International Practice Development Journal

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CRITICAL REFLECTION ON PRACTICE DEVELOPMENT

Novice to transformational leader – a personal critical reflection

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Abstract
Background: This is a critical reflection in relation to the nine months I spent on the Clinical Leadership Programme organised by a large NHS acute trust in England, underpinned by practice development methodology. The programme aimed to support 23 consultant clinicians from different medical specialties in their leadership development.
Aims: To develop insights into my personal development as a transformational leader from exploring the concepts and tools introduced in the programme in relation to my role as a clinical lead for anaesthetics services across the trust.
Conclusions: From my reflection, I now have a clear understanding of what leadership is, how it relates to management and that a good leader is often a good manager too. In addition, I have concluded that investing time in developing self-awareness in terms of my leadership behaviours has clarified my leadership role and also how to be a transformational leader in everyday practice. Additionally, using the headings person-centred care, safe care, effective care and effective workplace culture, I have been able to reflect and review some of my achievements as follows:
  • Person-centred care: I visited the home of a patient with learning difficulties to enable them to access the hospital from the community
  • Safe care: I have enabled a reduction in the number of 'never' events by promoting the stop before you block (SB4UB) programme in my anaesthesia department
  • Effective care: I facilitated the enrolment of major elective surgical patients into the Enhanced Recovery Programme
  • Effective workplace culture: I have zero tolerance to incidences of bullying and harassment
Implications for practice:
  • Good leaders have the skills to develop with their teams shared priorities and purposes that guide everyday actions
  • Good leaders and good managers are needed to enable teams of people to work together
  • Successful leaders sometimes make changes that may be unpopular
  • Anyone, regardless of position or discipline, can develop transformational leadership behaviours

Keywords: Reflection, practice development, personal development, clinical leadership, teamwork, anaesthetic practice

Introduction
To guide my reflection, I have drawn on ideas from Johns (2000), Gibbs (1998), Rolfe et al. (2001) and Roth (1989). I have structured my reflection around the areas that have made the most impact on me and have helped me to transform and develop my clinical practice (and, in some aspects, my personal life), specifically:
- The tools I have used on my journey to become a transformational leader
- Five behaviours of transformational leaders

The journey
At the beginning of 2015, I enrolled in the East Kent Hospitals University NHS Foundation Trust's Clinical Leadership Programme (CLP). The programme was facilitated by experts in the area of practice development, assisted by co- facilitators in the field, with guest speakers from the human resources department and senior management.

I am a consultant anaesthetist and have previously experienced being clinical lead for anaesthetics at one of the trust's three acute hospitals.

The CLP was a day-release course, involving 23 consultant clinicians from different medical specialties. We met once a month at a venue away from the main hospitals, when we engaged in interactive and creative activities involving: the concept of leadership and its difference to management; action learning; exploration of leadership/ management issues of importance to the group; using observation of practice (Bate and Robert, 2007; Royal College of Nursing, 2007; McCormack et al., 2009) and emotional touchpoints (Edinburgh Napier University, 2012; Akhtar et al., 2016) in the workplace, which involved giving feedback on a specific clinical area (Manley et al., 2008).

Each course participant conducted a series of self-assessments throughout and at the conclusion of the course, and was given personal feedback based on these. In addition, a 2,000-word reflective piece was submitted midway and a reflective review completed at the end. What I hoped to gain from this was to enhance my personal development and broaden my understanding of leadership and management within the NHS. As a clinical leader, I was leading and interacting with multidisciplinary teams, leading and representing the views of my team against the framework of set professional standards for my specialty and the UK General Medical Council's *Good Medical Practice* (2013). Alongside the 'first do no harm' essence of the Hippocratic Oath, the various teams aimed for and aspired to a common goal – better patient outcomes. Before the programme, my view of leadership and management tended to mirror what I had picked up from my considered role models and successful leaders, politicians and clinicians alike. It is clear to me now that I did not fully understand the roles of any one of them.

On reflection, I had tended to adopt the attitude of 'them against us' (managers against clinicians) in my professional relationships and interactions. I was suspicious of managers, seeing them as 'woodpeckers'– irritating and noisy – as opposed to 'hawks', who have sharp eyes and a wide field of vision, and don't miss anything.

