**Paired Learning - Improving Collaboration between Clinicians and Managers**

**Abstract**

*Purpose*

Close collaboration between NHS clinicians and managers is essential in providing effective healthcare, but relationships between the two groups are often poor. Paired learning is a peer-peer buddying tool that can break down barriers, increase knowledge and change attitudes. Paired learning has been used with doctors and managers but not for multi-professional clinicians. The purpose of this study was to assess whether a paired learning programme (PLP) can improve knowledge and attitudes between multi-professional NHS clinicians and managers.

*Methodology*

A PLP pairing clinicians and managers over a four-month period to participate in four buddy meetings and three group meetings was delivered. A mixed methods study was completed which collected quantitative and qualitative data in the form of pre and post course questionnaires and focus group discussions.

*Findings*

Participants reported increased understanding, changed attitudes and better communication between clinicians and managers following the PLP. Self-rated knowledge increased across all domains but was only statistically significant for ability to engage, ability to establish shared goals and knowledge of decision-making processes.

*Research Implications/Limitations*

This paper highlights the value of paired learning in encouraging collaboration between clinicians and managers but is of a small size. The PLP did not provide enough data to examine relationships and interaction between clinicians and managers, this should be considered in any future work.

*Originality/Value*

To the authors’ knowledge this is the only published paper showing data from a paired learning programme involving multi-disciplinary health professionals.

Keywords: Paired Learning, Clinicians, Managers.

Type: Research Paper

**Introduction**

*What is Paired Learning?*

Paired Learning is an innovative peer-learning tool that buddies together different professional groups to improve knowledge, attitudes and relationships.

*Background*

Good quality management is essential for the NHS with the current pressure on the health service. The Kings Fund discuss how the NHS is likely to be under rather than over-managed and that the role of the NHS manager should be ‘celebrated and not undermined’(Ham et al., 2011). Managers cannot work in isolation but need to work in close collaboration with clinical staff. Organisations with better relationships and shared decision-making between clinicians and managers lead to the inclusion of shared values in policy-making(Dickinson and Ham, 2008).

Higher levels of engagement of medical staff with management can improve patient experience, and lower mortality rates and absenteeism(The Kings Fund, 2012). Definitions of engagement vary, but include opportunities to connect with colleagues and managers, and a state of mutual value between employer and employee(MacLeod and Clarke, 2011). The need for better relationships in NHS organisations applies to all healthcare professionals including but not limited to Nurses, Physiotherapists, Occupational Therapists (OTs), Doctors and Paramedics. The Nursing and Midwifery Council and General Medical Council both state that collaborative working across the multidisciplinary team is a key part of the values and professionalism required for Nurses and Doctors(General Medical Council, 2017; Nursing and Midwifery Council, 2017).

However, there is often a low regard for NHS managers among clinical staff and there remain a number of barriers to clinical engagement with management(Edwards, 2005). These barriers include differences in culture and perspective, and a lack of contact time between clinicians and managers (Andersson, 2015; Atun, 2003; Forbes et al., 2004). There is no easy solution to these barriers and the literature reflects a long history of an uneasy relationship between clinicians and managers(Clancy and Happell, 2014; Davies and Harrison, 2003; Sims, 1991; Smith, 2001). There remain very few practical tools to encourage more widespread collaboration between managers and clinicians.

Some of the main barriers to collaboration between different professional groups are reciprocal awareness of roles and shared information (Supper et al., 2014). In 2010-11, Klaber et al ran a paired learning programme involving 17 managers and 17 SpR doctors(Klaber et al., 2012). This programme increased self-rated ‘preparedness’ for working with managers and improved knowledge of roles and attitudes in participants. A paired learning programme for managers and doctors was also run at Birmingham Children’s Hospital(Kelly, 2014). They showed an increase in preparedness for working in partnership, leading Quality Improvement initiatives and understanding structures and hierarchies. They also found evidence of increased knowledge and collaboration in qualitative feedback. To the authors’ knowledge, all previous published paired learning initiatives have involved doctors and managers. Our research team designed a paired learning programme (PLP) that buddies healthcare professionals from a range of different professional backgrounds in the form of clinical leadership fellows and NHS managers. The PLP aimed to improve reciprocal knowledge, attitudes and relationships between clinicians and managers, and this study intended to assess its effectiveness in achieving these goals.

**Methods**

The study design was of mixed methodology, which involved both quantitative data from pre and post-programme questionnaires and qualitative data from focus groups. The programme was advertised through emails to all potential participants. Potential participants self-selected, indicating their interest via email.

