

Discussion paper

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# The leadership challenge for general practice in England



An Inquiry into the Quality of General Practice in England

# **The leadership challenge for general practice in England**

A personal view on working in a zone of emergence

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# 1 Introduction

The White Paper *Equity and Excellence: Liberating the NHS* (Department of Health 2010) sets out a vision for the National Health Service that promises to be one of the most extensive reforms in its history, and the role of the general practitioner (GP) is at its heart. These reforms are intended, in part, to create co-ordinated care close to the communities where patients live, with the patient experiencing seamless and frictionless care no matter where it is practiced. General practice will be given new commissioning responsibilities, and will be able to design integrated care pathways for patients that span primary, secondary and social care. GPs will co-ordinate care, and integrate information and knowledge derived from many sources for a single patient.

The principal interactions between the patient and health care will therefore be through general practice: the practice will be both the starting and the ongoing reference points for most patients. Consequently, general practitioners will need to build working relationships with all aspects of health and social care, including local authorities and secondary care. Such relationships are new for general practice, and new leadership capabilities are needed to prepare GPs for them.

However, there is little mention of which leadership capabilities are necessary for general practitioners to bring about these reforms, either in the White Paper or in the National Leadership Council's consolidated business case 2010–11 (Dept. of Health 2009). This discussion paper attempts to outline a set of leadership capabilities appropriate to GP leaders who work across organisational and functional boundaries. It builds on the Royal College of General Practitioners (RCGP) publications *Being a General Practitioner* (RCGP 2007a) and *The Future of General Practice: A roadmap* (RCGP 2007b, referred to here as 'the Roadmap', and should not be seen as a replacement for either. Instead, it attempts to augment both, given the context of the White Paper.

The discussion paper does not attempt to examine all aspects of leadership development and organisational development implied by the White Paper. Instead, it focuses on how GPs can build relationships across functional and organisational boundaries that engender processes and behaviours that are responsive to local contexts, adaptive to change and innovative. It is not intended as a final, discrete set of necessary GP leadership competencies, and should not be construed as such. Instead, it identifies the management of complex relationships as the kernel of GP leadership in a new NHS, and outlines some approaches that should spawn timely discussion and debate in advance of the proposed reforms.

## 2 The primacy of the doctor–patient relationship

There can be little doubt of the importance of the GP in everyone's life. GPs play a central role in society because, as Ferrer *et al* (2005, p 691) says, both plainly and accurately, 'Health care is an essential means for promoting human development'. Any discussion of general practice should therefore start with the essential human relationship in medical practice – the doctor–patient relationship – because, from the patient's perspective, the quality and key characteristics of that relationship are, in many instances, everything. Every citizen has a right to be registered with a GP, and this right should bring them access to personal and organisational continuity of care, comprehensiveness and co-ordination. The doctor–patient relationship is particularly important for certain groups, because GPs often play the role of a safety net – especially for the most vulnerable (RCGP 2007a).

The role that GPs play in society suggests that the quality of their interactions with patients has a special significance. With more than 90 per cent of interactions between the public and the National Health Service taking place in primary care settings, the GP is the public face of the health service (Jackson and Burton 2003). Care for the whole person, informed by the person's values, beliefs and community, along with health interventions constructed in participation with the patient, comprise the core values of general practice (RCGP 2007a).

Unlike many specialists or consultants, such as surgeons or dermatologists, GPs largely practice 'cognitively'. They search for patterns through observation and dialogue with the patient, and through this build both a personal relationship and an understanding of the patient's biological, psychological and sociological states – the Biopsychosocial model (Engel 1977; Frankel *et al* 2003). Indeed, many patients expect GPs to form close, long-term relationships based on trust, mutual respect and understanding (Kearley *et al* 2001). This is especially true for the most vulnerable patients and their caregivers, who may have multiple long-term conditions, complex conditions, serious illness or emotional or psychological problems (Kottke *et al* 2008; Schers *et al* 2002; Tarrant *et al* 2003) problems.<sup>1</sup>

