Global health partnerships: leadership development for a purpose

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Abstract

Purpose – The purpose of this paper is to describe a novel approach to leadership development for UK healthcare workers, while contributing to health service improvement in a developing country.

Design/methodology/approach – A quality improvement faculty are used to teach and mentor National Health Service (NHS) International Development Clinical Fellows in quality improvement (QI) methods. Using accepted QI methods, sensitive and practical improvement projects are selected in partnership with local people in Cambodia in order to start achieving United Nations Millennium Development Goals related to child and maternal health. Simultaneously, NHS International Fellows gain an unparalleled opportunity to develop their leadership skills, which should benefit the NHS on their return to the UK.

Findings – Healthcare quality improvement methods, developed in First World countries, are transferable to the developing world and also function as a vehicle for developing leadership skills in experienced healthcare workers.

Practical implications – This leadership development programme fits with the stated aims of the Global Health Partnerships report, which encourages the NHS to play a global role in healthcare development in the developing world. Other First World healthcare systems could adopt this leadership development method to both improve the leadership capability of their own staff while also making a significant contribution to less well-developed healthcare systems.

Originality/value – The combination of leadership development through quality improvement is novel – promising to benefit both providers and recipients.

Keywords Quality improvement, Leadership development, Health services, Developing countries

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1. Background
Many of the challenges facing healthcare in the developing world are very different in scale and scope to those facing the western world, but both are bound by the need for leadership of sustainable change.

NHS South Central, an English Strategic Health Authority responsible for the healthcare of 4 million people, has a history of innovation in leadership development. The publication of Lord Crisp’s report, *Global Health Partnerships* (Crisp, 2007) and the subsequent UK Government’s response (www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083509) provided welcome support for the NHS to combine leadership development with international support. The focus on clinical fellowships in the Next Stage Review (Darzi, 2008) added further legitimacy to the notion of equipping NHS professionals with leadership and service improvement skills early in their careers. Therefore, International Development Clinical Fellows were sought from the training grades, as well as from more senior “ranks” of all clinical professions.

A partnership was developed with the Maddox Jolie-Pitt (MJP) Foundation in Cambodia. The NHS offers a broad range of highly qualified and experienced healthcare professionals, while MJP offers significant expertise in overseas development, and an established and stable infrastructure with quality project management. Furthermore, the MJP programme in Cambodia addresses the wider determinants of health (e.g. sanitation, education, agriculture, clean water) offering NHS colleagues a unique experience with transferability back to the UK.

This paper, intended to be the first in a series, describes the approach to leadership development that has been adopted. We aim to report the resulting impact on leadership development skills from an external and ongoing evaluation, which completes at the end of 2009.

2. Cambodia and the NHS partnership
Cambodia, one of the poorest countries in South East Asia with a predominantly rural population of 14 million, continues to feel the after effects of the Khmer Rouge regime. This regime, led by Pol Pot from 1975-1979, resulted in the genocide of approximately 2 million people. Professional and technological classes were ruthlessly targeted, leaving only 50 doctors in the country at the end of the war. Cambodia now spends 1.7 per cent of its GDP on health compared with 7 per cent in the UK and 17 per cent in the USA (http://hdrstats.undp.org/en/indicators/50.html). Comparative data are shown in Figure 1.

Since the genocide, the international community has provided support to Cambodia often through Non-Governmental Organizations (NGO’s) focusing on their own particular areas of interest and expertise. The Maddox Jolie-Pitt Foundation (MJP), an NGO founded in 2003 by the US philanthropist and actress Angelina Jolie, focused initially on conservation and preservation of a large forested area in the rural northwest close to the Thai border. This initial focus expanded into an integrated community development project which now encompasses agriculture, education, conservation, infrastructure and latterly, healthcare.

The MJP Foundation, based in Cambodia’s second largest city Battambang, also has a field headquarters 80 km away in Samlaut. The Samlaut area, with a population of approximately 5000, has been designated as the first United Nations Millennium
Village outside of Africa, due to its high rate of rural poverty. In 2000, supported by the United Nations development group, the nations of the world committed to eight Millennium Development Goals:

1. Eradicate extreme poverty and hunger.
2. Achieve universal primary education.
3. Promote gender equality and empower women.
4. Reduce child mortality.
5. Improve maternal health.
7. Ensure environmental sustainability.
8. Develop a Global Partnership for Development.