The programme was carried out in the Yorkshire and Humber region in the UK. Clinicians from around this region can take part in a 12 month secondment to the ‘Future Leaders Programme’, run by Health Education England (HEE) (Health Education England, 2017). Participants of the Future Leaders Programme are clinicians from a range of clinical backgrounds with a minimum of 4 years clinical experience. Clinicians were recruited from this body of clinical leadership fellows. Managers were recruited from HEE, NHS Hospital trusts and NHS Graduate Management Training Scheme (GMTS)(NHS Leadership Academy, 2017). All managers were required to have at least one year’s experience of working as an NHS manager to take part in the programme.

Following recruitment, participants were asked to complete a pre-course questionnaire including basic information regarding role, location and details of why they would like to take part. Questionnaires explored participants’ knowledge and attitudes of the opposite group using likert scale and short answer questions. The questionnaires were not validated, but were developed jointly by the research team and managerial colleagues in order to ensure questions were appropriate for both clinicians and managers.

Once participants had completed the pre-course questionnaires, they were paired with a member of the opposite group. Participants were paired taking into account location, seniority and any particular areas of interest from the pre-course questionnaires. This process was used to avoid the poor feedback of the ‘speed dating’ approach used for pairing by Klaber et al(Humble and Garvey, 2017; Klaber et al., 2012).

Participants then carried out a series of one to one ‘buddy meetings’ using a template structure shown in table 1. Participants also attended three group sessions to encourage group learning, networking, and provide an opportunity to identify and address any problems with the programme. The mid-point group session took the form of a “systems leadership lab”, a simulation whereby participants are allocated ‘top’, ‘middle’ or ‘bottom’ roles in a fictional organisation in order to develop systems thinking. The content for each group meeting is shown in table 2. The programme ran over a 4-month period. After the final group meeting participants completed a post-course questionnaire, either in person or via email.

Tables 1 and 2

Focus groups that explored barriers and facilitators to clinician-manager collaboration were held at the initial and final group meetings. The group was split into two in order to create the right numbers for effective discussion (Barbour, 2014). At the first focus group a second facilitator was available and one of the focus groups was recorded using an encrypted digital recorder. Ideas from focus groups were recorded by participants on flip-boards, and written notes were taken by the research team. All of this information was collated, key themes were identified and integrated to the thematic analysis of questionnaire data.

Formal ethical approval was not required, however participants were required to sign a written consent form (NHS Health Research Authority, 2017). It was made clear to all participants that information from the study may be published in an anonymised form.

The mean values for likert scale questions before and after the programme were compared using a paired ‘t-test’. Qualitative information was collated and analysed to explore and group themes by the chief investigator. Qualitative data was analysed using the five-step process outlined by Richie and Spencer:

1. Familiarisation
2. Identifying a thematic framework
3. Indexing
4. Charting
5. Mapping and interpretation(Richie and Spencer, 1994).

Combining qualitative and quantitative methods in the form of questionnaires and focus groups allowed for triangulation of the data, providing a more reliable overall picture than any of these in isolation.

**Results**

17 clinical leadership fellows and 17 managers were recruited. There were 6 further leadership fellows who were interested but unable to take part due to a lower numbers of managers recruited. One of the leadership fellows identified a manager with whom to participate in the PLP independently. 11 of the managers were from Health Education England, 5 were GMTS trainees (based in a variety of NHS organisations around Yorkshire and the Humber) and 1 was from an NHS hospital trust. The breakdown by role of the leadership fellows is shown in figure 1.

Figure 1

16 of 17 (94.1%) managers completed the pre-course and 9 of 17 (52.9%) completed the post-course questionnaire. All 17 clinical leadership fellows completed the pre-course and 12 of 17 (70.5%) completed the post-course questionnaires.

*Quantitative Data*

Self-rated ability to engage and establish shared goals with, and awareness of the decision-making process for the opposite group all increased significantly in the post-course questionnaire compared to the pre-course assessment. There was no statistically significant difference in the reciprocal awareness of roles, adaptation of communication style, or the development of a professional network.

Table 3

*Qualitative Data*

The reasons for wanting to take part in the PLP give some insight into the background perceptions and relationships between the two groups. The majority of participants wanted to take part in the PLP to increase their understanding due to a lack of knowledge about the opposite group.

*“In theory I know what they do, but I don’t know how they make decisions, who they are accountable to, the structure of management in the NHS or how they manage their budgets”* [Clinician]

Some of the participants stated that a lack of contact with the opposite group was a motivating factor.