I had received previous introductory training in clinical leadership, both as a registrar and during my new consultant induction, but this was of short duration and the content was basic. During the CLP I was regularly exposed to new and exciting situations that I found highly challenging; this took place within the safety net of the programme's action learning group, with the assurance that things shared in the group stayed in the group. The group facilitated and guided me to find my own solutions to issues and problems. The trust's CLP was both highly challenging and highly supportive. One early group activity – a self-portrait exercise – was a powerful tool. It involved talking about something that each member of the group considered special to themselves and was an effective ice breaker. Also, I had many 'eureka' moments during the course. The skills I developed helped me break down perceived barriers to learning about myself and others. They gave me an insight into what makes people tick – what drives and motivates us.

Whatever leadership knowledge, skills and attitudes I had demonstrated up to the start of the CLP were picked up along the way, as opposed to having been developed through formal theoretical insights. The CLP was more detailed and included new tools and terminology that were initially unknown to me but became clear in the action learning group. By the second week, I was using terminology like 'high support, high challenge', 'claims, concerns and issues' (Guba and Lincoln, 1989), 'leadership styles' (Lewin et al., 1939; Kissane-Lee et al., 2016; Google Sites, n.d.) and 'perceptual positions P1 and P2' (Grinder and DeLozier, 1987; O'Connor and Seymour, 1990) in my leadership roles at work.

At the beginning of the programme, I was guided to undergo an assessment of myself as a leader, which was designed to inform my self-awareness using a range of self-assessment tools. I used qualitative 360-degree feedback (Garbett et al., 2007), Kouzes and Posner's assessment (2012) and an assessment of where I stood in relation to the trust's own shared purpose framework (Manley et al., 2014), as well as using a cognitive mapping tool to capture my confidence in relation to a number of statements about how I saw my own leadership.

The 360-degree feedback request letters were distributed mostly in paper form to targeted groups of people within my sphere of influence – colleagues, middle-grade doctors (those between senior house officers and consultants), trainees, line managers, administrators, theatre support workers and porters – all people with whom I work and interact on a daily basis within the surgical division. I particularly requested feedback from the responders about areas where they felt I could improve my role. The response rate was 95%.

To assist me with my self-awareness and my reflection as a transformational leader, I used the Johari window model (Luft and Ingham, 1955) – a simple and useful tool that helped with personal development and to improve communication, interpersonal relationships and team development (see tinyurl.com/luft-johari). The model particularly struck a chord with me because I am naturally a touchy-feely person. In my journey, I looked to expand three of the windows and minimise one – the unknown by self and others.

The self-assessments focused on the desirable attributes of a good leader and highlighted three areas where I needed to improve. It showed some of my strengths and weaknesses. My heart was gladdened by comments such as 'very supportive and approachable', 'a good listener', 'a diplomat'. Comments such as 'needs a new watch' have been taken quite seriously; timekeeping is a particular aspect of myself as a leader I intend to develop. I have extracted some useful tips to achieve this from the programme (Covey et al., 1994). The other areas of improvement mentioned were learning to say no and being firmer with colleagues.

The assessment tools enabled me make sense of the five behaviours of transformational leaders (Kouzes and Posner, 2012):
- Models the way
- Inspires a shared vision
- Challenges the process
- Enables others to act
- Encourages the heart

At the beginning of the programme, I assessed my way of working against these five behaviours. I struggled to understand what was required but this was soon clarified during a session with my CLP mentor.

Modeling the way
A good leader leads by example; I am never willing to ask anyone to perform tasks I would not be willing to undertake myself. For instance, I am always the first person to volunteer to cover overrunning lists.

Inspiring a shared vision

We have a vision within my trust to reduce cancellations on the day of planned elective surgery. Patients' procedures will be cancelled only for medical or surgical reasons, and cancellations are only authorised by senior surgeons or anaesthetists, after having explored every other option. The human impact of a cancellation is far reaching – patients have to take time off work and may have travelled some distance to present themselves for surgery. Avoiding cancellation on the day of planned surgery is an intentional vision developed by and shared by all members of the team.

Challenging the process

In my trust, we have three separate acute sites with average travelling times between sites in excess of an hour. All three are under financial strain. I have had to challenge traditional ways of doing things:

- I was able to use technology to my advantage when I conducted a FaceTime video call assessment of a patient who had a morbid fear of hospitals and was reluctant to leave the safety of his apartment. I was able to make eye contact and make a measured pre-assessment of this person with learning difficulties who required routine bloods to be taken. Following the administration of a sedative premedication, the patient had his blood test in the hospital and successfully returned to the community
- I made a short instructional film that was shared at the trust's leadership academy study day on how leaders should think differently. This is an illustration of how leaders challenge the process by demonstrating how thinking differently can improve care for the person experiencing it

Enabling others to act

I have learned that people feel empowered and have ownership of tasks when given the required high challenge and high support to perform well and flourish. They do not want to be micromanaged. I have set up a reception area within my hospital's day surgery unit for persons with special needs who are referred to the hospital from the community. I have enabled the ward staff to become empowered and they have claimed ownership of the service, to the extent that they volunteer to come in on their days off to assist. The ward has received an award for helping people stay healthy.

