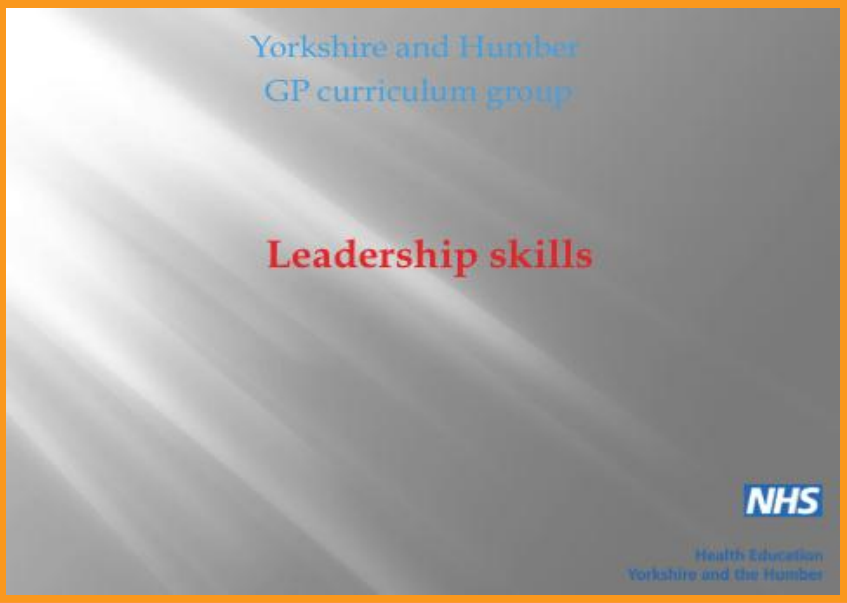
Developing people for health and healthcare



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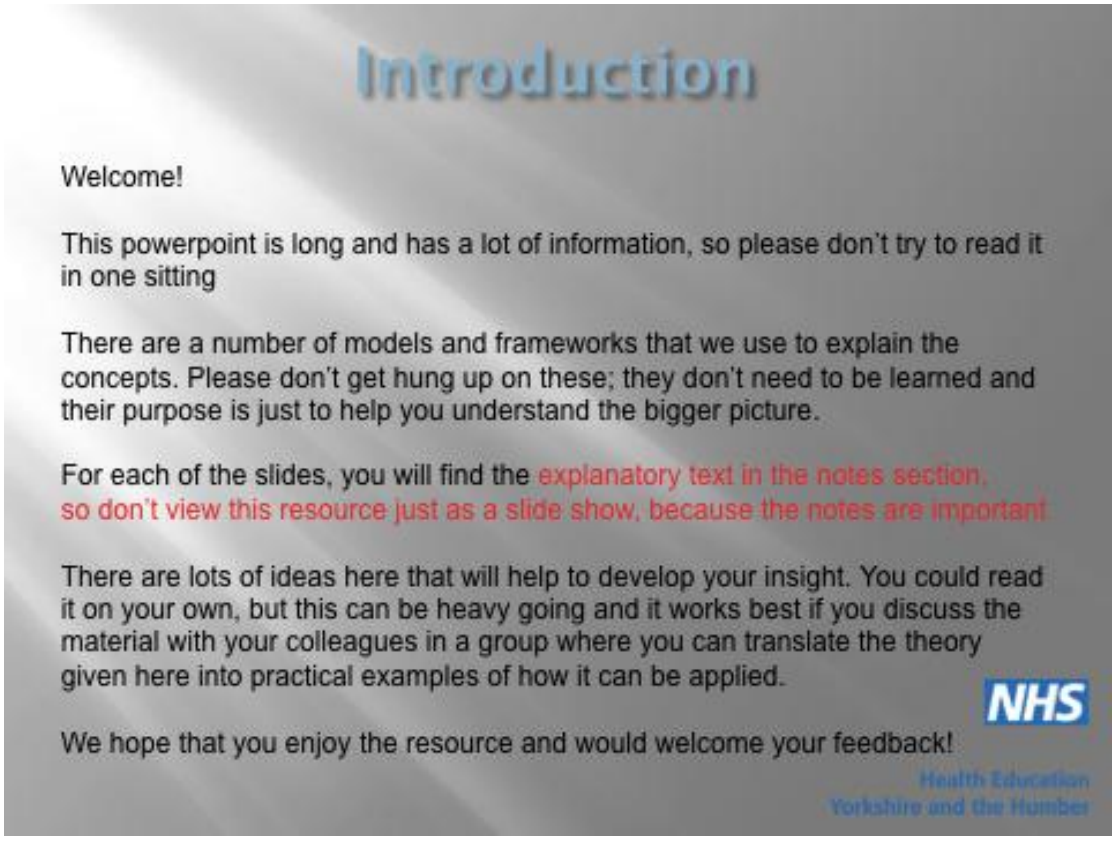
Contents

Section		Page
1	Introduction……	3
2	Why leadership?.....	4
3	What is leadership?.....	8
4	Skills of leadership……	10
5	Skill groups……	20
5.1	Listening, feedback and reflection……	22
5.2	Organisational skills……	26
5.3	Working in teams……	28
5.4	Dealing with conflict and pressure……	36
5.5	Improving services……	39
6	Developing an action plan for your scheme……	42
7	Share your experience……	45


Introduction
Welcome!
This powerpoint is long and has a lot of information, so please don't try to read it in one sitting
There are a number of models and frameworks that we use to explain the concepts. Please don't get hung up on these; they don't need to be learned and their purpose is just to help you understand the bigger picture.
For each of the slides, you will find the explanatory text in the notes section, so don't view this resource just as a slide show, because the notes are important
There are lots of ideas here that will help to develop your insight. You could read it on your own, but this can be heavy going and it works best if you discuss the material with your colleagues in a group where you can translate the theory given here into practical examples of how it can be applied.
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We hope that you enjoy the resource and would welcome your feedback!
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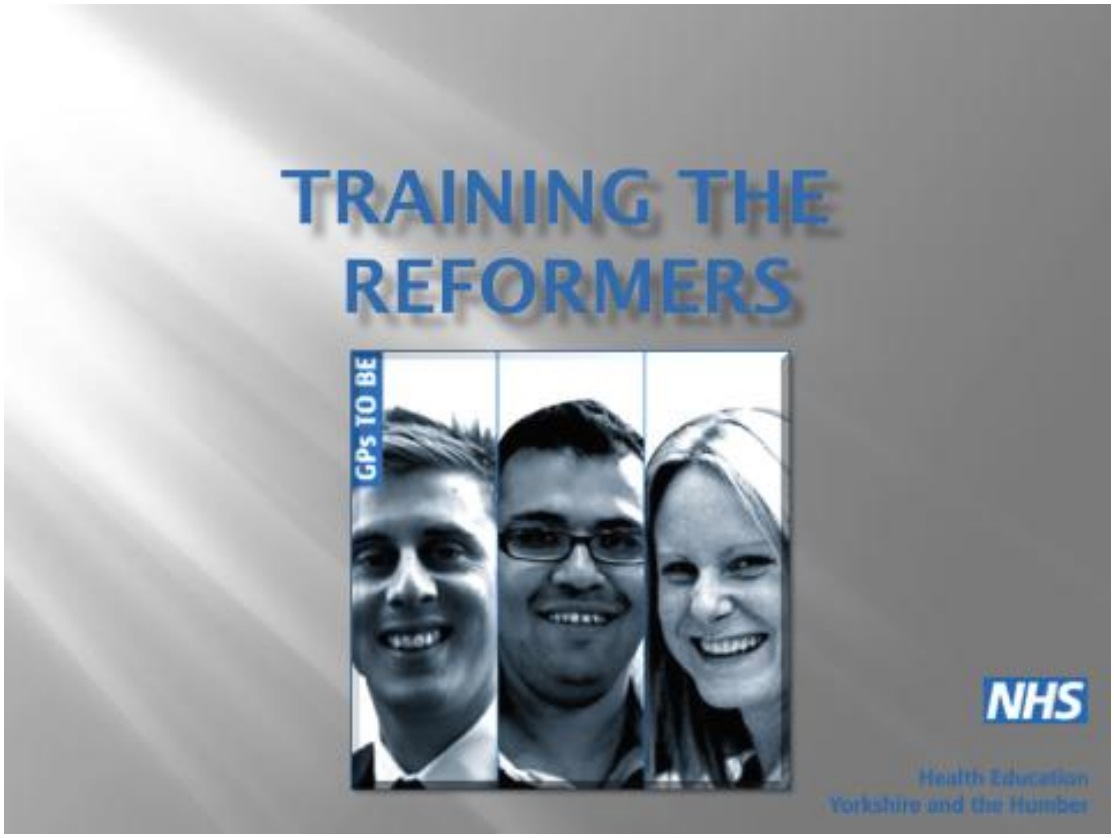
We wouldn't blame anyone for looking at the topic of 'Leadership' and having great concerns over what it means and how on earth to teach it on top of the already overloaded curriculum!