These set time-bound and measurable targets for halving extreme poverty by 2015. The Millennium Villages initiative seeks to end extreme poverty by working with the poorest of the poor, in partnership with governments and other committed stakeholders. It aims to provide affordable and science-based solutions to help people lift themselves out of extreme poverty.

MJP launched its rural development programme to achieve the millennium development goals in Samlaut in 2006 and aims to be completed by 2012. In order to reduce child mortality and improve maternal health, MJP and the Cambodian government have partnered with South Central Strategic Health Authority, a regional healthcare organization of the UK’s National Health Service (NHS). Global Health Partnerships such as this not only have the potential to contribute to improving global health but also enable the opportunity to learn from the developing world.

2.1 Samlaut Millennium Village Healthcare
Samlaut Millennium Village has three basic formal primary care facilities – one supported by the government and one supported by MJP with a second MJP facility opening in June 2009. These facilities are staffed by a combination of nurses and
healthcare workers, only some of whom have had formal Cambodian Ministry of Health training. Treatment is free only at MJP facilities. A largely unregulated and informal private sector provides a significant proportion of local healthcare. All hospital care is provided 80 km away in Battambang and requires payment of both transport and treatment costs. The health team at MJP consists of a Cambodian trained doctor and medical assistant who co-ordinate the Samlaut programme from Battambang. In addition there are between 1 to 4 members from the NHS partnership at any one time working either in Samlaut or at the paediatric ward in the Battambang referral hospital.

3. Leadership development through quality improvement

Leadership development for clinicians has received much focus in the NHS over recent years, and many local programmes now exist to support clinicians to develop skills, which will enable them to take up positions of influence within their local health economy. An increasing focus on QI and outcomes since the NHS' Next Stage Review, led to the institution of a novel leadership development programme using QI methods as the vehicle to expose clinicians to healthcare system development. An approach to quality improvement, the Review, Agree, Implement and Demonstrate (RAID) model (Rogers, 2006) described by the NHS Clinical Governance Team, evolved as the best framework to expose NHS International Fellows to leading QI in healthcare. The widely used Plan/Do/Study/Act cycle (PDSA) (Langley et al., 1996) can also be applied alongside RAID and provides an approach to testing small changes applied to the system of care when targeting and evaluating improvement work.

In the Cambodian context, the RAID model was used to help NHS International Fellows to shift their understanding about leading QI from “implementing the solution I think is the right one” to “enabling local staff to develop the right solution for them” to bring about the implementation of improvements to the system of care.

The RAID model involves a thorough review of the way the local system of care currently works through engaging all the key stakeholders. This is followed by making agreements between the stakeholder group about what needs to change, what projects would help to achieve these changes, who will take responsibility for leading them and what help will they need. Implementation involves delivering the agreed projects using PDSA cycles to test the changes in the system. QI measures are currently under development and will ensure that improvements resulting from the changes are monitored.

The QI principles that underpin RAID are summarized in Figure 2.

The NHS and MJP continually strive to implement the following ten principles with local villagers and we believe that these will have application in other developing systems and are tabled below:

1. A clear and shared vision for the future of healthcare locally and nationally.
2. Assessment and development of local leadership and management capability (clinical teams and healthcare management).
3. Establishment of new patterns of interpersonal relationships i.e. between healthcare teams and local people, within healthcare teams, with local and national government officials etc.
(4) Clarification of work group norms/values i.e. team work capability, perceptions of roles etc.

(5) Understanding of perceptions of trust, risk taking behaviour and approaches to risk management style.

(6) Establishing communication systems, both formal and informal.

(7) Understanding influencing patterns of those who are perceived to have power and authority, e.g. opinion leaders, sources of resistance to change.

(8) Clarifying value systems i.e. attitudes to health and healthcare, attitudes to collective social responsibility, impact of the legacy of the civil war etc.

(9) Developing strategies for building on local networks of support embedded in local communities.

(10) Assessing the impact of the legacy of poor opportunities for education and personal development.