1 There are some caveats to the role of the doctor–patient relationship, interpersonal continuity of care and patient satisfaction. In many cases, interpersonal continuity of care and patient satisfaction are not causally related. What seems to matter most for all patients is the *quality* of the encounter with the GP; patients will tend to switch GPs if they are dissatisfied with the quality of the encounter even if they enjoy a long-term relationship with that GP. It should be noted that interpersonal continuity of care and patient satisfaction are, in many cases, not causally related. What seems to matter most for all patients is the *quality of the encounter* with the GP; patients will tend to switch GPs if they are dissatisfied with the quality of the encounter *even* if they enjoy a long-term relationship with that GP. The quality of the consultation rests on encounters where the GP recognises the patient and remembers the patient's previous ailment or condition, (Frederickson *et al* 2009) or when a patient believes that the GP is treating the person, not just the illness, (Tarrant *et al* 2003) and where the patient believes that s/he is being heard, understood, and shown respect. (Williams *et al* 1995). Younger patients and those with minor acute conditions or minor injuries do not necessarily value interpersonal continuity (Fletcher *et al* 1995), but being heard and shown respect count high in influencing the level of satisfaction with their care. Furthermore, it is not unknown for patient satisfaction to rest occasionally on unrealistic demands, such as the overuse of diagnostic testing to re-assure a healthy patient. [Kravitz & Edward, 2000] For example, one study quotes a patient, 'I would like to have a test for all diseases you can possibly get. So that at least you know that you're in good health and don't have to worry. If your blood is okay, that means you're healthy' (van Bokhaven 2006, p 3).

### *The web of relationships*

Important as it is, the doctor–patient relationship is just one of a web of relationships for the GP. GPs are the anchor of the health care system, who should have knowledge both of individuals and populations (Curry *et al* 2008), who sit at the intersection of medicine, public health and social care (Blue Ribbon Panel of the Society of General Internal Medicine 2007; Rosenthal 2008) and who are expected by government to make the best, and most efficient, use of resources available in a health economy (Curry *et al* 2008).

As we saw in the introduction, in 2007 the RCGP laid out its Roadmap for the future direction of general practice (RCGP 2007b). In this new model of care, the GP provides a comprehensive service that brings treatment and interventions closer to the community, brings co-ordination to a range of providers, and makes the GP practice the basic unit of care. Comprehensive services – many of which are now provided only in hospitals – would be offered partly through formal or informal federations, or consortia, of GP practices. Moreover, the Roadmap called for increased GP access to diagnostics and improved continuity of care – in particular, inter-organisational continuity.

The Roadmap envisaged part of the GP role as being to design and co-ordinate care pathways that span health care teams and organisations. While specialist teams located at acute trusts and elsewhere may have discrete knowledge of the patient, or the disease, the GP is the critical link that maintains the big picture. In effect, for the GP this means that the distinction between secondary care and primary care is blurred, as is the distinction between social care and health care. General practice is therefore the crucial component in creating frictionless, holistic care for the patient.

This vision is echoed – indeed, amplified – in the most recent White Paper on the future of the NHS (Department of Health 2010). Although the details of the proposed changes will emerge in the final drafts of the Health Care Bill, due in 2011, the White Paper calls for commissioning to move to local consortia or federations of GP practices, shifting PCT responsibilities to local authorities, and for GPs to design care pathways and packages for patients. The White Paper also calls for the systematic integration of health and social care, particularly for mental illness. Despite many uncertainties, it is apparent that the GP will play a central co-ordinating role for all patients in primary care, secondary care, social care and health promotion.<sup>2</sup>

So, the doctor–patient relationship is just one of a set of relationships, which will include those:

- between the GP and members of interdisciplinary health care teams (including secondary care)
- between the GP and health care systems and the community (including local authorities and social care)

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<sup>2</sup> For example, aside from commissioning powers, it is not clear if GP consortia or federations will provide the range of services envisaged by the RCGP Roadmap or if the primary logic of consortia is to create economies of scale and risk pooling in commissioning (see Ham 2010). See also Ham, 8 July 2010. While the details of the proposed integration of care are currently hazy, the White Paper indicates that GP consortia will have a duty to promote equalities and to work in partnership with local authorities in relation to health and social care, early years services, public health and the well-being of local populations (Department of Health 2010, p 29).