*“Despite almost 10 years working as a doctor in the NHS I have little leadership experience in a clinical context, and have so far had little contact with managers”* [Clinician]

Participants also gave examples of divisions or antagonistic relationships between clinicians and managers and wanted to participate to improve relationships between the two groups.

*“There seems to be a disconnect on occasion between the patients’ needs and the strategic aims of the organisation, and this could be bridged by the clinician but there is often frustration at being restricted by the ‘corporate rules’ ”* [Manager]

The themes of lack of contact and hostile relationships between the two groups were echoed in the focus groups, represented in table 5.

*“Never going to build a relationship with someone you never see”* [Clinician]

*[Clinicians and managers are like]“magnets pushing away”* [Manager]

Table 4

The description of reciprocal roles did not change significantly with regards to terms used. However, there were less negative comments noted on the post-course descriptions and there were more references to complexity or challenge when clinicians described the role of managers in the post-course questionnaire. There was also broader understanding of roles and training in manager descriptions of clinicians in the post-course questionnaire.

*[Clinicians are] “Patient focussed, expert in their field but not necessarily skilled (or trained) in management, finance etc. But there is an expectation that they should be. One of the surprises for me in this process has been how little exposure junior doctors have to this part of their training, and indeed other clinicians be they paramedics, OTs* *etc.”* [Manager]

There were consistent themes of increased understanding, awareness and changed attitudes throughout the qualitative data.

“*I have worked with senior clinicians for a number of years but this process has made me realise how different it is for junior doctors. I have limited contact with them but when I do now, I won’t expect them to know or understand management or finance structure in the way I assumed before*” [Manager]

“*Hugely influenced my view of managers in the NHS. Encouraged me to think of them as a resource*” [Clinician]

Participants also felt that the opposite group was much more accessible following the PLP.

“*I will be seeking a much more collaborative approach and actively seeking out and introducing myself to managers when I return to clinical practice*” [Clinician]

Improved ability to communicate with the opposite group was also a dominant theme. Both groups felt that as a result of the PLP they were more likely to engage with the opposite group, at that they had more confidence to do so.

*“I now have much more open and exploratory conversations with managers”* [Clinician]

When asked what they most valued from the PLP, clinicians particularly seemed to value opportunities to shadow managers and networking opportunities. Both groups valued the opportunity to gain insight into another area or speciality. Managers valued the opportunity to reflect on their roles away from their normal place of work.

“*Stepping out of the day job and reflecting on what I do, why and my place in the wider NHS*” [Manager]

Table 5, 6 and 7.

There was also a theme of ‘no change’, when participants were asked how the PLP impacted on their practice at work. In one case, there was a personality clash between a pair that led to poor engagement, with only two meetings taking place between them. These participants felt they had benefited most from the group sessions but little from the paired learning meetings. Two other clinicians also felt that there had been no change on their practice at work as a result of the PLP.

*“I have not yet had the opportunity to put into practice the knowledge I have gained through the PLP”* [Clinician]

Looking to the future, both groups were keen to see paired learning rolled out more widely across a variety of staff groups and organisations.

“*Widen the scope, include more staff groups, advertise the benefits. So ultimately it becomes part of everyday working practices, not just ‘a course’*” [Manager]

Clinicians felt that more information and better ‘framing’ of the PLP at the start would be helpful. There were conflicting opinions as to whether the PLP would be most effective when used across or within different organisations. There was also conflicting feelings on whether the PLP should be kept open and flexible, or whether it should have more defined, prescriptive objectives.

Table 8

The second focus group explored how manager-clinician collaboration could be encouraged in future. A consistent theme from both groups was to increase contact time, whether this was through managers ‘walking the wards’, joint educational sessions, or collaborative projects involving both managers and clinicians. There were also discussions around decreasing the language barrier between groups with tools such as an ‘acronym buster’ or avoiding abbreviations in meetings. Improving communication through networks including shared bulletins, ‘Yammer’ and ‘twitter’ was another main theme.

**Discussion**

Participants of the PLP reported increased knowledge, changed attitudes and improved engagement between clinical leadership fellows and NHS managers. Quantitative data showed an increase in knowledge that was statistically significant for the domains of ability to engage, establish shared goals, and awareness of the decision-making process of the opposite group. Qualitative data showed a positive increase in knowledge, a positive change in attitudes and increased confidence in communication and engagement with the opposite group.

Strengths of the project were that it was flexible and self-directed with no obligation to produce a project or defined output from the programme other than learning about the opposite group. The pairing process was relatively effective with only 2 of 17 pairs reporting any negative opinions on the pairing. One of these was due to a discrepancy in seniority and the other was a combination of personality clash and lack of time to engage in the process. Another strength was that there was generally good engagement with the process, with even those initially sceptical about the programme finding benefit in the process.