We now have well-established care pathways, which were set up by me and have been recognised by the trust for these groups of service users. We have two champion clinicians willing to facilitate and promote access for persons with special needs within and outside my hospital.

Encouraging the heart

I have created an environment that is free of stress and I encourage team members to feel free to speak up without fear or intimidation. One 'never' event (NHS England, 2015) was prevented by a relatively junior member of the team speaking up during a WHO Checklist (World Health Organization, 2009); they questioned the correctness of the operation site and avoided an adverse outcome (Safe Anaesthetic Liaison Group, 2017). I use my role as a transformational leader to facilitate the checks and empower team members to voice any concerns. We regularly audit compliance with the checks and celebrate our successes at the team debrief.

Learning points

Having triangulated the data from the assessment tools, some themes emerged that gave me greater insight and encouragement to continue to improve myself as a leader. I am generally considered as approachable and a good listener with lots of empathy. At times this trait has clouded my view and judgement to the extent that I sometimes find it difficult to say no, which can mean I have little time to myself to recharge my batteries. On a few occasions there has been a clash in my diary, requiring me to be in more than one place at the same time. So it is clear that I need to pace myself. I need to manage my time well and be assertive and clear about my priorities. Covey et al. (1994) in their book on time management *First Things First* describe things that need to be done to meet a deadline using the analogy of a pail, into which important tasks – 'the big rocks' – are inserted first, followed by less

important aspects (the small rocks and gravel). Proceeding in this order allows room to fit in more things if the time is available to me.

A leader has been compared to an eagle (Hetri, 2015; DifferenceBetween.net, 2014). The eagle is considered to be at the top of the food chain among birds. It has vision and is fearless and tenacious, – a high flyer possessing vitality and nurturing its young. The eagle and the hawk are both birds of prey and belong to the same family, although the eagle is considered the bigger and more powerful. At a distance, it is impossible to tell them apart. A manager is like a hawk and I have come to realise that a good leader also needs to be a good manager, managing the time to teach, job plan, roster staff and colleagues, study/write protocols and juggle their dairy. Not all managers are good leaders and this is perhaps what brings about this feeling of 'them against us' that lots of clinicians harbour. Clinical managers and clinical leaders are supposed to assist and complement each other, forming a team in which the members likewise complement each other. I no longer have that 'them against us' feeling, rather I am aspiring to become a better manager of my time and of the important duties that make up the small rocks and gravel described by Covey et al. to help make me a better manager of people and a transformational leader.

I am satisfied that I am endowed with a large dose of perceptive positions P1 and P2 (Grinder and DeLozier, 1987; O'Connor and Seymour, 1990) and caring attributes; I listen and consider myself to be a nice person who empowers others. Yet there remain areas where I need to continue to develop. I need to continue to 'challenge the process' and 'inspire the process'. I need to learn to say 'no', as revealed in my self-assessment.

I need to manage my time better, so that I have time to read, understand and digest the finer details of information presented to me. I need to adopt a more P2 perceptive position stance – see things through the other person's eyes and be more assertive and authoritarian when required. Good successful leaders sometimes need to make decisions and changes that are unpopular.

The knowledge and skills acquired from the programme have boosted my confidence and motivated me to aspire to a second term as clinical lead or another leadership role within the trust; I wish I'd had this kind of knowledge at the beginning of my first term as a clinical lead. I would like to channel my newfound energies into changes that are occurring across the trust. I am considering joining the trust's leadership academy as a next step. I have made a film sketch, shown at the academy launch day, demonstrating a leadership role in driving delivery of care to individuals with learning difficulties. This, I hope will inspire others to develop their own leadership potential.

I no longer feel I have to bear all the claims, concerns and issues around clinical and workplace problems by myself; I am establishing a network of like-minded colleagues, with whom I can share these. I shall work collaboratively (Australian Institute of Business, 2016) with my colleagues in multidisciplinary groups, enabling these ways of working to become the norm in our everyday practice.

A journey of a thousand miles begins with the first single step, declared the Chinese philosopher Laozi. My clinical leadership journey has begun and the future is the colour of Cyprus blue and summer yellow.