- between the GP and management professionals, such as financial directors
- between the GP and local or regional policy professionals.

These extended relationships are not unknown to the GP, but they are generally unfamiliar territory in their day-to-day work. To make sense of these relationship and to use them effectively, GPs need to understand themselves well enough to know when to ask for help, and to be aware of and honest about their own professional and personal values when making decisions. In addition to the relationships outlined above, we therefore believe that the GPs as leaders build a relationship between their clinician identity and themselves (Tresolini 1994).

The White Paper and the Roadmap correctly suggest that the web of relationships that GPs need to navigate will be increasingly complex in the coming years. Such relationships are fundamental to effective health care. GPs will therefore need to engage in 'a complex responsive process of relating' (Suchman 2006). The critical leadership challenge is to build the capacity of GPs to navigate these waters.

### *Leadership capacities in a world of complex relationships*

In order to make the most of the planned changes for the NHS, and to follow the RCGP Roadmap, GPs will need to develop a set of leadership capacities that enable them to influence people and events, and to maintain excellent care for every patient. A set of necessary but insufficient capacities include new or enhanced skills in:

- change management at the practice level
- strategic management and planning (particularly for the development of consortia and federations)
- building leadership capacity among GPs to support lagging GP practices
- knowing how to interact with news media
- influencing local and national politicians
- influencing policy
- serving on and chairing boards at both the consortia and secondary care levels
- knowing how to work effectively with management, and knowing when/how to use managerial support
- having excellent financial management skills
- building teams within and across organisational and functional boundaries.

Important as these leadership capacities and skills are, they are insufficient because they do not engender flexibility, innovation, and creativity aligned with existing (and future) local contexts and needs. There is something special about the structure and relations outlined in the White Paper and, to some extent, the RCGP Roadmap. Organisations are to become as autonomous from central control as possible and to develop and enact their own solutions to local circumstances. The White Paper is particularly clear that a centrally driven, target-oriented culture will be replaced with a culture that encourages local initiatives (spanning functional and organisational boundaries) that respond to local needs (that are both locally and nationally

accountable) and increase clinical quality and efficiency.

If nothing else, this means that local health care organisations must become, and remain, aligned with emergent local conditions, and develop services that best respond to them.

Aside from co-ordination, some new key capacities are needed to make this work, including:

- an organisational ability to self-organise quickly
- an organisational ability to learn and adapt
- a willingness to engender leadership behaviours in everyone at all levels and function of the organisation
- a culture of innovation
- the ability, among all parties, to understand at once the local context – from a unit as small as the office visit to the big picture (national policy) – and their place in it.

The challenges of meeting the goals of the White Paper are immense. It is supremely difficult to co-ordinate across functional and organisational boundaries – for example, by integrating health and social care, or by truly co-ordinating primary and secondary care so that the result appears seamless or frictionless to the patient – because the world views of people working in different organisations, or different functional areas, are strikingly dissimilar. What may be important for one group will be unimportant to the other.

Consider, for example, how different groups might define 'good quality of life'. The economist may explain the concept in terms an individual or group's capacity to acquire scarce resources, the philosopher might focus on the ability of the individual to achieve authenticity, the psychologist might focus on the ability of the individual to know him or herself and construct a coherent life narrative, while the clinician might define quality in terms of health.

Moreover, over time different groups may rely on habits of working and thinking in order to get the day-to-day work done. Consider the challenge of trying to persuade a district nurse to think in the style of social worker, or vice versa. If we consider funding streams, we will find that social workers may not think like district nurses—even if they wanted to—because they are neither paid nor rewarded to think like district nurses. The habits of thinking and the institutional structures that support them create a path dependency in work and thinking that is hard to overcome (Carlile 2004; Star and Griesemar 1989). Consequently, there is an inbuilt tension when working across boundaries (Lichtenstein *et al* 2006) when different work styles, habits, values and rewards become clear and, indeed, clash.