We would like to reassure our colleagues on both counts. Firstly, this vision of 'leadership' is not about training the hierarchical leaders of tomorrow, the 'leaders' of our profession and institutions. It's about helping everyone to have the skills to make a difference and we explain this further in the text.

Second, our experience is that leadership skills are in the main, not a new and additional part of the curriculum. As educators, we teach most of this already although we usually don't signpost how what we teach in a clinical context can also help trainees to become better leaders. So the challenge is not in adding a new module to the curriculum, but in adding leadership awareness and insight to the teaching we already do.

In addition to this resource, we would recommend those of you using the MRCGP eportfolio competency framework to look at the word pictures in the final column (labelled 'excellent') as many of these describe the skills that doctors use when acting as leaders to make changes to their workplace.

As an educational community, our purpose is to train the next generation of GPs. This has always been an exercise in guesswork because we can never be certain what the future will hold. The skills and values that we teach today may not be the ones that a future society will consider the most important and as someone once said, if we teach students to master what we currently know, they will be ' perfectly adapted for a world that no longer exists'……. so why bother?



There's no need to be despondent, however, because there is nothing new in what has just been said; the curriculum will almost always lag behind the needs of the contemporary workplace. However, we are living through times of great change for the NHS and therefore for health professionals and for the patients we serve.

The future GP will not only provide 'general practice' but will redefine what general practice means and how it is delivered. As teachers, we are becoming aware that we are not so much training GPs in our own image, but are training a generation that will different from us…a generation of *reformers*.

We know from the feedback of GPs recently trained, that although they want to take an active role in the changes happening around them, they feel inadequately prepared. What does this mean for us as educators?

We believe that it means that our educational community has to develop its understanding of *what it takes to make changes happen* so that we can help trainees develop their skills and be better prepared to face the future. All doctors in training are expected to become clinical leaders in the future, but what does that mean and how can it be achieved?

It’s not enough just to raise the expectation; we also need to provide trainees with a toolkit of skills so that they can firstly work out what needs to change, then work with people to make improvements and finally evaluate the outcomes and learn from the process of change.

Of course, none of this can occur if we have a situation in which the blind are teaching the blind and so the first step must be to help teachers feel that they are prepared for the educational challenge ahead. This is is new territory and many of us were not taught leadership skills. For this reason, we certainly don’t claim to be experts and our purpose with this resource is to help colleagues develop insight and to encourage the process of local discussion and sharing of teaching experience that will prepare us all for the future.

You might like to discuss this!

The word 'leadership' has many interpretations and often evokes strong feelings, both positive and negative. There is no 'correct' definition, but we use the term to mean a set of attributes that allow individuals to take responsibility for being a ***driver***, taking a leading role in identifying where change needs to happen, setting direction for the group and facilitating the changes.

However, leadership also encompasses attribute that allow individuals to engage constructively in the ***process*** of change, working within a team. This means that very often, the individual will contribute constructively under the direction of others within the team. Put another way, the skills of leadership and the skills of 'followership' are related. Notice that we talk of 'individuals' rather than 'doctors'. This is because even though the members of a team will have different expertise and levels of responsibility, most of the skills are applicable to all those who engage in making changes…. and these individuals will not (and should not) always be doctors.

The aim in GP training is to educate trainees to have the skills of **'distributed leadership' as** described above that can be applied to practice life. Later in the doctor's career, some GPs may take on levels of responsibility and leadership beyond the practice and become leaders in the more traditional hierarchical sense, perhaps associated with a position or title that reflects that role. However, the skills that we teach in training remain relevant to *any* form of leadership that the doctor may aspire to whether formal or informal. As you read about the skills in more detail it is

important to remember that although trainees may need to be familiar with all the skills, they do not have to develop or practise all of them, or do so to the same level of expertise.

In the context of GP training, we can begin to see that leadership is *not* a matter of personality. It doesn't matter whether individuals are charismatic, bland, introvert or extrovert; distributed leadership can be practised by anyone because anyone can learn to use initiative and take a lead role with a team.

By understanding these ideas we can explain to trainees, many of whom do not see themselves as leaders, what we mean by the term and why this form of leadership is for ***everyone***.

Leadership is a large term that comprises a number of concepts. In the next few slides, we will describe the ***concepts*** that are relevant to leadership in the GP context and then go on to show how these concepts can be used to derive a ***skill base***.

We should clarify for the purists amongst you, that we use the term 'skills' as shorthand for the ***knowledge, skills, values and attitudes*** that are required.

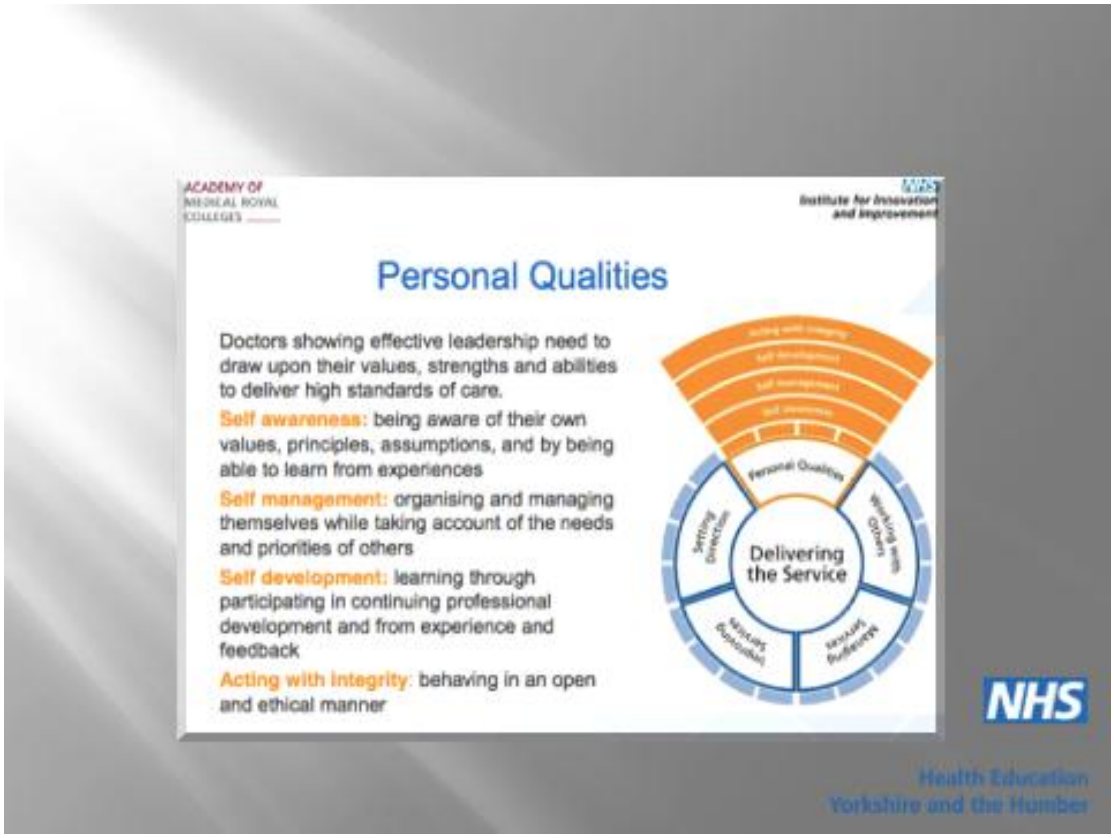
It is useful to think about leadership skills in a similar way to **consultation skills.** Being a good consulter is absolutely central to being a good GP. We could argue that being a good leader is in its own way equally central to the needs of the patient community and the profession. Both are highly complex and require individuals to bring together a number of skills, tailoring them to the context and using the right skills at the right time and in the right place. As teachers, we understand the different consultation skills and teach these both separately and together. Crucially, the most important learning occurs by ***doing***, i.e. by applying skills in context and learning the art of bringing the right skills together at the right time.

Just as with the consultation, leadership cannot be learned just by practicing the skills separately. The most important leadership lessons occur by having the opportunity to combine the skills in a leadership situation, and the challenges for educators are to:

•Understand the skills

•Create opportunities to practice the skills

•Give feedback that allows students to improve their skills and bring them together in a more fluent and proficient way



The next 4 slides show the domains of leadership that were developed by the working group representing all the medical specialties i.e., not just general practice. The framework is known as the **medical leadership competency framework or MLCF**. This was a complex piece of work and it forms the best developed evidence-base for our understanding of leadership in a medical context. These domains describe a number of ideas and attributes but are not in themselves a list of trainable skills.

As you will see, the domains of leadership centre around 'delivering the service'. In other words, leadership is not an abstract idea or theoretical notion, but has a very clear practical application that we must not lose sight of in our training.

