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Managing Editor
Jane Jervis

Administrator
Charlotte Hulme

Telephone
+44 (0)1782 734436

Email
jade@keele.ac.uk

Web
https://www.keele.ac.uk/kiite/publications/jade/

Address
KIITE, Claus Moser Building, Keele, ST5 5BG

Exploring leadership styles of Advanced Clinical Practitioners to initiate change in clinical practice: A reflective account from a primary care perspective

Joanne Holland, Coventry and Warwickshire Partnership Trust

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Abstract:

The concept of advanced practice has been developed to not only enhance the capacity and dimension of the healthcare workforce but improve clinical continuity, demonstrate high quality, patient-focused care and provide visible leadership in the hope of shaping organisational culture whilst advocating evidence-based change to continually improve the way healthcare is delivered.

Advanced practice is demonstrated across four pillars: advanced clinical practice, education, clinical leadership and management, and research. The focus of this paper is on leadership in a primary care context and will present a reflective account of an Advanced Clinical Practitioner's journey in initiating a new service within a primary care setting. The paper will define leadership; consider the impacts of existing cultures whilst exploring contemporary leadership styles to determine which best reflects the fundamental values of advanced practice and therefore most appropriate to apply when initiating change. It will conclude on the purpose and value of reflective practice in this health care context, building on the personal experiences of the author.

Key-Words:

Transformational
Change processes
Advanced clinical practice
Leadership

Introduction

Ambulance crews are left with a decision to either admit a patient into secondary care or refer to an alternative primary care pathway if the patient is deemed safe at point of assessment to be managed within the home environment. Unfortunately, it has been identified that there is a national medical shortfall within primary care, with overstretched General Practitioners (GPs) simply unable to respond as an alternative pathway in a safe and timely manner (NHS England, 2016, Majeed, 2017). This has impacted significantly on the increased numbers of patients presenting to Accident and Emergency (A&E) departments (Kings Fund, 2012a, 2018) with the magnitude of the issue reflected in the National Health Services 'Long-Term Plan' released in January 2019 (Kings Fund, 2018). This has prompted a national commitment of increased funding into primary care services with a focus on the development of existing clinical workforces to ensure a more responsive primary care sector (Kings Fund, 2018).

To be successful in its transition, it has been recognised that the healthcare environment requires the development of a clinical workforce that demonstrate

effective leadership underpinned by the right fundamental values. Internationally, it has been agreed that leadership is an integral part of advanced practice (Department of Health, 2010) placing Advanced Clinical Practitioner's (ACP's) in a prime position to lead change. What is not clear is the definition of leadership at an advanced level and guidance on how to apply it successfully within the healthcare environment.

This paper will provide a reflective account of the author's role in developing a new service, focusing on how the author considered and applied leadership to their practice. To achieve this, the paper will explore contemporary leadership styles to determine which best encapsulates the essence of advanced practice. It will begin by introducing styles of leadership and critically evaluating their effectiveness in this context. To provide a reflective framework, Gibbs 'reflective cycle' (Gibbs, 1988) has been used as it is a familiar model of reflection used within the health professions and allows a clear and precise use of stages to assist the author in making sense of experiences.

Step 1: Description

To address the medical shortfall locally within primary care, the clinical commissioning group (CCG) proposed the development of a new service to act as an urgent care pathway with a view of managing patients presenting with acute illness. In response, the primary care trust; in collaboration with secondary care and local ambulance services, introduced an ACP led service at the beginning of 2019. The aim of this service was to provide advanced medical intervention within the home environment to support demand within general practice, add a new dimension to the traditional offering of community services and allow a more holistic approach to care delivery. The service would target patients who would otherwise present to emergency services such as ambulances and A&E departments, thus providing an alternative to hospital admission whilst meeting the national health agenda of providing acute care closer to home (Department of Health, 2010, Kings Fund, 2012b, NHS England, 2014).

Step 2: Feelings

The author was concerned that the introduction of an ACP led service would be met with an element of resistance from both nursing and medical colleagues which could be perceived as a restraining force (Lewin, 1951) and make the process of change more difficult. Hewison (2012) explored nurse manager's accounts of change and forces working against. Key themes such as threats to the existing order of healthcare, workload saturation and fear of the unknown were identified.

Similar themes from a medical perspective had previously been shared by Wilson et al (2002); who suggested threats to the pre-existing order of healthcare and GP status, capabilities of nurses regarding responsibilities as well as structural and organisational factors were four main drivers fuelling GP concern, resulting in a reluctance amongst medical colleagues for the use of ACPs within primary care. It is important to note however, that the focus group study conducted by Wilson et al (2002) represented the views of only four GP practices based within Yorkshire. To enforce this argument, a broader perspective would need to be gained. It's also

important to note that the study (Wilson et al, 2002) is outdated, with more recent evidence suggesting that the substitution of doctors with nurses has the possibility to produce financial savings and reduce the burden of general practice workloads without compromising patient care or experience (Biezen et al, 2016).