How can we overcome this tension? The solution to the problem lies in the problem itself.

### 3 Zones of emergence

To lead across organisational and functional boundaries, the GP leader has to build and then nurture complex relationships, and to ensure that those relationships result in innovative behaviours that are responsive to local contexts. This is hard to do because, as we have seen, each group in the web of relationships already has its own ways of doing things that are difficult to change.

Recent sociological and business studies suggest that path-dependent knowledge – relying on habits and thought styles peculiar to a group – hinders new ways of doing things. This research, however, also strongly suggests that the act itself of bridging a boundary between functional groups helps to break that path dependency, and tends to create new ways of thinking and behaving (see Burt 1992 and Carlile 2004). The tension that often accompanies the bridging of two or more groups occurs because both groups are holding on to past ways of working and thinking while being confronted with new ideas and practices as they interact and as each group makes explicit its values and beliefs.

The interaction among members of different functional or role groups brings to the surface new ways of working and thinking that become explicit. The more diverse the group, the more diverse the clashing ideas, practices, and thoughts—and the greater the chances for innovative approaches. It is in this space, where neither group knows what it doesn't know, where new knowledge and practices are created. We can call this space a 'zone of emergence'.

But innovation in a zone of emergence does not happen on its own – if it did, then the landscape would be abundant with innovation. In most cases, this tension results either in gridlock or an acceptance of the status quo. Making the most of interactions in a zone of emergence requires a special kind of relational or adaptive leadership (Lichtenstein *et al* 2006) to take advantage of the tension and clash that comes with that territory. Leadership in this context is not about persuading people to follow the leader, but generating the conditions for participants to create new outcomes and processes. A leader in a zone of emergence views all participants as leaders, and encourages them to negotiate. The leader has the self-awareness and confidence to drive responsibility downwards, so that diverse ideas and practices held by diverse individuals can spark innovation, responsiveness, adaptation and self-organisation (Heifetz *et al* 2009).

Butler and Allen (2008) argue that this type of leader creates these conditions by:

- widening the space of possible solutions and approaches
- reframing decision-making to be as open as possible and acknowledging that there is no single best practice (because best practice depends on context)
- engendering learning and creativity
- reviewing and learning from past successes and failures
- continuously reflecting on and adapting how they enact leadership, vision and implementation.



### *Relational and adaptive leadership capacities and behaviours*

After reading the White Paper, a GP said to me 'This is a new game – how are we going to learn it together?' A cursory review of the literature provides some pointers (Butler and Allen 2008; Eriksen 2008; Heifetz *et al* 2009; Lichtenstein *et al* 2006; Proudfoot *et al* 2007; Roland 2007; Rushmer *et al* 2007, 2004a, 2004b, 2004c; Troop 2003).

The GP leader has to build an honest relationship between the self as a GP and the self as a whole person. When working in a zone of emergence, the GP leader will call on those relationship qualities that create the trusted doctor–patient relationship. They may sometimes have to face their own latent arrogance, learn humility, listen to the whole person, and be comfortable sitting with uncertainty. Most of all, they have to build the capacity to learn with others.

We offer some key advice for GPs to build relationships across functional and organisation boundaries, and to encourage innovative thinking to local problems and contexts.