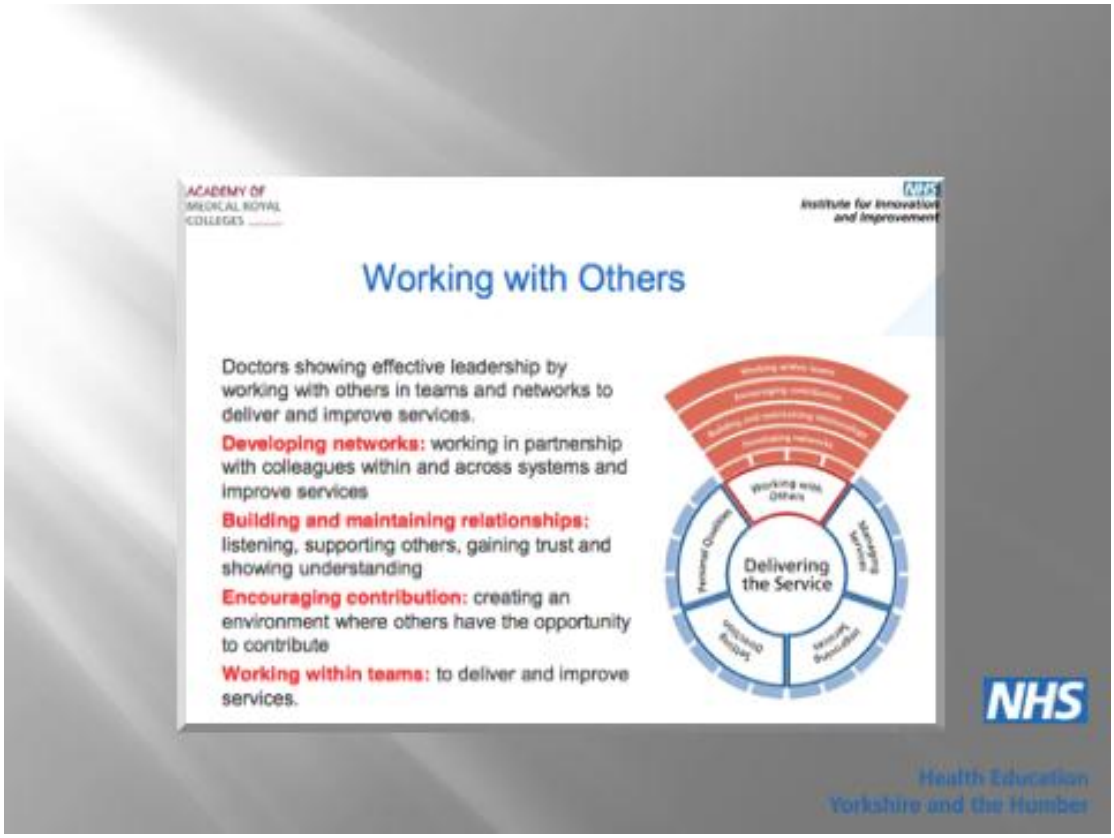
Although it isn't mentioned explicitly, the ***motivation*** for developing leadership skills is very important and should be discussed openly. One important motivation, which every professional shares, is the simple but profound wish to 'make a difference' to the community, organisation or service that we are part of. The leadership skills enable us to do exactly that, whatever the scale of our ambition.

The MLCF shows us the deep foundation of leadership rather than its superficial features. For example, this first slide shows that the doctor's 'personal qualities' are at the heart of being a leader. This makes sense when you read the detail, which shows the importance of being self-aware, of

learning from experience being committed to ongoing development. Thus we can see that by teaching leadership, we are also teaching many of the most important aspects of professionalism.

Leading on from this, many of the attributes that are listed under leadership are vital to our other functions as clinicians and team workers. In other words, by teaching leadership we are teaching many important ***transferable*** skills that the trainee will use in clinical and non-clinical activities. This opens up the important (and we believe, necessary) opportunity to teach these transferable skills across the many contexts in which they are used, helping the trainee to understand leadership not as a 'bolt on' to the GP curriculum, but as a suite of mostly generic skills that underpin the curriculum and help doctors to understand some important aspects of professionalism.

This is a useful area to discuss as educators and learn from each other's teaching experience. For example one of the leadership skills identified later is the ability to 'work flexibly'. How does this skill become apparent in clinical as well as in non-clinical activities? Leading on from this, how might the trainee be shown examples of this skill in action in these different situations, how might they learn that these skills are transferable between contexts and how might they be supported in taking their skills to a higher level?



This domain is about working in teams, but goes beyond just being a good communicator or someone who is easy to work with. Leadership requires us to network with people, seeking out others who might help to develop ideas or help to share the commitment to make changes happen. Working with others not only requires the ability to build trust and engage with people, but also to encourage **and create opportunities for them,** something that many employers and 'bosses' fail to do.

Change, particularly significant change, is rarely easy to bring about and often the most significant barriers are not resources, but (as you will know from your own experience) …..people!

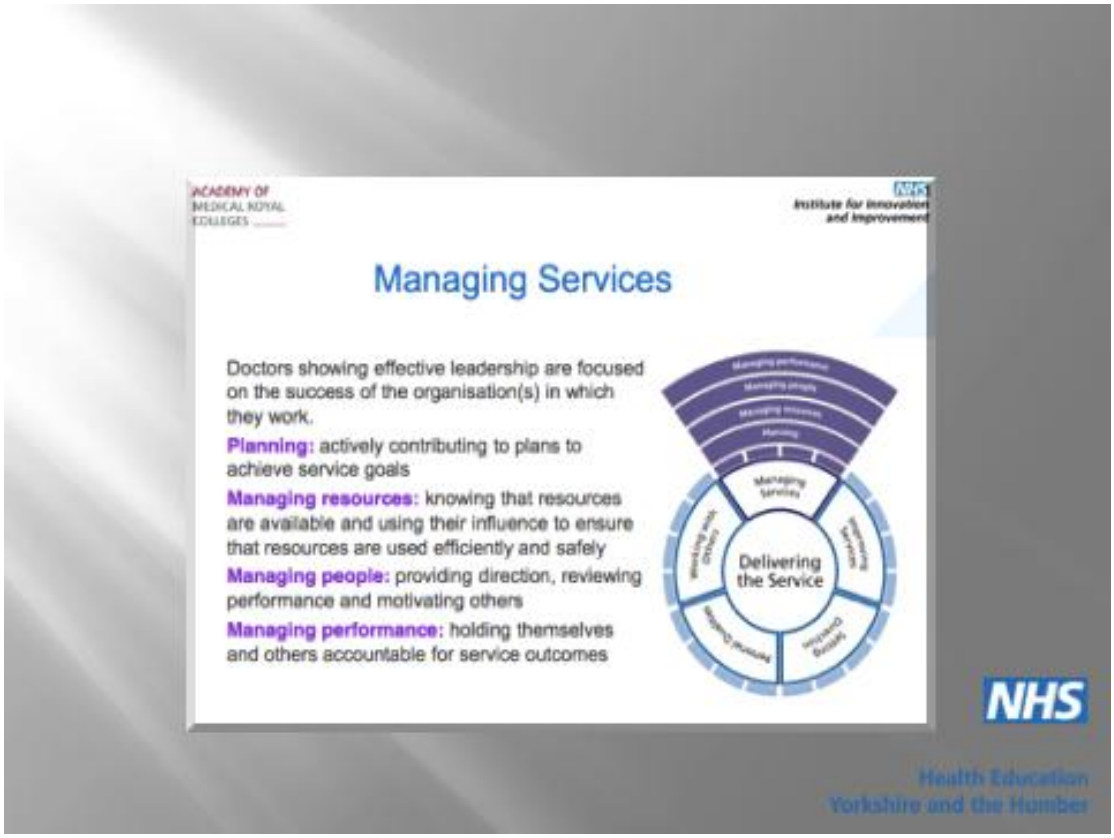
How, then, do we handle people who are resistant to change, need to be won over, block ideas or create difficulties?

This is the more difficult side of team working and at present, is rarely taught explicitly despite the fact that we all know as practitioners how difficult but necessary it is to develop these skills…… if only to survive the process of working with our colleagues and to maintain our job satisfaction.