The author used this information when communicating with key stakeholders to gain acceptance and support of the service. It allowed the author to feel empowered as there was evidence to support the advantages of an ACP led approach from not only a patient care perspective but also an organisational perspective, which appeared to alleviate any initial external fears.

Step 3: Evaluation

The use of a change model when initiating change assists managers in anticipating areas of resistance and provides an opportunity to implement counter strategies to reduce, if not fully eliminate issues prior to commencement. There are many widely recognised processes of change including McKinsey's 7S model-based framework (Hanafizadeh and Ravasan, 2011), Kotter's 8-Step Theory (Auguste, 2013) and Kübler-Ross Five Stage Model (Rosenbaum eat al, 2018). To support the change management process in the instance of the proposed new service, the author utilised Lewin's (1951) "unfreeze, change and refreeze' theory, namely due to its simplicity.

The model has been previously criticised for being outdated and irrelevant to contemporary society as it is felt change is inevitable and could happen at any time leaving little or no time to settle into routines. The concept of 'refreezing' gives an impression of stability which could create inflexibility and the need to readdress organisational culture with every new innovation, therefore proving incompatible with current thoughts that change is continuous (Burnard and Gill, 2009).

Although outdated the model is still widely used and serves as the basis for many modern change models. The author noted that the simplicity of the model allowed flexibility in its interpretation and execution of the process. It influenced the author to follow a series of key phases which started with creating the perception that a change was needed amongst colleagues and external stakeholders, then a shift toward the new, desired level of behaviour by implementing a clinical response for referred or identified patients and finally, solidifying new behaviour as normal practice by maintaining the level of service delivered. The author found that Lewin's (1951) "unfreeze' phase encouraged communication and engagement with all those involved in the process of change, resulting in the whole process being met with less resistance (Manning, 2006).

Step 4: Analysis

Leadership is defined as the art of motivating a group of people to work towards achieving a common goal. The leader is considered the one that possesses a combination of personality traits and leadership skills that makes others want to follow their direction (Avolio et al, 2009). Despite a consensus on definition, there are many styles that can be utilised to demonstrate leadership.

Authoritarian

A breakdown of communication is one of the first signs of organisational difficulty and one of the main criticisms associated with the authoritarian leadership style (Marquis and Huston, 2015). The authoritarian model promotes decision making at a managerial level with dissemination downwards to those expected to adhere. This 'top-down' delivery of change is often met with confusion, frustration, and resistance with innovative and proactive members of the team left feeling demoralised and undervalued by an organisation (Porter-O Grady and Malloch, 2010).

It has been argued that the authoritarian's dictation of rules to achieve organisational objectives and establish desired behaviour results in a normative mind-set, ensuring team adherence opposed to conflict (Sullivan and Garland, 2013). Debatably, this instilled mind-set could be considered depthless and non-conducive for inspiring creativity and innovation within a team, suggesting the model may be ineffective in the process of change (Manning, 2006). This does not negate the authoritarian's ability to produce prompt outcomes in crisis situations (Stone et al, 2003). However, the under-utilisation of the internal workforce's experience and insight could risk unmet population need and unexplored, potentially more efficient ways of delivering care.

When considering an authoritarian approach to lead the project, the author recognised that organisational need can sometimes conflict with the traditional values of nursing practice. This could place ACPs from a nursing background in a compromising position in regard to nursing principles. There is a strong argument that the need to provide high quality, patient focused care is a nurse's internal compass, providing a sense of direction representative of the nursing professions values (Govier and Nash, 2009). It is these values that facilitate a more genuine approach to leadership, suggesting an ACP would find it difficult to transition into a predominately dictatorship role.

Laissez Faire

The laissez faire model which promotes complete autonomy within a team has been criticised for its lower productivity as a result of lack of direction and guidance (Manning, 2006). Arguably, this form of leadership is only considered appropriate when dealing with a team of experienced and highly motivated individuals, capable of working independently (Avolio et al, 2009). But this too has been disputed, with the author concerned that an experienced cohort of senior clinicians, as required in the implementation of the proposed new service, can become dissonant due to professional conflicts, thus impacting on team efficiency (Ashurst, 2010).

This suggests a laissez faire approach may not always be ideal in the process of change as dependant on the dynamics of the group a visible leader may be required to maintain a state of equilibrium (Burnard and Gill, 2009). This is supported by Ashurst (2010) who suggests that '*engaging leadership*' is fundamental in maintaining a constructive culture and in the development of effective interpersonal interactions.