- **Be comfortable with uncertainty** Working across boundaries often means that we are working in complex environments. Complex environments, by their nature, are not stable – they adapt. You will be a leader of adaptive change. Your key role is to manage relationships and interactions, and ensure that new ways of working and innovation emerge from those interactions.
- **Be honest with yourself** Know your own assumptions, your likes and dislikes, your pet solutions and approaches. Reflect on how these affect your behaviours with others, and be especially aware of how they might stop conversations, debate and creativity among those with whom you work. In order to effect change, the adaptive leader working in a zone of emergence needs to practice self-authorship to become the person they want to become.
- **Drive responsibility downwards** Everyone has the capacity to lead, and everyone has expertise. As contexts change and new approaches are needed, assume that someone in the group has that expertise and can lead on an approach or solution.
- **Identify emerging leaders by valuing autonomy** Draw on people from the group to come up with solutions, and prepare and encourage them to develop innovative organisational experiments. Give them room to think and explore. As well as encouraging innovative practices, this helps to identify new, emergent leaders who think creatively and independently.
- **Tolerate and engender disagreement, and don't strive for consensus** Working across boundaries means that the leader will be working with diverse views and diverse knowledge. Harness this diversity in the service of creative solutions. Encourage healthy debate rather than cynical disagreement, and use such debate to surface divergent views that lead to better and responsive services.
- **Ask new questions of the team that reveal assumptions, mental models, contradictions and tensions** Make sure that the team clearly sees these assumptions too, and works with them. Making assumptions explicit helps everyone to understand what is important to individuals,

and helps to create the conditions where participants can identify and make trade-offs. In the best circumstances, individuals learn from each other and help to create new ways of thinking and new ways of behaving.

- **Observe and listen** Make sure the team members knows that you have heard them. Avoid posing your own pet solutions or processes.
- **See possibilities rather than impediments** Widen the range of possible approaches. One way of doing this is to invite a range of solutions from all team members and encourage them to ask 'Why not...?' or 'What if...?'
- **Develop the ability to influence others** The leader often has to negotiate and persuade individuals and groups from other organisations, practices, professions and cultures. Understand how others evaluate and understand what you are saying, and how your behaviours are interpreted by them.
- **Support and develop others** View members of your team as individuals who have the capacity and willingness to learn, and help them identify and build on their strengths.
- **Strive for duplicative and redundant knowledge among members** This builds adaptability in the team, and allows members to understand how others work, and what is important about each other's work.
- **Be willing to be a co-learner** If the focus of the group is to learn and to innovate, leaders at all levels must show a willingness to learn and apply learning to innovative practices. Be self-critical, and seek ways to improve your own performance.
- **Help people through change, and support mistakes** Most learning systems learn what to do by learning what not to do, through experience. Mistakes, false starts and blind alleys are a fact of life in any learning environment. The key is to learn from a mistake.
- **Mentor your team** Set an example to others by reflecting on your practice and seeking ways of improving it.
- **Set aside time and space where learning and reflection are both encouraged and expected** The leader encourages two kinds of learning: double-loop (what are we learning from our work) and triple-loop (how are we learning). No group can adapt and change unless learning is encouraged, takes place, and is applied.

## Conclusions

The vision of GPs at the nexus of health and social care is exciting, and promises to deliver seamless care for patients. However, it will call on GPs to identify and build relationships across organisational and functional boundaries. The leadership challenges are considerable. GPs have not normally worked in this way, and there are inherent barriers to working effectively across functional roles.

The boundaries – and the tension they create among groups (the zone of emergence) – offer real opportunities to create innovative services that are responsive to local needs, and that can constantly adapt. But identifying and taking advantage of these opportunities does not spring from thin air. It demands a set of leadership skills from the GP that is focused on building and managing relationships, and on encouraging innovation through interactions that emerge from those relationships.

## Questions

This paper is designed to stimulate discussion, and we look forward to hearing from readers with their own views. The following questions might encourage debate:

- Do you agree with our assessment of the leadership challenge facing GPs?
- What other approaches to leadership is useful, given the White Paper?
- What roles can the royal colleges and other organisations play in meeting GPs' leadership needs?
- Who should pay for GP leadership development?
- What skills are needed to manage GP consortia?
- Should GPs develop management and financial skills, or should they learn how to work effectively with non-clinical management professionals who have those skills?
- Do you believe that there should be a National Leadership Competency Framework for GPs?
- What else can be done?

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