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Acknowledgements

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A commentary by Peter Davey follows on the next page

COMMENTARY

Novice to transformational leader – a personal critical reflection

Peter Davey

NHS trusts have made progress in involving doctors in leadership roles but the journey that started with the Griffiths report of 1983 is by no means complete (Dickinson et al., 2013). Appointing doctors as clinical directors is unlikely to be sufficient to enable hospitals to undertake transformational change (Dickinson et al., 2013). Kenneth Adegoke's article in this issue makes a valuable contribution by describing and reflecting on clinical leaders' participation in a transformational leadership programme, which considers the importance of influence and persuasion in addition to formal authority.

My connection with medical leadership is as an educator and researcher in healthcare improvement. I was a consultant in infectious diseases but have not held a formal leadership role in the NHS. Since 2010, I have been part of a learning partnership on patient safety and quality improvement at the University of Dundee Medical School with Vicki Tully, a nurse from NHS Tayside's patient safety team. We have developed workplace-based learning experiences such as incident review and improvement projects. Initially we focused on final-year medical students but since 2013 we have enabled second- and third-year students to do improvement projects (Anderson et al., 2013). We began with a four-week, full-time optional course entitled Leadership and Quality Improvement. However, students suggested we change the course title to Improving Care with Clinical Teams, which has significantly improved student engagement. In 2015 two of our third-year students volunteered to work with NHS Tayside on patient experience interviews, with feedback given to clinical teams – a project covered in the article by Monica Hytiris in this issue (Hytiris et al., 2017). Their experience showed the potential of developing service learning on patient experience, whereby students learn through gathering information that, in turn, is valuable to the NHS. We are introducing service learning as a core assignment for all second-year students from November 2017, and we are changing the name of our medical school website from Patient Safety and Quality Improvement to Healthcare Improvement, with learning structured around the Habits of Improvers framework (Lucas and Nacer, 2015). These developments were recognised in *Realistic Medicine Around Scotland*, an appendix to the Chief Medical Officer's annual report for 2015/16 (Calderwood, 2017).

At his acute trust in England, Kenneth Adegoke was one of 23 consultant clinicians on the Clinical Leadership Programme (CLP) described in his article. It entailed monthly day release for the participants – an impressive commitment of valuable time to the CLP. The challenge is to maintain this commitment in day-to-day clinical practice and surely, as Kenneth states, 'collaborative working' within multidisciplinary teams is essential to this. We are working with five clinical colleagues in medicine, nursing and pharmacy who have completed NHS Scotland's Quality and Safety Fellowship Programme. They have found that students and trainees can be effective change agents by learning about improvement in the workplace. Our Quality and Safety Fellows have found that fulfilling their commitment to support undergraduate and postgraduate education becomes a driver for service improvement. This is an example of what the IT industry calls bidirectional alignment, defined as being 'capable of reacting or functioning in opposing directions' – a beneficial two-way flow of

information (Johl and Grigsby, 2017). In industry it is increasingly common to use intelligence gathered from 'rookies' within the organisation alongside information from customers to inform the setting of major organisational priorities (Johl and Grigsby, 2017). Complex healthcare organisations are typical of the type of workplace environments that may benefit most from this type of learning. Incorporating bidirectional alignment in healthcare challenges us to set organisational priorities that originate from the vantage point of learners as well as of leaders. Learners bring fresh perspectives and can energise clinical teams by sharing their learning approach with the experienced frontline staff (Johl and Grigsby, 2017).

I like the concept of 'transformational leadership'. However, I did not have access to the Kouzes and Poser (2012) book that Kenneth Adegoke uses in his discussion of this topic. In searching for more accessible information I found a discussion paper about nursing and medication safety education that is structured around four elements of transformation leadership: idealised influence; inspirational motivation; intellectual stimulation; and individualised consideration (Vaismoradi et al., 2016). These four elements are worded differently from the five behaviours cited by Kenneth. More importantly, I find that both lists use terminology that can be hard to understand or explain. Are 'idealised influence' and 'models the way' the same thing? Kenneth says the CLP introduced him to previously 'unknown' tools and terminology and I confess that the meaning of terms like 'high support, high challenge' and 'Perceptual Positions: P1 and P2' was unclear to me too. Lucas and Nacer (2015) say the choice of the word 'habit' in their framework for learning about improvement was deliberate:

> *'For knowing something or even being skilled at doing something does not of itself lead to improvement. Only when people habitually and reliably use their knowledge and skills in the real-world context of caregiving will behaviours change.'*