4. First steps
The first phase of work was undertaken over a period of seven months. During this time, an initial review was undertaken which focused primarily on developing an understanding of the type and quality of care provided by the current system in the Cambodian Millennium Village. This initial review enabled the International Fellows to use the “Review” and “Agree” components of the RAID model by enquiring into:

- Health needs of the local population by conducting a door-to-door household survey to assess population demographics, perception of disease prevalence, health seeking behaviour and unmet health needs as examples.

- The resources (manpower and buildings/equipment etc) that were available.

- How these resources (manpower and buildings/equipment etc) were being deployed and used.

- Fitness for purpose of the existing resources and their deployment i.e. effectiveness (standards of care), and efficiency of utilisation.
The challenges for building sustainable improvements that are culturally appropriate and embedded into local communities and network into wider support systems.

The door-to-door household survey was conducted over a three-week period in November 2008 and included 224 households with a population of 1240 (approximately 20 per cent of the population of Samlaut). Information was collected on demographics, morbidity, mortality and maternal health as well as qualitative observational data. Key findings from this survey were poor immunisation rates, only half of women benefiting from any antenatal care, high rates of illness and 20 per cent of those surveyed sought care initially in a health centre or health post versus 69 per cent using unlicensed private clinics or pharmacies (Table I).

This early work has provided opportunities for International Fellows to have “on the job” experience of assessing health need and system capability and to develop new skills in these areas. For most NHS clinicians, this has been the first opportunity they have had to participate in health system development work.

The first UK team of International Fellows consisted of a midwife and two newly qualified General Practitioners, with the later addition of an Anaesthetic trainee and a second midwife (all with a variety of previous overseas experience). The International Fellows were supported by a UK Quality Improvement Faculty to help them develop the knowledge and understanding of the QI skills they used during the review work. This support continued through to the practical implementation of subsequent projects, as well as ensuring their personal leadership skills development. Three main methods of providing support to the International Fellows were used: an induction programme prior to deployment to Cambodia; faculty team visits to Cambodia and individual email support about project development, project plans and implementation.

5. First projects
As a result of the initial “Review” work outlined above, a number of projects were agreed between MJP, the International Fellows and local Cambodian health workers. Formal project plans were created by the UK fellows and the MJP health department for each of the projects in the format that MJP used for their other project areas, with particular consideration given to the Cambodian Ministry of Health guidelines and future sustainability of projects. The following projects were agreed upon.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Key finding</th>
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<tbody>
<tr>
<td>Measles immunisation</td>
<td>84 per cent coverage on history</td>
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<tr>
<td></td>
<td>43 per cent when evidenced by vaccination record card</td>
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<tr>
<td>Antenatal care</td>
<td>54 per cent deliver with a skilled birth attendant</td>
</tr>
<tr>
<td>Morbidity</td>
<td>25 per cent self-reporting illness in preceding two weeks</td>
</tr>
<tr>
<td></td>
<td>(common cold, fever, abdominal pain, malaria most frequent diagnoses)</td>
</tr>
<tr>
<td>Access to treatment</td>
<td>69 per cent accessing private care and wanting injections, intravenous fluid and antibiotics</td>
</tr>
</tbody>
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Table I. Key findings from Samlaut door-to-door survey
5.1 Family planning and contraception
An unmet need for family planning and contraception was identified during the health survey and interviews with villagers and village leaders. This complemented findings from the 2005 Cambodia Demographic and Health (http://cambodia.unfpa.org/docs/CDHS_Preliminary_Report_2005.pdf) survey that 79 per cent of married women either want to delay birth of a new child or have no more children at all, but with only 27 per cent using modern birth control methods. As no contraception was available from the health post in Samlaut but is integral to Cambodian National strategy, it was decided to set up a contraception and family planning service. This project has involved working closely with the Cambodian MOH and co-ordinating with other NGOs. The initial focus of this project is setting up a basic contraception project at the health post, providing quality training and contraceptives.

5.2 Maternity record card and breast-feeding
From interviews with health workers at the local health facilities, a need for formal training in maternity care was identified. As the rural health facilities have no medical input or facilities for operative deliveries and blood transfusion, early detection of high-risk pregnancy and labour is required to allow effective referral and transport to more advanced health facilities.