Dealing with the barriers is one side of the domain. The other is how we encourage the ***development*** of individuals and groups of people in order to make teamwork more effective. The two are separate

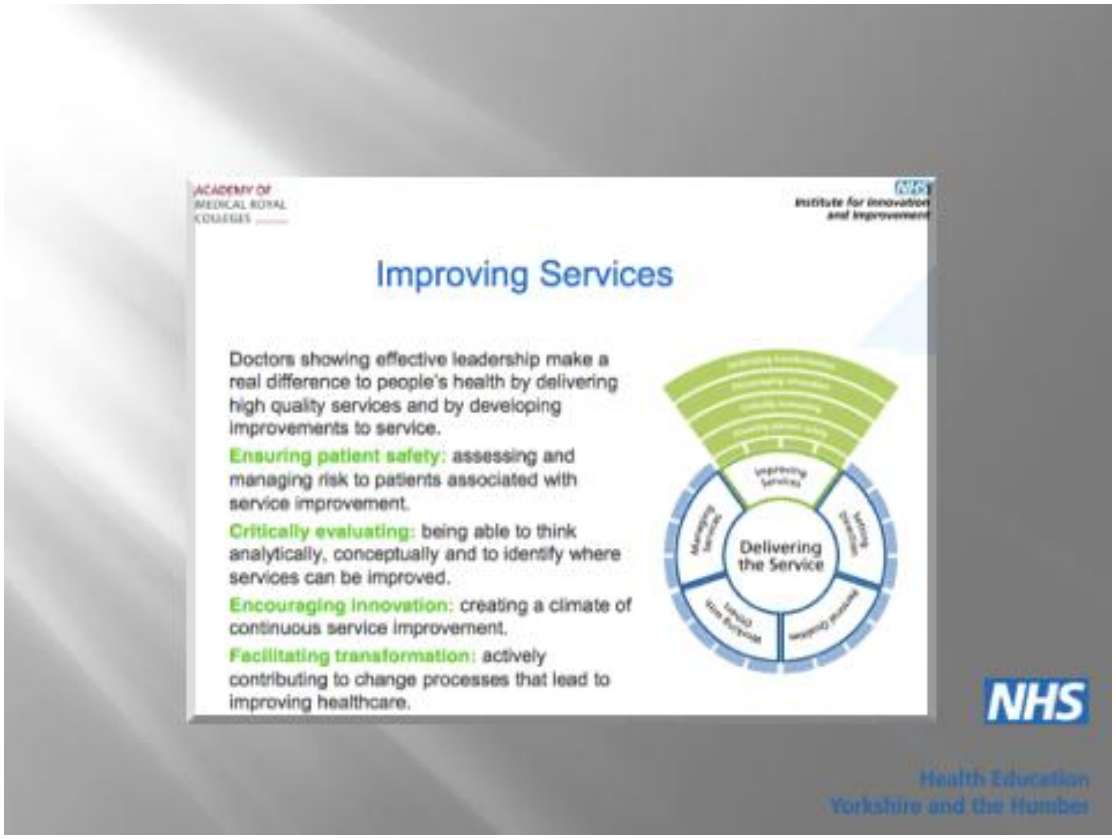
but related. For example, developing individuals will require us to understand the abilities and interests of individuals, which may include trying to understand personality types and preferences. This knowledge coupled with personal interest and support can be used to develop capabilities and the ambition to grow into areas of responsibility that colleagues thought was beyond them.

Team-working requires us to understand how people work as groups and how to bring people together, get the group to gel and then achieve results. Bruce Tuckman's four stages of group development (forming, storming, norming, performing) describes this well and also, interestingly, shows that because you can't perform to your best until you have 'stormed', conflict has a useful and necessary place in team development. Understanding such lessons helps us to see difficult behaviour in a more constructive light, anticipating problems and managing them in a more helpful way.



This domain describes one level of making changes, which is about looking at what we ***currently*** do and seeing if we could do it better. Compare this to the next slide, which goes a stage beyond this.

This domain also describes something that we touched on in the previous slide, which is the need to manage people by being aware of their performance and holding them (and ourselves) to account. You might want to think about how you would teach these skills. Although they can be appreciated through observation or reading, they are often better learned through direct experience, perhaps by being given the opportunity (with appropriate support and supervision) to bring about some change in the workplace.



This fourth domain builds upon the others. It goes beyond asking 'How could we do what we currently do, but do it ***better***?' and instead asks 'How could we do things ***differently***?'

'Innovating' brings greater risks than tweaking a system, because the system is being deliberately de-stabilised. These are not just risks to the business of general practice; there may also be risks to patient safety.

Partly for these reasons, the opportunity to transform services is generally entrusted to more experienced doctors.

If they can't take charge, how else then might trainees be involved in the process? If you look at the detail of the slide you can see how, even without taking responsibility for a service improvement, they can be encouraged to suggest innovations, undertake analyses/evaluations and take a lead role in *part* of a larger project.

As we can see, there is a relationship between the last 4 slides:

1 Personal qualities underpin everything else…… if we can't reflect and develop insight, we won't learn from experience and thereby make changes more effectively in the future

2 Distributed leadership is all about working with others; knowing how to motivate and facilitate, knowing how to manage individuals and groups who are resistant to change and ultimately helping people to improve in attitude, ability and performance.

3 The first stage in making changes happen is often about looking at what we currently do and seeing if it can be done better. By 'better' we mean more safely, clinically effectively, cost effectively etc.

4 Then, we can apply leadership skills to the process of ***transforming*** what we currently do i.e. doing things differently by: selling the idea, generating support and providing the initial drive to make it happen.

As we can also see, many of the domains touch upon organisational or 'management' skills. An area that is under-represented in the domains are the ***business*** skills that GPs need in order to lead and develop their small businesses as independent contractors. This model might change in time to come but because it will remain relevant for the foreseeable future, we will refer to these business skills later in this resource.

OK… now that we have looked at the domains of leadership, we can think about the ***skills***. In Yorkshire and the Humber, we undertook an exercise with educators in the GP School in which we looked at each of the leadership domains and then developed a set of skills drawn from them. It isn't necessary to know which skills are drawn from which area of the MLCF as in any case, many of them overlap.

Instead, in the next few slides we describe the skills and cluster them in ***skill groups*** for ease of understanding

Here are the skill groups that we derived from the leadership domains. The detail will be given in the next few slides and this exercise is intended to help clarify the set of skills that need to be taught.

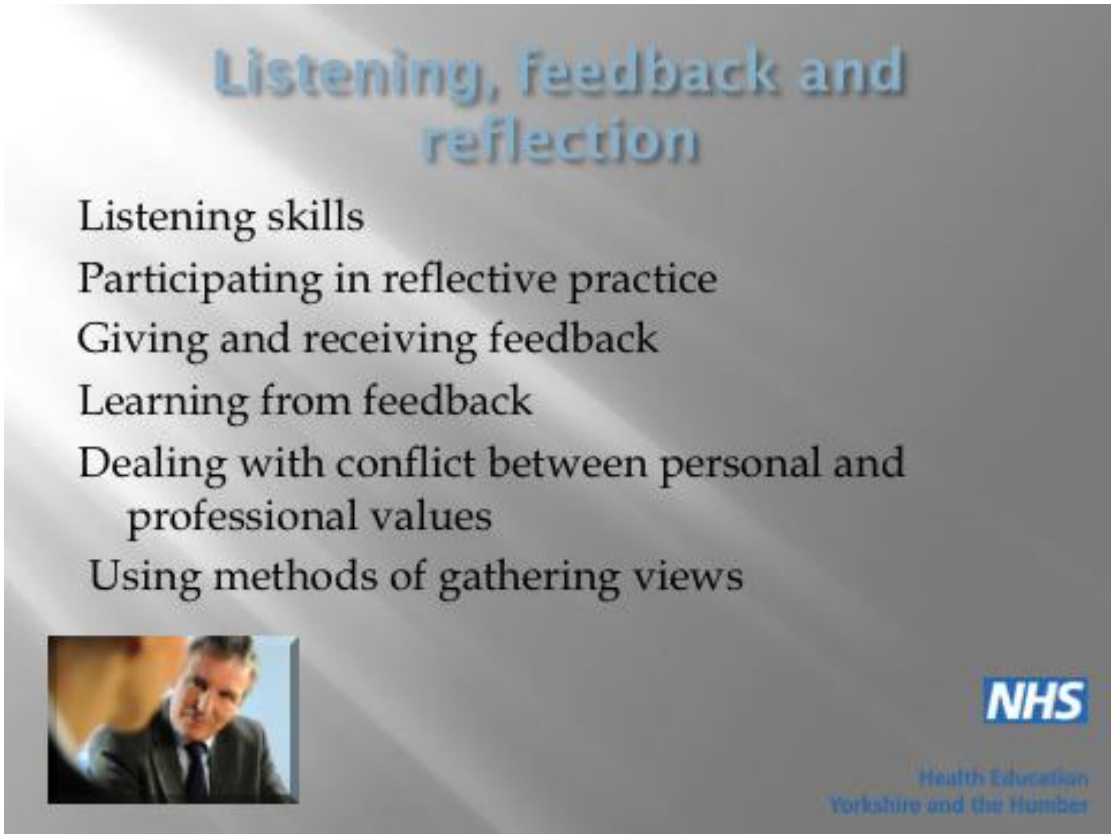
Although the skills are being separated in groups, this is simply to help us understand the ***range*** of skills; we are not suggesting that the skills should be ***taught*** separately except where you consider it appropriate.

As you will recognise, these skills are rarely used in isolation but are usually used in combination, tailored to a particular task or function. They are therefore usually better taught in an integrated way within the natural context such as a task, in which they are used.

As you discuss these skills with your colleagues, think about ***when*** in the training timeline you would seek to introduce them. Of course this will partly depend on the trainees' prior experience and readiness to be taught. However, there are other factors that we should consider such as the types of experience that need to be made available and whether the skills can only (or best) be taught in primary care or whether they can also be taught in secondary care.

'Leadership' is not a new area and as you will see, many of the skills are ones that you will recognise even if some of them have never been formally taught. There are several challenges when it comes to teaching. One is to make the skills explicit when they are being taught. Another is to develop techniques by which to teach them.