A theme of ‘no change’ was noted in participants’ responses to how the PLP had changed practice at work. Two contributors to the theme were part of a pair that experienced poor engagement with the PLP process as a result of a personality clash. Unfortunately this issue was only raised at the end of the programme therefore it was not possible to intervene to address the personality clash. It is not possible to comment on whether the experience of these participants would have been different had they been re-paired with partners with whom they had a better dynamic. There were two further contributors to this theme, both of whom were clinicians. In both these examples there was good engagement and there is evidence of increased knowledge and understanding as a result of the PLP. It is suggested by one participant that they have not yet had time to put into practice what they have learned on the PLP. As the other did not specify it is possible that they also have not yet had the opportunity to work with managers, putting their experience from the PLP into practice. However, it is also possible that the participant felt that although knowledge and understanding had improved, that this would not have any effect on their clinical practice. If this were the case, organisational impact of the PLP would be reduced. Further study in this area could consider assessing the ‘real life’ impact of paired learning schemes, although it is recognised this would be challenging.

One of the main limitations of the study was its small size. This was necessary given the constraints on resource and ability to recruit participants, however the small number of participants decreases the validity of the quantitative data from questionnaires. Another limitation was the attrition rate for the post-course questionnaire. This could have biased the responses if those with more negative or ambivalent views about the PLP were less likely to complete the post-course questionnaire (Dumville et al., 2006). Another limitation was the lack of ethnographic data, making it difficult to comment in detail about the relationships and interaction between the two groups. For future iterations this could be done using smaller groups with two or more facilitators, so that one could facilitate the group and the other(s) take notes about the group interaction. The fact that there were more clinicians than managers that applied to this PLP reflects initial uncertainty regarding how many leadership fellows would apply and inadequate advertisement to managers. More targeted and widespread advertising to managerial staff should be considered for future iterations in order to achieve more balanced recruitment.

The PLP recruited clinical leadership fellows and managers from a range of backgrounds. This contributed positively in terms of a wealth of knowledge and experience, however it is recognised that the terms ‘clinicians’ and ‘managers’ cover a broad range of roles. In some cases this lead to a lack of focus when participants answered questions about reciprocal roles. Another limitation was the fact that participants were recruited from a range of locations across the Yorkshire and Humber area. This limited options when it came to pairing. It also meant that the effect of the learning and networking was spread over a wide area and a range of organisations, reducing its effect on any single organisation. There are benefits to this approach however, including transcending organisational culture (including barriers), and participants from this programme may act as key stakeholders in building momentum for paired learning in their own organisations. These relative strengths and weaknesses should be considered in the design of future paired learning schemes. It should be noted that as all the clinical participants of the PLP were of a relatively junior level, views of consultants, GPs, senior nurses and senior allied healthcare professionals were not included and may differ. However, given that all these staff groups work in a similar organisational context, there are likely to be similarities.

Paired learning can help to dispel unhelpful attitudes towards both clinicians and managers and start a dialogue between the different groups. The concept of medical management as ‘the dark side’, and the lack of support and training for doctors in managerial roles contribute to negative attitudes(Dickinson et al., 2017; Loh et al., 2016). A common theme discussed by the PLP participants was the need for more systemic management teaching for clinicians. This need is echoed in the literature across the medical workforce(Kerridge, 2013; Swanwick and McKimm, 2012). Paired learning aligns with concepts presented by Swanwick and McKimm as it is work-based, aimed at relatively junior managers and clinicians, and facilitates participants to learn about the relevance and importance of management to clinical practice(Swanwick and McKimm, 2012).

Klaber et al found that paired learning improved knowledge and attitudes between doctors and managers(Klaber et al., 2012). This study has shown that paired learning can also do this for a wide range of multi-professional clinicians and managers. As there is very little published data for paired learning this study provides valuable evidence to support paired learning as a tool to break down barriers and encourage collaboration between different NHS staff groups.

The authors plan to run a further paired learning programme in the region, involving participants from a single hospital trust. The design should address many of the issues from this study including targeted advertising and geographical issues. The second iteration will focus more on ethnographic data to consider in more detail the impact of the PLP on communication and relationships.

*Implications/Conclusion*

This study has shown that a paired learning programme increases knowledge and improves attitudes and engagement between multi-disciplinary NHS clinicians and managers. Although more research is required to determine the impact of paired learning on the relationships between clinicians and managers in future, this study provides evidence to support the use of paired learning as an organisational tool to improve collaborative working in future.

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