Transformational

The concept of '*engaging leadership*' reflects the foundation of Transformational Leadership (TL). In its purest form, transformational leaders (TL's) are visionary, have the ability to motivate others and generate valued and positive change (Stewart, 2006). It has been suggested that clinical knowledge and competence provide a necessary foundation for TL within healthcare. This places ACPs in an advantageous position as they maintain a largely clinical element of their role and are considered clinical experts in their field of practice (Marshall, 2011).

Despite evidence to suggest its benefits, TL carries several criticisms. Firstly, it is felt that the definition encompasses more personality attributes than the skills and values required to deliver effective leadership (Hall et al, 2002). Trait theories attempted to identify the specific personality attributes that distinguished leaders from non-leaders with little evidence recovered at that point (Stogdill, 1948, Mann, 1959). A more recent mixed method review of literature (qualitative and quantitative) revealed common phrases used to describe TL such as innovative, inspirational and purpose driven (Judge et al, 2004). The vagueness of the selection process with literature simply comprising the words 'leadership' and 'personality' and a sample size of only 12% of all available literature questions the validity of the outcomes. So, although beneficial, the author concludes that attributes in isolation may be insufficient for the delivery of effective leadership, suggesting further and more up to date research is required to standardise the TL concept.

Another concern expressed by libertarians in relation to TL is the potential abuse of power, questioning the morality associated with this style (Hall et al, 2002). It is believed that TLs can exert powerful influence over predominantly dependant followers (Tappen et al, 2001). This becomes problematic when those in a TL position demonstrate narcissistic tendencies, thriving on the ability to manipulate others and feel powerful (Stone et al, 2003). The author argues that this should question the morality of the individual opposed to the style and believes an adherence to the ethical codes of nursing practice, namely beneficence and non-maleficence, will provide a moral foundation and ensure the demonstration of true TL in nursing (Stone et al, 2003; Nursing and Midwifery Council, 2015).

Surprisingly, enthusiasm associated with the TL approach has been met with an element of negativity. Followers expressed that although inspirational for change the relentless application had a tendency to leave individuals feeling overwhelmed, worn down and ultimately withdraw (Mullins, 2000). There were also concerns expressed that the passion expressed by TLs could result in an emotionally driven decision that was not necessarily reflective of the best interests of the group (Sovie, 1993). This could be perceived as self-serving and prove detrimental to the leader's integrity.

The author believes that an awareness and application of the 'Emotional Intelligence' model, which explores the understanding and management of one's emotions as well as those around, will support self-regulation, self-awareness and awareness of others. This will ultimately guide interactions internal and external of the team, facilitate a general awareness of morale and avoid any reckless decisions (Bratton et al, 2011).

Born vs. Developed

Behavioural genetic studies have discovered a link between personality and genes, suggesting personality traits have a genetic foundation (Livesley et al, 1998). If the personality driven definition of TL is accurate, this supports the argument that TLs are born rather than developed. This thought is supported by behavioural theories such as the 'Great Man' that believe individuals inherit qualities from birth, making them naturally more suited to leadership roles (Avolio et al, 2009).

Historically, this has been argued by Sociologist Herbert Spencer (1896) who felt leaders were products of environmental exposure, highlighting society as a prevalent influence. It has been more recently supported that leadership is not based on popularity or extroversion but the willingness to apply the principles to emerge as an effective leader; advocating leaders can be developed (Northouse, 2016). Although an outdated perspective, the view of Herbert Spencer remains well supported and has inspired organisations to invest in leadership and its development within teams.

Step 5: Conclusion

The introduction of an ACP led service has the potential to not only provide an alternative pathway to hospital admission but influence the perception of medical colleagues and re-shape existing, local community services. Throughout the paper there is clear support for TL with the essence of the model embedded heavily into the ACP concept. This places ACPs in the fortunate position to positively influence clinical practice through the use of motivation and engagement to create a shared vision. However, it is recognised that the choice of leadership is dependent on circumstances and that an eclectic approach may be required to achieve desired outcomes in some instances.

Step 6: Action Plan

The author has recognised throughout this process that a participative leadership style will promote a sense of ownership amongst team members, resulting in a greater commitment to a shared vision and ultimately resulted in a greater utilisation of the new service (Marquis and Huston, 2015), securing its future success.

Moving forward, the author intends to exhibit the qualities and attributes of a transformational leader, to ensure multidisciplinary input in future projects whilst acknowledging that a multi-pronged approach is needed to challenge resistance as well as acknowledge fears and address any barriers collaboratively (Schifalacqua et al, 2009). This coupled with the demonstration of political astuteness; an attribute associated with the advanced practice role (DH, 2010), and ability to communicate on local issues and drives for change, will promote not only support of a concept but increased confidence in the leader's abilities (McGee and Radford, 2009).

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