We point out a number of times that the skills are transferable across clinical and non-clinical contexts and between our lives in work and away from work. When we start to understand how and where the skills are seen in these different contexts, we begin to see a whole new range of opportunities for learning. To give an example, people can learn to lead a group in the scouting movement or learn to work as part of a team when playing sport. What is learned from these activities can be applied in medical practice and more than in many areas of the GP curriculum, teaching leadership skills gives educators ample opportunities to be creative and novel in their teaching.



Most of this will seem familiar as it is a central part of our communication skills curriculum and 'personal and professional development' teaching. We can also appreciate that this group of skills is transferable to all contexts, clinical and non-clinical, in which the doctor works with other people.

The leadership skill groups describe many facets of how change is made in the workplace but this particular suite of skills (listening, feedback and reflection) describe how doctors learn to make the most important changes of all i.e. the changes within *themselves*.

The skills seem familiar and teaching them may seem straightforward; however, there is an important general point to be made. Leadership, management and business skills are also taught by other professional communities and we are at the start of an exciting journey as medical educators in learning from them and translating their insights into medical contexts.

Looked at another way, although we are expert educators, we would be short-sighted to be too self-reliant and we would also be foolish to attempt to reinvent a wheel, parts of which are understood much better by other communities than by ourselves. As well as accessing a literature-base that is new to us, we have access to communities such as our practice managers who may be much better placed to teach part of the skill set.

So: how can we broaden our teaching base and empower others to share the opportunity?

What can communities, particularly non-medical ones teach us? As an example, think about one of the skills in this slide: **'learning from feedback',** and how you currently teach this….and indeed whether you do.

Then, look at this article from the Harvard Business Review

http://hbr.org/2014/01/find-the-coaching-in-criticism/ar/1

How does this influence your attitude to learning from other communities? In practical terms, how would this article influence your teaching?

Now, let's look at some of the skills listed in the slide in more detail:

Listening skills are often taught in relation to the consultation by observation and feeding back using video, joint consultations, role-play etc. Let's consider two ways in which 'Listening' is important.

Firstly, especially when coupled with questioning, it is a vital tool for gathering and interpreting information. Doctors who don't 'data gather' well by asking and hearing, or who don't make reasonable interpretations, will have great difficulties in the consultation and beyond. We increasingly understand that the interpretation of information is culturally mediated and that doctors trained in other cultures need particular support in being taught to interpret well. To make a wider point, with 'leadership' we are moving into territories outside the consulting room door, beyond the traditional medical culture. We could therefore argue that ***every*** trainee will need help with listening and interpreting in new communities which include managers, employees and patient groups.

Secondly, techniques such as active listening help greatly in showing that the doctor is interested, and this can be the start of developing a trusting relationship.

How do these two aspects of listening transfer to situations outside the consulting room? For example, how could trainees learn to listen better to their colleagues, interpret better (with fewer misunderstandings) and show that they are interested at a human level? What types of feedback

might help us here? ….and who would be the most appropriate people to give feedback and to teach the trainee?

Participating in reflective practice is a sine qua non for developing insight into oneself and into the work environment. Insight into both is needed, because both need to change over the course of a professional lifetime. Although reflection is indispensable, we cannot assume that trainees know how to do it or that they necessarily value it; for example they may simply regard it as navel gazing or as a chore to be undertaken for the eportfolio! The mechanism can be taught explicitly through such models as Kolb's learning cycle and practised so that it becomes routine. To help doctors see that reflection is not an unfamiliar activity, they could be encouraged to discuss how reflection is used when thinking about issues, such as relationship problems, outside work.

The great power of reflection comes when it stops being just a 'competence' that is demonstrated through log entries and group discussions and becomes a habit… a routine part of the way the doctor thinks in order to make sense of experience and learn how to improve. Reflective practice encourages us to:

Be alert to information (perhaps gained through listening and feedback),

Articulate our thoughts and emotions in order to make sense of them and then

Use these insights to improve our future understanding and behaviour.

The practical relevance of reflection has to be *demonstrated* and this can be done, for example, by linking the reflection around important events (such as complaints and near misses) to commitments made in a personal development plan and ultimately, to the realisation that some self-improvement has occurred as a result.

Once the importance of reflection is appreciated, we can enhance it by discussing how 'reflective practice' can be improved when dealing with life issues, and how reflection could be used in the workplace e.g. with non-clinical colleagues, in order to learn from experiences and improve the service.

These skills are attracting greater attention as professionals increasingly struggle with changes to the volume of work, the types of work and the routines of work in practice. They could be thought of as **'survival skills'** but beyond simply surviving, these skills also help us to contribute to change, gain job satisfaction and thereby sustain a rewarding career in the workplace. Because of this, they should be on the agenda from the earliest days in training, because if they are not, then the ability to cope and maintain morale in the longer term will be at risk.

Time management

Time management may be learned in many contexts from being punctual and running surgeries to time (!), through coping with on-call and OOH to completing assignments such as ePortfolio work by the deadlines.

Interestingly, repeated failure to complete administrative tasks and meet deadlines has been correlated with poor professionalism more generally. In terms of teaching techniques, discussion of the experiences of being pressured is always useful but in addition to this, having the chance to observe doctors who manage time well (perhaps by sitting-in on the doctors surgery) can be a powerful way of learning helpful behaviours.

Look at the following questionnaire to evaluate your **time management skills**:

http://www.mindtools.com/pages/article/newHTE_88.htm

‘**Prioritisation**’

Prioritisation is an important skill in a clinical context, but may not be recognised as such. For instance, the process of deciding which patient we deal with next, which problem from a patients list to deal with now and which to postpone, how to use our knowledge of priorities to safety-net safely….and so on….are all examples of using the skills of prioritisation.

These can be made more explicit so that the trainee develops insight into the process and can then be discussed more widely, such as the process of making choices (e.g. childcare arrangements) that impact on work-life balance. Lessons learned from clinical practice could be applied to other problems.

There are some awareness-raising questions that we could ask, for instance: Is the doctor *aware* that choices are being made and of their influence over them? What’s the process of deciding what’s important and what’s less important? What’s the doctor’s justification of the choices made? How does the doctor check that the priorities remain appropriate? And so on.

Prioritisation games such as ‘in-tray’ exercises, where a doctor has to choose a priority from a number of simultaneous problems in the in tray and justify the choice, can be helpful and fun.

Delegation

The art of good delegation might be learned in the early days from the doctor’s experience of being delegated to…maybe through comparison of a good experience and a poor one. Later in training, the trainee may get an opportunity to delegate to a team member…. maybe even to someone more senior?

‘**Working flexibly**’

Working flexibly contains the notion of ‘adaptability’ . At one end of the continuum this might be represented as *responding* to change but at the other end it would include the ability to set limits through assertiveness/decisiveness. Somewhere in the middle is the ability to negotiate, manage change and to prepare oneself for change.

In *intellectual* terms, adaptability requires trainees to be open-minded, constructive and creative. In *organisational* terms, the trainee might need to adapt to the needs of the workplace by for example working shifts, taking on different types of work (such as triage) or working with new colleagues. Situations of potential conflict, where the trainee feels pressured to change, can be useful starting points for discussing this area.

As we can now appreciate, the organisational skills that we have discussed have a powerful role to play in helping the doctor to cope with change and **cope with pressure**. Put another way, if the

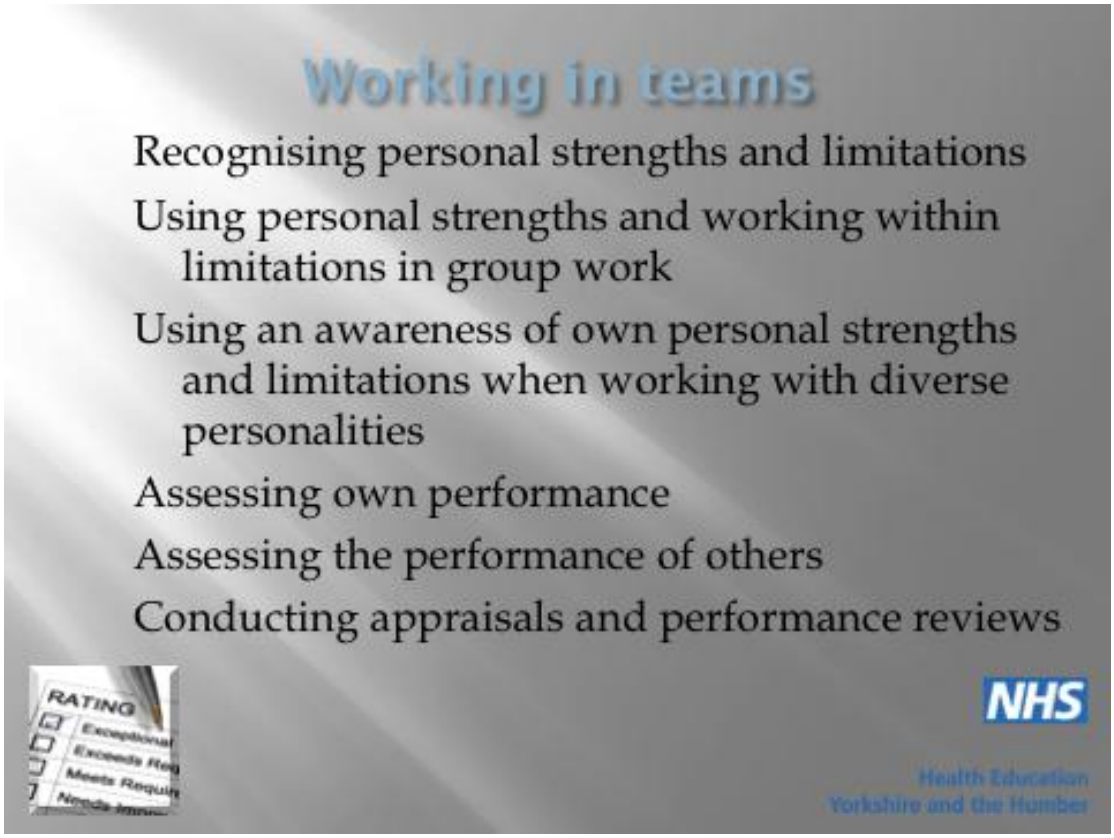
trainee is struggling with coping with pressure, we might look closely at the organisational skills to see to what degree the problem lies there and to what degree, elsewhere.