UNICEF has developed a maternity record card with the Cambodian MOH to aid the provision of health promotion to pregnant women and the early detection of complications with a detailed plan of management and referral (www.unicef.org/eapro/media_10039.html). While local staff were familiar with the existence of this card, it was not in use at the health facilities. A project plan has been formulated to give training, both theoretical and clinical, on the use of the card and to put it into general use for all pregnant women. Correct use of the card aims to educate the local midwife to give health promotion advice to the pregnant woman about her own health and that of her unborn child.

A further project plan has been developed to increase the rate of early initiation of breast-feeding known to be low from national Cambodian data on child survival and a local nutrition survey in Samlaut. This has been identified as a high impact intervention to reduce infant mortality. The aim is to educate the health workers, in particular the midwife and local women on the importance of early breast-feeding and to work within the local culture to introduce acceptable practices such as skin-to-skin contact at birth and support breast-feeding within the first hour of life.

5.3 Child health programme
Integrated Management of Childhood Illnesses (IMCI) is a system designed by WHO and UNICEF for the assessment and treatment of children aged 0 to 5 years (www.who.int/child_adolescent_health/topics/prevention_care/imci/en/index.html). It aims to reduce death, illness and disability by promoting good quality care in health facilities, speeding up the referral of sick children and teaching caregivers appropriate health seeking behaviour. A project plan to implement key elements of the guideline has been developed. Following discussion regarding learning needs with the staff at the health post, the first steps in the project implementation have been to create and deliver a series of eight tutorials using the IMCI handbook and Cambodian guidelines. The next step in this process is engagement with community pharmacists and village
health volunteers targeting the conditions that cause the highest mortality in children in Cambodia (diarrhoea, acute respiratory infection and malaria).

5.4 Paediatric ward at Battambang Hospital
MJP Foundation had funded the renovation of the Paediatric ward in early 2008 after a serious dengue fever outbreak. However hygiene and staff morale remained poor, which highlighted a need for a more comprehensive QI initiative especially as this hospital facility is the referral centre for children from Samlaut. Using RAID methods again, a detailed review of the paediatric ward was undertaken. 8 project streams were identified and these included the appointment of a Cambodian programme manager to give leadership to the work who will be supported initially by MJP’s local health coordinator in cooperation with a UK manager, improving basic ward hygiene to reduce infection, reorganization of patient pathways including triage of sick children and a focus on staff clinical training and education. Prior to and during their instigation, these projects sought ongoing support from MJP, hospital management and paediatric staff in order to create a sustainable change.

6. Cambodian and NHS outcomes to date
6.1 Cambodian outcomes
This programme has only been operational for seven months and initial outcomes should be viewed in this light. All QI practitioners are aware of the time required to implement sustainable improvement and the following reported outcomes are preliminary improvement steps on a longer journey.

The NHS is attempting to embed the following principles in the clinical work streams previously described:

- The implementation of higher standards of clinical care with improved systems and processes.
- Appropriate service delivery and improved access to care – getting the right skills, equipment and people in the right place and encouraging patients to use them.
- The transference of technical, clinical and problem solving skills to MJP staff and other stakeholders.
- The development of a culture of continuing professional development.
- Supervision and support for Cambodian health workers.
- Data collection for the assessment of outcomes, knowledge and skills from the current baseline position.

Practical examples from the projects outlined earlier of these principles in action are demonstrated in Table II.

6.2 NHS outcomes
The Cambodia program is a unique opportunity for experienced NHS staff to work with, educate and learn from health workers in the developing world. While its primary objective must be to support the development of sustainable healthcare systems in Cambodia, it is also an unparalleled opportunity to develop a set of leadership skills in UK participants, which are generally not achieved through standard clinical training.
The NHS Institute (the NHS’ leading quality improvement division) has developed the Medical Leadership Competency Framework (MLCF) in conjunction with professional bodies (www.institute.nhs.uk/assessment_tool/general/medical_leadership_competency_framework_-_homepage.html). This aims to identify leadership competencies, which need to be developed during the course of training and is applicable to all NHS practitioners. For staff sent to Cambodia, this has been a useful tool for assessing learning and development and has proven well suited to supporting each of the five domains highlighted by the MLCF (Figure 3).

