very powerful for the physicians, as it started from their existing knowledge of neuroanatomy and neurophysiology from medical school.

Humans construct and share their knowledge through narrative rather than theory. The design of the intervention and the analysis of the findings were informed by a conceptual framework featuring narrative medicine and complexity theory. The stories of leadership and evidence of impact developed through this program weave patient stories with improved professional satisfaction and improved care and therefore bring the intervention to life.

Because it is rare for educational programs to be able to demonstrate this direct link between educational

processes and outcomes, this article is therefore a call to action to implement this research and develop a new way of learning to inform a new way of thinking, to inform new models of care. By enabling GPs to think differently and by empowering them to practice differently, new thinking, new relationships, new solutions, and renewed professional satisfaction emerged as a result of the complex, emergent, narrative-based program.

The PLP educational approach brings research into practice and education into action and is particularly suited to leading innovation in distributed-care systems, where health and social care in a community is provided by many independent but networked people and organizations. These care systems are typically complex and adaptive. This is important because these types of care systems will increasingly characterize 21st-century health and social care.¹⁵

With this in mind, the PLP approach will now inform higher-level academic programs and community-oriented inspirational projects. The PLP approach will underpin a master's degree in person-centered medicine¹⁶ with Buckingham University, bringing narrative medicine, complexity, and quality-improvement processes together to improve patient care and, through local action learning sets, bringing the public, professionals, and policy makers together to improve thinking and to improve patient outcomes and the quality of care. The approach is becoming embedded in NHS education for leadership models¹⁷ and contributing to the evidence base for professional education programmes aimed at improving the quality of patient care in complex adaptive distributed systems.¹⁸ ❖

Disclosure Statement

The author(s) have no conflicts of interest to disclose.

Acknowledgment

Katharine O'Moore-Klopf, ELS, of KOK Edit provided editorial assistance.

References

- Equity and excellence: liberating the NHS [monograph on the Internet]. London, UK: Department of Health; 2010 [cited 2010 Nov 15]. Available from: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353.
- Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. The improvement guide. A practical approach to enhancing organizational performance. San Francisco: Jossey-Bass; 1996.
- Charon R. The patient–physician relationship. Narrative medicine: a model for empathy, reflection, profession, and trust. *JAMA* 2001 Oct 17;286(15):1897–902.
- Charon R. Narrative and medicine. *N Engl J Med* 2004 Feb 26;350(9):862–4.
- Ringleb AH, Rock D. The emerging field of neuroleadership. *NeuroLeadership Journal* 2008;1(1):3–19.
- The Emerging NeuroLeadership [monograph on the Internet]. New South Wales, Australia: Field NeuroLeadership Institute; 2010 [cited 2010 Nov 18]. Available from: www.neuroleadership.org/index.shtml.
- Wilson T, Holt T, Greenhalgh T. Complexity science: complexity and clinical care. *BMJ* 2001 Sep 22;323(7314):685–8. Erratum in: *BMJ* 2001 Oct 27;323(7319):993.
- Johnson G. Mapping and remapping organisation culture: a local government example. In: Johnson G, Scholes K, editors. *Exploring public sector strategy*. Essex, England: Pearson Education Ltd; 2001. p 300–17.
- Kline N. Time to think: listening to ignite the human mind. London, UK: Octopus Publishing Group; 1999.
- De Bono E. Six Hats Thinking. 2nd Revised Edition. London: Penguin; 2000.
- Briggs-Myers I, McCaulley MH, Quenk N L, Hammer AL. MBTI Manual. A guide to the development and use of the Myers-Briggs Type Indicator. 3rd Edition. Menlo Park, CA: CPP Inc; 2003.
- High quality care for all: NHS next stage review final report [monograph on the Internet]. London, UK: Department of Health; 2008 [cited 2010 Nov 15]. Available from: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825.
- Medical Leadership Competency Framework [monograph on the Internet]. Coventry, UK: NHS Institute for Innovation and Improvement; © 2006–2010 [cited 2010 Nov 15]. Available from: www.institute.nhs.uk/assessment_tool/general/medical_leadership_competency_framework_-_homepage.html.
- Kirkpatrick DL. Evaluating training programs: the four levels. San Francisco: Berrett-Koehler; 1996.
- Murray R. Danger and opportunity: crisis and the new social economy [monograph on the Internet]. London, UK: National Endowment for Science, Technology and the Arts; 2009 [cited 2010 Nov 15]. Available from: www.socialinnovationexchange.org/files/Prov%2009%20-%20Danger%20and%20Opp%20v9%20methods.pdf.
- International Network for Person-Centred Medicine [homepage on the Internet]. International Network for Person-Centred Medicine; © 2009 [cited 2010 Nov 15]. Available from: www.personcenteredmedicine.org.
- Leach C, Scallan S. Practice Leaders Programme Evaluation. Winchester, UK: NHS Education South Central; 2009 [cited 2010 Nov 21]. Available from: www.workforce.southcentral.nhs.uk/pdf/NESC_RD_SS_PLP_20090707.pdf.
- Lynch M, McFetridge, N, Scallan S, Leach C. Poster abstract: Practice Leader Programme: stories of leadership. WONCA Conference; 2009 Sep 16–19 [cited 2010 Nov 21]; Basel Switzerland. Muttentz, Switzerland: EMH Swiss Medical Publishers, Inc. p S203. Available from: www.smw.ch/docs/PdfContent/smw-12931.pdf.