This group of skills is a good example of how each skill should not be considered in isolation because in reality, they are used together when addressing real life problems or issues.

As an example, all of these organisational skills are used in the change management context when the doctor has a lead role in managing a project.

Have a look at the following questionnaire to evaluate your **project management skills**:

http://www.mindtools.com/pages/article/newPPM_60.htm



This is a large and important group of skills, continued on the next two slides. As we can see, working in teams is not just about the other people we have dealings with.

Teamworking starts with the ability to understand *ourselves*, make best use of our abilities and hold ourselves to account.

Some of these skills are relatively new territory for most trainees and move the doctor into more difficult areas such as making judgements on the performance of other people, which changes the nature of relationships because it goes beyond 'fitting in' and just being nice to the staff. When done appropriately, relationships are deepened and improved, rather than destroyed, by such action.

'**Recognising personal strengths and limitations**'

These skills may be manifest in a number of ways, including at its most basic level, knowing when to call for help. Strengths and limitations could refer to any aspect of personal competence, but we will focus here on some attributes that are particularly important to leadership:

1. ***Leadership style.*** Leadership ability should not be thought of not as an inborn trait, but as a suite of capabilities that people bring into play according to the situation. The Hersey-Blanchard Situational Leadership theory is instructive in showing how leaders should be able to balance emphasis on the ***task*** with emphasis on the ***relationships*** with the people they're leading, depending

on what's needed to get the job done successfully. As individuals, our natural or 'default' preference may be more towards one than the other. Raising self-awareness can help us to understand the importance of both and to modify our approach accordingly.

Leadership style can be tailored to the level of maturity/experience of the person or group being led, with less developed people or groups needing a more directive style and those with higher maturity needing support and delegation rather than being given detailed instruction on what to do. (Tannenbaum and Schmidt)

'Mind tools' is a useful resource which we will quote several times. Look at the questionnaire ' How good are your leadership skills?'

http://www.mindtools.com/pages/article/newLDR_50.htm

2. Understanding our ***personality type*** can be useful and is part of raising self-awareness and insight. This is a complex and sensitive area (see http://www.businessballs.com/personalitystylesmodels.htm).

Some models are worth knowing about, such as the 'Big Five' personality types, which is an academically validated model. In addition to this, the Myers Briggs model and Belbin team role model are powerful and widely used tools of analysis. However, like all tools that claim to probe the psyche and personality, they do not represent an absolute truth and can be toxic if misused. If they are to achieve the intention of personal growth and development, they need to be used at the appropriate time(s) and interpreted carefully through discussion with someone who understands how the tools are applied.

3. ***Problem-solving & decision-making*** are key thinking (cognitive) skills. Try the following questionnaires:

http://www.mindtools.com/pages/article/newTMC_72.htm

http://www.mindtools.com/pages/article/newTED_79.htm

This area is not new to clinicians, but there are some facets that have a greater emphasis in these questionnaires than in the context of *clinical* decision-making. Which do you think these are?

We have suggested before that leadership skills are often generic and are used in both clinical and non-clinical contexts. The area of problem-solving & decision-making is a good example of that; having used the questionnaires, what have you learnt from the 'leadership' application of problem-solving and decision making? Looking at it in reverse, how could this make you a better clinician by changing/ enhancing the way you apply these skills in the consultation?

‘Using an awareness of own personal strengths and limitations when working with diverse personalities’

This requires trainees to be able to reflect and develop insight into their performance. Beyond this, a knowledge of team types, such as described by Belbin, and how the performance of a group benefits from each type, can be invaluable in learning to understand …and later value…. the approach of people who are very different from ourselves.

What teaching techniques might be used here? One entertaining example is where individuals act out particular roles or personality types in a simulated team meeting!

There is an overlap here with respecting ‘diversity’ more generally, which we will discuss on the next slide.

These skills mainly relate to the doctor's ability to be a 'formative' influence on people. This depends upon having an active interest in others, respecting the differences between people not just in a theoretical way but practically, by making the best use of the different perspectives and skills that team members bring. Building on this, the skills involve motivating and nurturing the team, particularly through difficult times when morale might be under threat.

We mustn't lose sight of the fact that good leadership is about the people. As one respondent to the Yorkshire and Humber survey said:

The key to leadership is making yourself as a leader available and accessible. Making every person in the team an individual by spending time with them and learning about them and their knowledge and skills, empowering them is vital as they are more likely to work with you.

Motivating individuals and teams

This is also a transferable skill. Many trainees nowadays are taught motivational techniques designed to help patients to change their thinking (e.g. addressing low mood and poor self-esteem) and behaviour (e.g. lifestyle issues, recurrent DNAs). How could these techniques be applied to team working?

Advocacy

Advocacy is to do with the ability to support an interest or a cause on behalf of other people less able or willing to speak up for themselves. It has gained greater prominence through high-profile issues such as whistle-blowing on poor care and the 'duty of candour' that the Francis report puts upon all medical professionals not to' look the other way' when they are aware that something has gone wrong.

Advocacy requires us to integrate mental skills (particularly *problem-solving*) with the relationship skills of good *communication* (through speech and writing to present a persuasive case) and the ability to *collaborate* to find a solution.

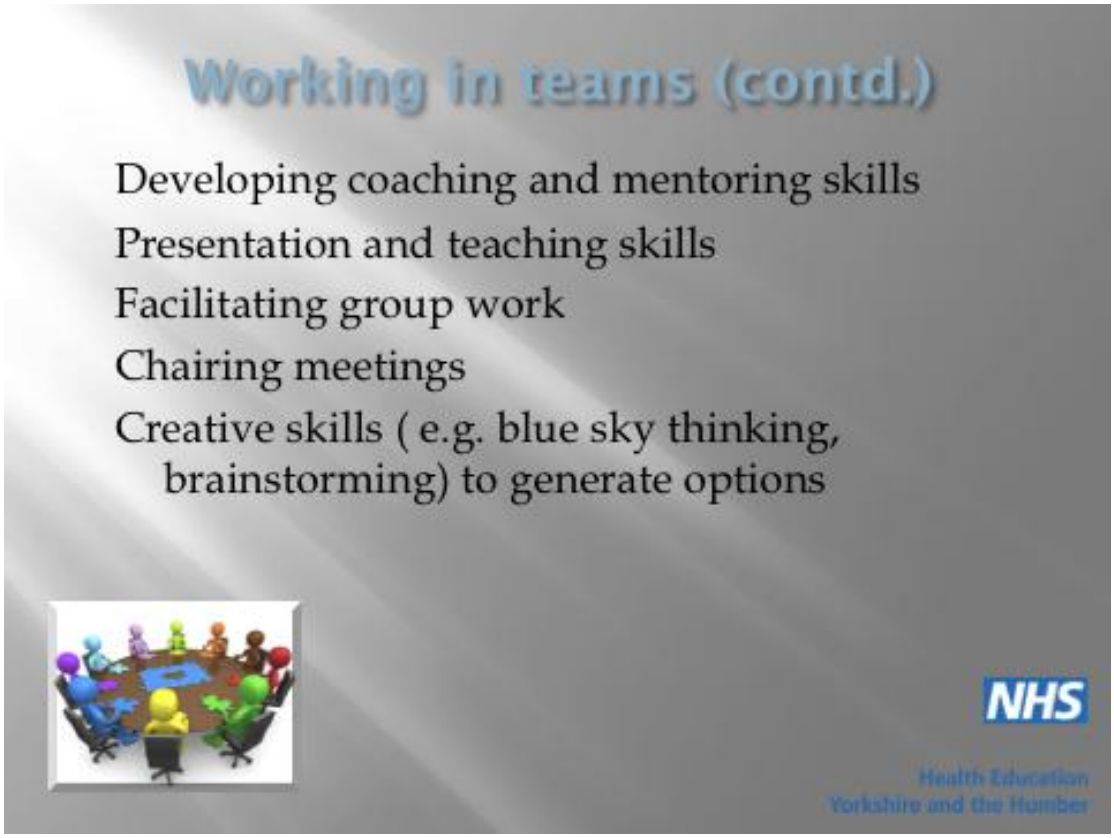
Advocacy will go nowhere if the trainee has no influence. However, influence is built upon credibility, partly related to competence, and to trustworthiness. These features are not dependent upon experience, position or status and there is therefore no reason why junior doctors should regard themselves as being without influence.