For the NHS staff sent to Cambodia it was assumed that competency in the domains of “Personal Qualities” and “Working with others” had been obtained to some extent through participation in leadership development courses and formal learning agreements in the UK. The Cambodia project provides innumerable opportunities to further self-management and awareness whilst working within Khmer and English teams, and skills in relationship building are continually challenged by cultural and linguistic barriers. For medical staff, the maturation of skills in these areas of professionalism and healthcare management are explicitly laid out by the Royal Colleges and are regarded as highly desirable professional attributes. “Managing services” and “Improving services” are those domains emphasized most by the Cambodia Program. In having complete ownership of a healthcare improvement project, each staff member is channelled into processes of planning, management, critical evaluation, systematic enquiry and encouraging innovation in order to attain a sustainable change agreed amongst all stakeholders.

In “Setting direction” the RAID model is used, as described above. Intrinsic to its use is the understanding of the internal workings of a non-government organization, its position and perceived role in Cambodia and how internal and external politics affect all of these. UK staff working in Cambodia are therefore maturing in their appreciation

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<tr>
<th>NHS input</th>
<th>Cambodian outcome to date</th>
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<tr>
<td>Implement higher standards of clinical care by improving systems and</td>
<td>Design and implementation of a triage system in Battambang Paediatric Department</td>
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<tr>
<td>processes</td>
<td>Institution of a Pharmacy Management System</td>
</tr>
<tr>
<td>Appropriate service delivery and improved access to care</td>
<td>Installation of equipment and internal leadership development in the new-build health centre of Boeng Run</td>
</tr>
<tr>
<td>Transference of technical, clinical and problem solving skills to MJP staff and other stakeholders</td>
<td>Family planning education in Samlaut</td>
</tr>
<tr>
<td>The development of a culture of continuing professional development</td>
<td>Implementation of breast feeding guidelines and of WHO’s Integrated Management of Childhood Illness (IMCI) system, through tutorials in Samlaut’s Kampong Tuk health post</td>
</tr>
<tr>
<td>Data collection for the assessment of outcomes, knowledge and skills from the current baseline position</td>
<td>Midwifery education</td>
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<tr>
<td></td>
<td>Quality improvement skills workshop for local healthcare leaders</td>
</tr>
<tr>
<td></td>
<td>Institution of regular tutorials by staff for staff in Battambang Paediatric Department to improve staff motivation</td>
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<tr>
<td></td>
<td>Health survey in Samlaut gathered basic health statistics</td>
</tr>
<tr>
<td></td>
<td>All project plans, meeting minutes and reflections are documented and held at MJP to support evidence of achievement of Millennium Goals 4 &amp; 5</td>
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</table>

Table II. Initial steps to achieving Millennium Development Goals
of the multifactorial aspects of any organization, whilst applying quality improvement theory to their work. Throughout their placement, staff are supported by personal expert advice from QI specialists, as well as reading material drawn from a variety of sources including the NHS Institute (UK) and the Institute for Healthcare Improvement in the US. Subjects include concepts such as “total quality management” or “continuous quality improvement”, “power and influence”, and “systems theory”. The education and training resultant from the Cambodia program is highly relevant to the NHS where quality improvement is central to the government’s agenda. It should contribute well to the changing needs of the NHS and its workforce and lead ultimately to clinical engagement in improvement work and improvement in patient care.

7. Conclusion
The partnering of an NGO committed to sustainable community development in the developing world with an external national universal payer healthcare provider is novel in its own right. While principles of social justice underpin the tenet of the “haves” helping the “have-nots”, the partnership described in this paper is far more than a one-way street of beneficent support to the developing world. The experience gained from this partnership has demonstrated the clear benefits that both parties should accrue – Cambodia benefiting from experienced clinicians and improvement experts and UK participants enhancing their leadership skills in a manner not achievable through their usual employment within a rigid and managed hierarchy. A formal evaluation of the impact on leadership development skills has already commenced and aims to report towards the end of 2009. Achievements gained by both parties during the first seven months of this partnership suggest that this model is one which is both sustainable and successful – truly leadership development for a purpose where everyone’s a winner.
References


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