Kenneth makes a similar point, talking about enabling the ways of working inspired by the CLP to 'become the norm in our everyday practice'. Lucas and Nacer (2015) found that undergraduate and postgraduate curricula in quality improvement tend not to distinguish clearly between knowledge, skills and habits. Interestingly they found that leadership development was absent from a list of 11 categories of training identified by a previous evidence scan of more than 350 articles about training on quality improvement techniques for health professionals (Health Foundation, 2012). This omission reminds us that finding language to capture learning for improvement in its broadest sense is problematic. We find that the Habits of Improvers framework makes sense to frontline staff, managers, patients and students (Academic Health Sciences in Partnership in Tayside, 2016). Through conversations with these stakeholders the medical school has come to realise that student involvement in quality improvement projects only develops two of the five habits of improvers (influencing and resilience). This is because the goals for improvement have been set by clinical teams before the students begin. We are broadening the range of service-learning opportunities to focus on learning through problem finding and questioning, creativity through critical thinking with clinical teams and systems thinking through service design. We would certainly benefit from increased capacity in transformational leadership in NHS Tayside in order to develop these broader learning opportunities, unlock the potential of these learners and enable organisations to benefit from bidirectional alignment.

However, this will only happen if we all speak a common language that links learning to the improvement that matters to patients, reflecting the multidisciplinary 'network of like-minded colleagues' highlighted by Kenneth as central to the potential of transformational leadership.

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A response to this commentary by Kenneth Adedeji Adetokunbo Adegoke follows on the next page

International Practice Development Journal

Online journal of FoNS in association with the IPDC (ISSN 2046-9292)

RESPONSE TO COMMENTARY

Novice to transformational leader – a personal critical reflection

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I would like to thank Dr Davey for his comments. I am encouraged to hear that he supports the involvement of clinicians in health management and leadership. I can clarify that the course lasted 10 months and acknowledge Dr Davey's recognition of our commitment – it has been well worthwhile. And I can confirm that at the beginning of the CLP, I and the other 22 clinicians involved were also confused by some of the specific management thoughts and terminology we encountered.

I recommend perseverance as such initial issues are readily surmountable. Management-speak is something to which I and most other clinicians were only introduced towards the end of our postgraduate training. In fact, we already subconsciously use some of the concepts in leadership and management courses on a daily basis.

Here is a 'translation' of some of the key terms:

- **Perceptual Positions P1, P2 – there is a P3! (Grinder and DeLozier, 1987)**
  P1 is your viewpoint; P2 is the viewpoint of an 'other'; P3 is the viewpoint of another interested, but not directly involved, person. There are many choices of position, depending on your leadership style – autocratic, democratic, dictator, and so on.

- **The five behaviours of transformational leaders, as described by Kouzes and Posner (2012), can be simplified as follows:**
1. Model the way: *leads by example*
2. Inspire a shared vision: *good leaders share their vision with their team, 'bringing the future to the present'*
3. Challenge the process: *a good leader thinks outside the box*
4. Enable others to act: *a good leader should empower others*
5. Encourage others to act: *the leader creates and supports a happy, lively work place and a good team ethic, showing a good sense of humour and letting them team know he is mortal too*

All five behaviours make good common sense; they are behaviours seen in all good leaders.

My take-home messages from the CLP are:
- That clinicians become more involved in managerial roles. This involvement may well commence while in medical school. There is a paucity of publications by clinicians sharing their experience of management and leadership; most such publications are by nurses. The nursing hierarchical structure is top-down while with clinicians, there is a far greater degree of autonomy and active engagement of other colleagues in bringing about change. Consultant clinicians are solely responsible for their own actions and decisions – within the limits of their code of practice. My personal observation is that clinicians and nurses are 'hard wired' differently.

- As part of a transformational change, clinicians should see managers as compatriots and themselves aspire to become good managers and good leaders, instead of being perpetually at loggerheads with managers
- With the tightening of the NHS finances, there is a greater call for clinicians to get more involved in transformational leadership within the NHS infrastructure and become drivers of change
- There is a great deal of 'silo working' among clinicians. There is a strong need to breakdown old traditional barriers and for clinicians to share experiences and network. There was a great deal of this demonstrated and practised in the action learning groups within the CLP course. All the participants attest to the usefulness of 'sharing' and networking and found it greatly beneficial. Dr Davey indicates that he has observed in his own experiences the benefits of this multidisciplinary team approach to patient care
- Any transformational leadership course must be directed at and inclusive of all main stakeholders in healthcare: clinicians, senior nurses, pharmacists, biomedical scientists, managers and so on. This enables each one to be 'perceptive' of the others' needs
- Clinicians need to be allotted protected time in their job plans for leadership and management.

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