It would be a shame if advocacy was simply seen as an externally-directed duty. Sometimes the most important changes can come though people who feel moved to advocate for change, perhaps because they see an injustice or some wrong that needs to be put right.

This is an Interesting area to explore with trainees: has there been a situation in which they felt they needed to speak up? What happened? If they had the desire to 'advocate' but didn't act on it, what were the reasons? What makes advocacy succeed?

Diversity

One important aspect of **diversity** is 'culture' and this can range from understanding the GP professional culture, which may be unfamiliar particularly to doctors trained abroad or doctors from another medical specialty, to understanding the beliefs and preferences of other ethnic groups. There are groups of people who have what are known as 'protected characteristics' which society believe are important to take into account. These include gender, religion, sexuality and disability all of which are aspects of social diversity that should be understood and respected. Good leadership means recognising these aspects and where relevant, using them to enhance the process of making improvements. Doing this in a way that *adds* something important to the work that is done rather than just because it is 'politically correct' to do so, is a challenge that society continues to struggle with.



Coaching and mentoring

Coaching and mentoring use the same skills and approach; essentially one-to-one meetings designed to encourage development in a non-directive way. Coaching is usually shorter term and task-orientated whereas mentorship is a longer-term commitment that requires a relationship to be built.

Facilitating group work

The starting point is to think about the skills the trainee needs in order to get a small group of people to work effectively when meeting together. These skills begin with welcoming people and breaking the ice, then initiating the task and encouraging information to be shared, clarified and summarised in order to keep the group to task. Along with this, the doctor needs to encourage contributions, acknowledge feelings and emotions and build consensus both through dealing with conflicts or disruptions and by recognising contributions. These are difficult skills to master and they represent in microcosm what the trainee needs to do to work successfully with groups of people more generally i.e. outside the context of meetings. For this reason, 'Facilitating group work' should not be interpreted too narrowly and deserves to be prioritised in a training programme.

Chairing meetings

Being the chair is seldom an opportunity offered to trainees, for perhaps understandable reasons. However, you might like to think about how opportunities could be provided for the skills to be

observed, for example, sitting in at practice meetings where chairmanship can be witnessed and then debriefing on the experience.

Creative skills

Creative skills should be thought of in terms of their main application, which is to improve our problem-solving abilities. You might like to evaluate your creative skills:

http://www.mindtools.com/pages/article/creativity-quiz.htm

This page then goes on to describe a number of methods used to enhance creativity. These methods are well worth playing and experimenting with. Think about your own experience in the workplace; how often do creative tools get used; why is that? We can't prejudge which tools are the most important as for each individual, there will be particular methods that they find more useful and the objective here is for trainees to see the value of using such tools and to become adept at using maybe one or two of them, chosen to supplement their problem-solving abilities.

As an example of the value of a creative tool let us think about de Bono's 6 thinking hats

http://mappio.com/mindmap/creativeinspiration/six-thinking-hats-mind-map

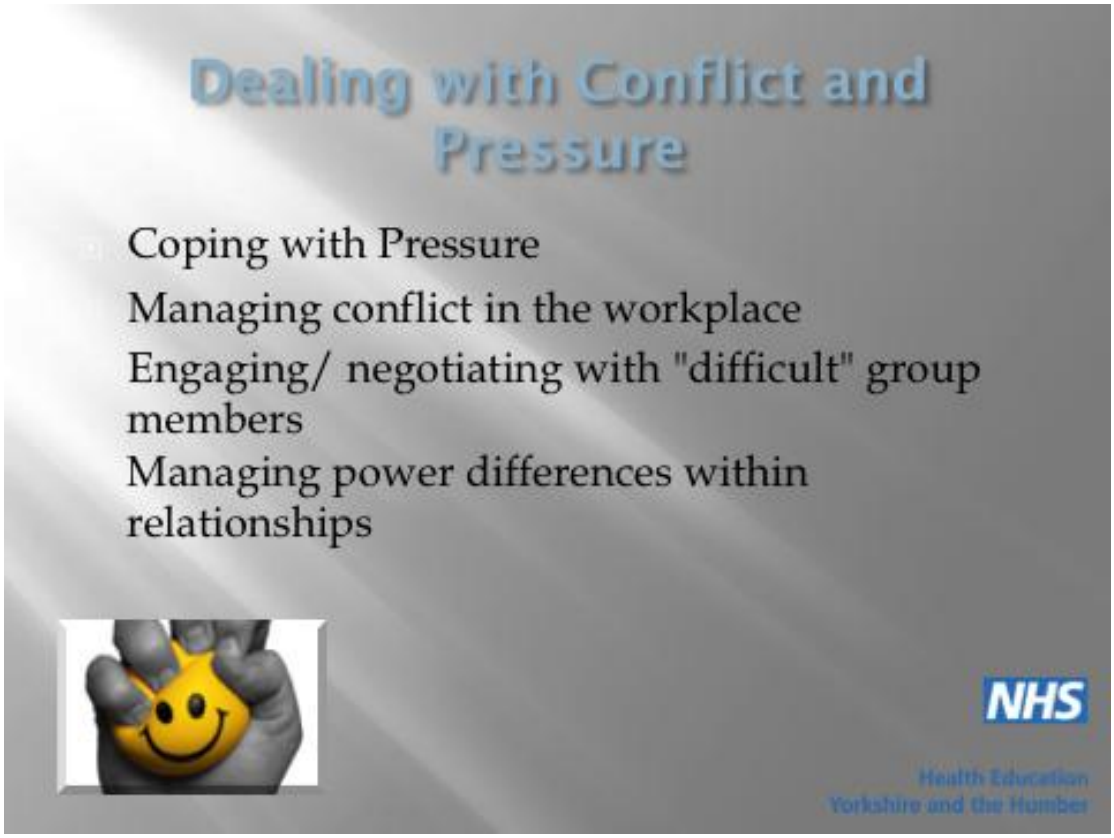
In most practice meetings there may already be a chairman (blue hat), whether formalised or not. Discussion of an issue is often driven by facts (white hat) and most people will quickly voice the *problems* (black hat) and sometimes the *upside (*yellow hat) of the issue or proposal. This means that unless we had de Bono's model in mind, we might forget to explore people's emotions about the issue (red hat) and their ideas about other possibilities and alternatives (green hat). The routine use of *all* these perspectives helps us to make better judgements.

Can you think of any examples of this in practice life? What opportunities could you create for the trainee to experiment with such tools?

Allied to the tools is the environment in which they are used. In medicine, the working context is one in which judgements are constantly being made but when it comes to being creative, tools can sometimes be an impediment or rather and they can be an impediment if brought in at the wrong time. The technique of brainstorming is a good example of this. The technique can work really well if it is used as intended, when everyone is encouraged to offer ideas and when participants know that all ideas are valuable, which means that there should be no censoring, debating or judging of the ideas put forward. In practice, this can be very hard to do without good facilitation as the temptation to pass comment or to pull faces over ideas that are inappropriate or unpalatable can be irresistible! Of course, judgements will later be made but if done prematurely, the flow of ideas will be turned off.

The last 3 slides have summarised a large and important range of skills. Many of these are complex and difficult abilities which take many years to hone. The aim here, as with the other skill groups, is to make the skills explicit so that trainees understand the various elements that are needed to work effectively when others. The theory helps us to understand the background and to improve our

insight as we start to gain experience. However, *experience* is the key; how for example would you create opportunities for trainees to develop a small task-orientated group and learn from team-building first-hand?



Although this is placed as a separate group , these skills clearly overlap with organisational skills and the ability to work with colleagues and in teams. Coping with pressure is sometimes described as resilience or the ability to ' bounce back'. It is widely talked about as a key element of survival in the workplace

Engaging/ negotiating with "difficult" group members

People can engage with change and even enable it but not infrequently, they can block progress at some stage. This parallels the situation we find ourselves in as clinicians, where we often deal with resistance in various forms. The skills we use to **influence** patients are transferable. They begin with developing a relationship and trying to understand each other's point of view and proceed, using good communication skills, to explaining, considering options, identifying common ground and generating commitment perhaps to a compromise position.

