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Leadership and governance: learning outcomes and competencies required of the family physician in the district health system

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The South African National Development Plan expects the family physician to be a leader of clinical governance within the district health services. The family physician must also help to strengthen the services through leadership in all his/her other roles as a clinician, consultant, capacity-builder, clinical trainer and champion of community-orientated primary care. In order to deliver on these expectations the nine training programmes must ensure that they prepare registrars appropriately for leadership and clinical governance. Currently training programmes differ considerably in what they teach and in workplace-based training and assessment. This article reports on a national process to reach consensus on what training is required for family physicians in this area. The process outlined the key conceptual principles and competencies required for leadership, clinical and corporate governance; it culminates in a new set of learning outcomes for the training of family physicians.

Keywords: clinical governance, community health system, family physicians, leadership, training programme

Introduction

In the South African National Development Plan the family physician has been recognised as the leader of clinical governance for the health district.¹ Clinical governance refers to a responsibility for improving and ensuring the quality of clinical care and has been defined as 'a framework through which organizations are accountable for continuously improving the quality of their services and safeguarding high standards, through creating an environment in which excellence in clinical care can flourish.'² It is clear that the family physician's responsibility for clinical governance also requires leadership capability within the district health care team. Leadership, and specifically leadership of clinical governance, therefore is a core competency required of the family physician.

This core competency has been recognised nationally by the postgraduate Family Medicine training programmes as one of the core roles of the family physician:³ clinical care throughout the district, being a consultant to the rest of the clinical team, being able to build capacity within the clinical team, leading clinical governance activities, championing and supporting a community-orientated approach, and finally supervising the training of medical students, interns, registrars or clinical associates. Currently postgraduate training in family medicine is a four-year training programme provided by nine independent university-based training programmes. Training is assessed by means of a final national exit examination offered by the College of Family Physicians. Both the training and assessment are guided by a set of nationally agreed learning outcomes.⁴

An appraisal of the current training programmes indicated that three programmes are attempting to address the challenge of leadership and clinical governance competencies, three are continuing to teach the older style approach to practice management and administration and three do not have a clear approach to teaching for this role. The current national learning outcomes still reflect the more historical focus on management and administration.

There was a need, therefore, to reach a new national consensus on what training is required to prepare family physicians for leadership and clinical governance. This article aims to report on the outcome of a process to define conceptually our understanding of leadership and governance and to develop new national learning outcomes for the relevant competencies.

The process

The development of a new training module on leadership and clinical governance for the training of family physicians was one of the goals of a project to strengthen primary health care through primary care doctors and family physicians, which was funded by the European Union. The project partners included all the universities training family physicians as well as the South African Academy of Family Physicians and College of Family Physicians. Two international partners, namely the Royal College of General Practitioners (UK) and the University of Ghent, Department of Family Medicine and Primary Health Care (Belgium), were also visited and consulted on their approach to postgraduate training in leadership and governance. One of the South African partner institutions conducted a scoping review of the literature on leadership and clinical governance.

All the SA partners came together for a two-day national workshop in April 2015 to reach consensus on new learning outcomes. Strategic partners with an interest or expertise in this area were also invited to participate and included:

- The Cape Wineland's district manager who shared her experience of implementing the Western Cape's clinical governance framework with family physicians as a key role player.
- The Health Systems Trust, which was working with the National Department of Health on defining the roles of the district health management team.
- A representative of the Oliver Tambo Fellowship Programme that teaches leadership and management to mid-level public sector managers.

- A public health specialist who runs a two-year Postgraduate Diploma on Healthcare Management.
- A family physician's experience of the Management Sciences for Health, Virtual Leadership Development Program.

Leadership

Important principles

Leadership was not seen as another specific role, but rather a set of competencies that should become visible in all of the existing six roles of the family physician. A definition that leadership is 'authentic self-expression that adds value' summarised the essence of this approach well. In other words the family physician should add value through his/her leadership ability in all his/her roles. This also recognised that family physicians often lead from their perspective as the most highly trained senior clinician within a team of peers and colleagues, rather than from a specific authoritative place in the hierarchy such as a line manager. The type of leader required, therefore, primarily makes sense of the organisation as a complex system of networks and relationships, within which paradoxical principles must often be balanced. For example, supporting people's freedom to act within the constraints set by a few simple rules, or tolerating uncertainty and ambiguity while also giving clear unambiguous feedback to people on their performance. Collaborative and complex adaptive leadership styles were therefore seen as best suited to the roles of the family physician.⁵

The 'I-we-it' model of leadership (Figure 1) resonated most with the group as a conceptual model of developing leadership ability.⁶

The foundation of this is the 'I' domain, which emphasises self-awareness, self-reflection, and self-management in terms of one's own values, strengths and weaknesses as a leader, and how one needs to change and develop in one's leadership styles and behaviour. A number of tools are available to assist with this (e.g. Values-In-Action Inventory of Strengths survey,⁷ Positive Leadership Assessment,⁸ Temperament Inventory,⁹ Emotional Intelligence,¹⁰ as well as reflective writing, group discussions and coaching).