Influencing people often requires a combination of persuasion and negotiation and this is explained further at this site:

http://www.kent.ac.uk/careers/sk/persuading.htm

Try looking at some of the elements of 'influencing' shown at this website and thinking about how they may be modelled in a context we know well, the consultation. For example 'perusading' by using positive language and logic, or 'negotiating' by using encouraging body language and making compromises. How would you use the consultation to train doctors in these skills? How could they be role played in a group session?

Managing conflict in the workplace

Managing conflict **i**s an ability that is well worth developing long before conflict resolution is required. This is because the skills that are learned will help the doctor to modify attitudes (thus making conflict less likely) and anticipate situations in which conflict might occur and then take action that would reduce its harmful effect.

Conflict is not in itself a bad thing; indeed people who provide opposition help us to reconsider the status quo and decide whether and in what way change is necessary. Conflict can therefore be seen as an opportunity…. although it is rarely felt that way!

If we aim to develop creativity in the workplace, we are likely to try and avoid 'groupthink' i.e. where everyone thinks along similar lines. Creative thinking and better problem-solving are more likely where a more diverse group of people are working on a problem together. The downside of this is that the very diversity that makes people think differently from each other will also increase the chances of disagreement between them. It's probably inevitable, but when seen as a sign of creativity, it can be valued. If groups of diverse people learn to value what their differences can bring to team-working, then people with divergent views can become valued and respected, which means that the energy that conflict creates can be channelled productively

In summary, conflict is an 'over-played strength' where the strength of diversity is taken too far. Managing conflict is therefore as much about valuing conflict as it is with dealing with its negative impacts.

This leads us on to conflict resolution. Take a look at the following Australian website:

http://www.crnhq.org/pages.php?pID=12

There is a great deal to learn from this summary but be warned that it skims over the difficult issue of attitudinal change.

Managing power differences within relationships

This is a fancy way of of saying that there are differences in power and influence between people. Some of these are appropriate, may come with experience or qualification and are helpful to the relationship between individuals for example in reflecting differing levels of responsibility. However, where power gaps seem unjustifiable, then problems occur e.g. though feelings of injustice, not being respected or appropriately valued.

Some power gaps are explicit but debatable; for example, should seniority automatically confer privilege? Other power gaps may be less explicit but perhaps because of this, they may be felt more deeply as a source of unfairness. These can include differences in influence due to age, sex, culture, ethnicity, disability, sexuality and religion. Before thinking about solutions, we need to ensure that the problems are understood. Getting these issues into the open is not without risk, but helps to raise awareness of issues that colleagues and even the individuals themselves, may not fully appreciate.

How can the power differences be managed? As so often, an understanding of oneself is a vital stating point. By understanding our values, beliefs, talents and expectations, we can learn to be appropriately self-confident. This leads to self-respect without which it can be impossible to stand up to people and situations in which this respect is undermined. Dealing with such situations requires good communication and such skills as negotiation, persuasion, diplomacy and the use of assertiveness techniques. See:

http://www.mindtools.com/pages/article/Assertiveness.htm

It is rare that any one party is completely in the right or in the wrong and having the genuine desire to move forward to a place where both parties feel valued and respected …..even in the face of provocation to do the opposite…..is the basis of progress. It's a desire that few of us naturally have, but perhaps one that wise people learn to nurture.

This section can seem the most dry, bit it is also one of the most pertinent for new GPs. The skill group is split into 2 sections. The first helps us to look directly at the clinical services we provide and to:

Use our current resources as effectively as we can

Identify where services are working well and where they are not

Identify gaps and deciding whether this matters

This is an extension of our clinical responsibility and doesn't require us to think like business people because the budgets and financial consequences seem removed.

However, the second section addresses an area that most new GPs quickly find is important and is poorly addressed in training i.e. our small business skills

Managing Resources, addressing capacity and identifying gaps

Many trainees are already used to the idea of taking personal responsibility for the use of resources. For example, cost-effective prescribing is a routine consideration and nowadays, most trainees will routinely review the effectiveness of their referrals. However, there is a dimension beyond the

doctors personal clinical behaviour, which relates to the practice's role in managing NHS resources more widely for example by reducing unscheduled care.

Capacity and demand issues may relate to appointment availability for routine and urgent consultations and may lead to discussions around manpower and methods of consulting beyond face-to-face interactions. Increasingly, practices are involved in looking at service design locally and finding different ways of using primary and secondary services more effectively.

To engage with these issues, to work out what needs to be done and how effective interventions have been, information is needed and this can come from analysis, audit and evaluation. This provides a scientific approach that informs the management issues in the same way that trainees use audit etc. to inform changes to clinical practice. As an educator, what could you ask trainees to audit or analyse that would feed into a management or service issue and how would you draw the parallel with clinical audit?

Some of the skills in this group are relatively new to clinicians and there is an opportunity to work closely with managers and learn from them. For example, when a change needs to be made, there are tools that can help clarify the elements to the problem, the people that need to be brought together to make it work, the sequence of events that might be the most efficient and so on.

Being part of the wider discussion on resources, capacity and demand (workload) and service development is key and trainees need both the ***information*** to give them background knowledge and the ***opportunity*** to debate the implications.

What does this mean in practical terms? It may mean that the communications from those who commission services locally (such as newsletters) or practice debates on the service implications for GPs are shared with doctors in training. Crucially, it should also mean that trainees take part in practice meetings where these matters are discussed. This not only helps to inform, but gives an insight on team dynamics and a chance for trainees to shape their attitudes as well as develop their skills. Many of the views expressed in such meetings may be negative and the process of change will meet much resistance, which is often at odds with the positive and constructive ethos of much of the educational experience. However, having a chance to witness this and be part of the real world' is vital if the trainee is to feel better-prepared for life as a stake-holder in a future practice. What is observed at these meetings is a rich source of discussion in debrief.

GP small business skills

GPs have a degree of independence in the health service which is reflected in the fact that **m**ost general practices are still run as small businesses. Although the finances are often managed by the practice manager and overseen by the practice accountant, the decisions that govern the profitability and growth of the business are made by the business-owners, usually the partners. Whether or not trainees wish to become business owners, the ability to understand, at least a basic level, the financial aspects of running a small business, is useful to all doctors. To illustrate this point, look at this Australian website for small businesses:

http://www.smallbusiness.wa.gov.au/managing-a-business/

The first 3 sections on **money, employing people and legal issues** are the most important. Although the site is Australian, the principles remain valid in the UK.

As example of how these skills are relevant to all doctors, look at the following section on understanding and analysing your accounts. There is useful link at the bottom on '10 questions to ask your accountant'

http://www.smallbusiness.wa.gov.au/understand-your-accounts/

One of the great values of acquiring the skills during training is that trainees feel much better prepared for finding a job and and for surviving the early years in practice life. They feel able to look over the practice accounts, get an idea of profitability, know what to look for in a sound business plan, and understand what should be within a fair contract. This leads to a greater degree of confidence which may be reflected in the type of posts that trainees are willing to apply for.

Several of the programmes in the Yorkshire and Humber GP School have used the skill groups as a basis for discussing **how and when the skills are taught**. This has then led to an **action plan** for how leadership teaching might be developed further at local level. This has been found to be a very useful exercise, which helps to embed a shared understanding of leadership within the educational community.

You may wish to consider doing this yourselves and to give you an idea of what such an exercise looks like, the Sheffield GPST programme directors have kindly allowed their discussions to be shared more widely via the embedded document originally on this slide but now embedded below:

Sheffield leadership action plan.dot

W ell done for making it this far!

We now have a much better idea of the skills that trainees require to take a lead role when it comes to making a difference in the workplace.

Making a difference **matters** because it will lead to improvements in care for the community. It also matters for the individual because 'making a difference' is at the core of being valued for our contribution. Without it, it can be difficult to maintain self-esteem and job satisfaction.

In 2013 we conducted a school-wide survey amongst GP trainers and trainees to find out how important the various skills were thought to be and how well they were being addressed through teaching. You can see the detailed analysis of this survey on the GP School Website.

In this slide the results are shown in traffic-light form. 'Green' means that the skill group is regarded by the respondents (trainees as well as trainers) as being **important** and is also being **well-addressed though training**. Red means the opposite. Therefore, the skills of listing feedback on reflection are given high priority because they are felt to be the most important. However, the skills involved in improving services are thought to deserve much less attention.

Because ***all*** the skills are needed if trainees are to be competent change-makers, the intention is that **all the skill groups should eventually be green**. At the moment there is wide range of attention being paid and you might like to discuss the reasons for this. The traffic light rating may not reflect your *own* experience or the emphasis that you give in your one-to-one or group-based teaching.

Nevertheless, it gives an idea of current views cross the region and a future survey will show us whether attitudes and teaching are changing as a result of raising awareness of the importance of these leadership skills.

This presentation is intended to help get the ball rolling and we would welcome your feedback on how it could be improved.

More importantly, we want to build **on this resource by collating the real-life experiences and training tips** of trainers and trainees. So please, share your ideas with us by sending them to:

leanne.sorby@yh.hee.nhs.uk

Wherever we can, these will be put on the GP School website so that we can all learn from each other.

Thanks!

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Andy Gill Curriculum tutor, West Yorkshire