The next important domain is the 'we', which focuses on building relationships and networks within which one can offer leadership. This domain emphasises skills in communication, teamwork, mentoring or coaching others, advocacy and coordination. Leadership in this domain shows up strongly in terms of capability-building, clinical training, clinical governance activities, and supporting COPC activities.



Figure 1: The 'I-we-it' model of leadership scheme.⁶

The next important domain is the 'it', which focuses on knowing the context of the health system within which one is being a leader. What are the important structures, processes and procedures? What are the important laws and policies?

Important issues for training

There was a consensus that training in leadership should take a longitudinal and incremental approach that develops leadership capability over the course of the four years; uses experiential or action learning in the workplace around concrete problems; includes mentoring by other effective leaders (role models), and specific coaching in personal leadership development.

Trainers themselves may need to receive training and support to develop the skills of teaching leadership.

Clinical governance

Important principles

While family physicians may take responsibility for clinical governance they need to involve the whole healthcare team and delegate responsibility for some tasks – in other words offer appropriate leadership. They need to lead and implement a proactive process, but not necessarily do everything. If not, they risk burnout, being overwhelmed and failing to enable ownership of the process by the whole team. Prioritisation, teamwork and managing one's personal boundaries are all important.

Clinical governance should pay attention not only to disease-specific or clinical processes (e.g. care for people with diabetes) but also systematic issues (e.g. continuity of care, coordination of care between levels (referrals)) and patients' perspectives (e.g. experience, satisfaction, formal engagement through clinic committees). Clinical governance also requires family physicians to consider how they contribute to an organisational culture that encourages openness, reflection, innovation, accountability and learning. However, operationalising clinical governance can be limited by the scarcity of resources and the extent to which the system supports a desire for improved quality of care. The relationships with facility and sub-district managers, who are responsible for these resources and help co-create the organisational culture, are thus central to the success of clinical governance.

Important competencies

The following roles and competencies were listed for the family physician:

- Contribute to the development of or revision of clinical guidelines by giving input from the perspective of the district health services.
- Facilitate the implementation of clinical guidelines within the sub-district or facility.
- Improve quality of care by facilitating quality improvement cycles (where the audit of clinical care is just one step in a cycle of feedback, reflection, planning and action at a local level).
- Improve quality and efficiency through reflection on routinely collected data such as the monitoring of prescribing or use of investigations.
- Build capability and quality care through teaching, training and role-modelling.
- Manage risk and improve patient safety through reflection on significant adverse events (e.g. conducting morbidity and mortality meetings) and use of root cause analysis.
- Critically appraise new research evidence for the team.

- Assess the competence of new clinicians and set appropriate levels of independence vs. support.
- Evaluate the quality of care in relation to the relevant clinically orientated national core standards.

Corporate governance

Key principles

Corporate governance involves all the more traditional managerial tasks of finances and budgets, procurement and supply-chain management, human resource management, and infrastructure. This is typically the role of the clinical manager and not the family physician. A clear principle was that the family physician is primarily a clinician and not such a manager. Family physicians need to understand the principles of corporate governance so they can be 'consciously incompetent' in this area and know how to engage, influence and ask the right questions of the managers responsible. They do not need to be competent to perform all these tasks, as this is the role of the clinical manager

or equivalent. They should therefore be able to contribute to these managerial processes without being absorbed by them.

Important competencies

The family physician needs to ensure sufficient two-way engagement and communication with those responsible for corporate governance as these issues have a direct impact on clinical care. On the one hand they need to ensure that they access information on corporate governance policy, decisions and plans, and on the other, create opportunities to give advice and advocate from the clinical perspective. This should not mean attending all of the managerial meetings and should include being able to set a clear boundary between their role as a family physician and the role of the clinical manager.

Being able to understand and influence corporate governance issues is key to improving patient care. This would require competency in communication skills, advocacy, motivating well,

Table 1: New learning outcomes for leadership, clinical and corporate governance

	1. Demonstrating self-awareness and reflection in terms of one's personality, personal values, preferred learning and leadership styles, and learning and development needs
Develop him or herself optimally as a leader by:	2. Demonstrating effective methods of self-management and self-care
	3. Demonstrating willingness to seek help when necessary
	4. Demonstrating an ability for self-growth and personal development
Offer leadership within the healthcare team and district health system by:	1. Communicating and collaborating effectively
	2. Demonstrating an ability to build capability, mentor or coach members of the healthcare team
	3. Demonstrating an ability to engage and influence others through advocacy, group facilitation, presentations, critical thinking, or behaviour change counselling
	4. Working effectively as a member of the sub/district healthcare team
Describe and contribute to the functioning of the district healthcare system by:	1. Demonstrating an understanding of the principles of the district health system in the context of existing and developing national legislation and policy
	2. Demonstrating an ability to contribute to the management of a facility, sub-district, or district
Lead clinical governance activities by:	1. Demonstrating the ability to lead a quality improvement cycle in practice
	2. Demonstrating the ability to build capability through training, teaching and mentoring others in the healthcare team [see unit standard 4.1]
	3. Facilitating reflection on health information (e.g. monitoring and evaluation, national core standards) in order to improve quality of clinical care (e.g. rational prescribing and use of investigations) in the sub/district
	4. Facilitating risk management processes and improving patient safety (e.g. conduct morbidity and mortality meetings, assess competence of new clinical staff, perform root cause analysis) in the sub/district
	5. Facilitating the implementation of clinical guidelines in the sub/district
	6. Critically reviewing new evidence (e.g. research) and applying the evidence in practice
	7. Contributing to the development or revision of guidelines by generating new evidence (e.g. perform research) or representing the viewpoint of the district health services in the process
Understand and influence corporate governance:	1. Understand the principles of human resource management (e.g. labour relations, recruitment, disciplinary procedures, grievances)
	2. Understand the principles of financial management (e.g. budgets, health economics, financial planning)
	3. Understand the principles of procurement and infrastructure (e.g. supply chain, equipment, buildings)
	4. Understand the principles of health information and record-keeping systems
	5. Understand the principles of rational planning of health services
	6. Be able to communicate effectively with those responsible for corporate governance

speaking to authority through the correct processes and structures, and constructive engagement. Occasionally this might also mean knowing when to challenge outside the structures (e.g. whistleblowing).

Discussion

The consensus on key principles and important competencies presented above led to agreement on new national learning outcomes, as shown in Table 1. These new learning outcomes have now been formally adopted by the College of Family Physicians (South Africa) and will be assessed in the national exit examination. This implies that appropriate learning opportunities must also be fully incorporated into the training of family physicians by all training programmes. In this regard Stellenbosch University has offered to share its newly developed module as an example for other programmes. Workplace-based training and assessment in the portfolio of learning must also ensure attention is given to evidence of leadership development and competency with governance activities.

An active debate during the workshop was whether the competencies required for leadership, clinical and corporate governance are the same in both the private and public sectors. The conclusion of the group was that the key competencies are essentially the same and therefore there is no need for separate training modules. Although there was previously an emphasis on more skills in corporate governance for those entering private practice the need for this is diminishing as many practices now employ a practice manager.

Internationally there is a mushrooming of books, resources and training programmes on leadership and governance. Our challenge, therefore, is not necessarily to create more resources but to be clear about what is relevant for the roles of the family physician in the South African context. Our approach to these issues should be included in our core textbooks such as the Oxford Handbook of Family Medicine¹¹ and SA Family Practice Manual.¹² Attention must also be given to upskilling the clinical trainers and ensuring that they feel confident to train and teach on these topics.

Ongoing advocacy with the national and provincial departments of health is needed to align our view of leadership and governance for the family physician with that of the district health services. As set out in our national position paper,³ family physicians need to be appointed at community health centres, sub-districts and district hospitals at scale in order for their contribution to be realised in the public sector. Effective training also requires designated registrar posts, and capable clinical trainers with real capacity to spend time training in the workplace context.

Conclusion

Family physicians have been given the responsibility to lead clinical governance activities within the district health system. A national process has led to a new consensus on what this means in terms of our approach to leadership as well as specifically in

relation to clinical and corporate governance. These key principles and competencies have enabled an agreement on a new set of national learning outcomes, which must now be implemented in both training and assessment. For their potential role in leadership and clinical governance to be realised, the training and deployment of family physicians needs to be an integral part of the district health system.

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