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A qualitative evaluation of a pilot leadership programme for dentists

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Abstract

Purpose – The purpose of this paper was to evaluate a pilot training programme run by Health Education North West to promote clinical leadership amongst general dental practitioners (GDPs). New powers and responsibilities for clinicians have caused a fundamental shift in the way that local services are planned and delivered in England. GDPs are being appointed onto the boards of local professional networks (LPNs) to influence the way that services are delivered at a local level. Analogous to clinical commissioning groups in medicine, the role of LPNs is to ensure that GDPs lead change and drive up the quality of service provision. Clinical leadership has been argued to be fundamentally important in these new structures, but has received little attention in the dental literature.

Design/methodology/approach – Semi-structured interviews and a focus group were held with participants of the pilot to explore their understanding and experience of clinical leadership. These were recorded, transcribed verbatim and underwent thematic analysis.

Findings – Nineteen codes were identified and organized into four themes: nature of clinical leadership, challenges for clinical leaders in dentistry, Leadership Exploration and Discovery programme evaluation and future direction.

Practical implications – The research provides an understanding of how GDPs conceptualise clinical leadership and provides recommendations for future leadership training programmes.

Originality/value – This is the first evaluation of a leadership programme for GDPs and so helps address the paucity of evidence in the dental literature.

Keywords Leadership, Health services

Paper type Research paper

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Introduction

Under the Health and Social Care Act, new powers and responsibilities for clinicians have caused a fundamental shift in the way that local services are planned and delivered in England (Health and Social Care Act, 2012). General dental practitioners (GDPs) are being appointed onto the boards of local professional networks (LPNs) to influence the way that services are delivered at a local level. Analogous to Clinical Commissioning Groups in medicine, the role of LPNs is to ensure that GDPs lead change and drive up the quality of service provision (NHS Commissioning Board, 2013, Securing Excellence). For the first time in dentistry, GDPs are being given the opportunity to influence the commissioning of primary care dental services to improve oral health and patient outcomes, by "helping to shape the entire dental pathway as an integrated model of service delivery" (NHS Commissioning Board, 2013, Securing Excellence).

Alongside these structural changes at a local level, a new National Health Service (NHS) Dental Contract is being piloted in England and Wales. Unlike previous models of care, the method of remuneration being explored is based on a capitation system rather than fee-for-service basis. As such, practice income will be determined by the number of registered patients, rather than the type of clinical activity undertaken and will move from a "cure" to a "care" culture with a focus on prevention. This is likely to encourage the greater use of the whole dental team (NHS Pilots, 2014), and again, emphasises the importance of leadership at a practice level to improve patient outcomes (Brocklehurst *et al.*, 2013a).

Clinical leadership has been cited as a key determinant in improving the quality of patient care (The King's Fund, 2012; Roland *et al.*, 2011). The Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement have developed the medical leadership competency framework and the medical leadership curriculum (AMRC, 2012; NHS III, 2012). However, there has been little "to develop an evidence base for the assessment and development of leadership skills and for the evaluation of the impact of clinical leadership in a dental context" (Brocklehurst *et al.*, 2013a). As a result, the body responsible for delivering post-graduate training in the North West of England (North Western Dental Deanery) held a number of workshops in 2013. These highlighted the need for support and training for local GDPs and led to the creation of a Leadership Exploration and Discovery programme (LEAD) to develop leaders across the region.

The pilots for LEAD were designed as a facilitator led series of exercises and activities over one day for 12 participants, followed by individual coaching. Three cohorts were run across a six-month period and were designed to improve GDPs' knowledge, skills and attitudes in clinical leadership. Participants were asked to complete a NHS Leadership Qualities Framework Self-Assessment, a Myers-Briggs Type Indicator questionnaire and identify three key learning objectives that would help them develop their leadership skills. Delegates were divided into small groups and participated in reflective exercises and situational role plays. The programme was varied and was framed in the context of the participant's own clinical workplace. Peer feedback formed an important component and an action, impact and desired outcome framework was used; observations being made against areas in the NHS Leadership framework by the facilitators. Within two to

six weeks, each delegate had also received a one-to-one coaching session with one of the facilitators.

The aim of this study was to qualitatively explore the concept of clinical leadership amongst GDPs, evaluate the LEAD programme and develop a series of recommendations for future leadership training within dentistry.

Methodology

Ethics

Ethical approval was provided by the University of Manchester Ethics Committee on the 20th of June 2013 (13029).

Procedure

A "topic guide" was developed from existing research on leadership, the NHS Leadership Framework, a Leadership Observation and Feedback Tool and from consultation with the North West Dental Deanery (Hoffman *et al.*, 2011; Judge *et al.*, 2004; LOFT, 2011). GDPs who had attended the LEAD Development Programme were then asked if they would like to participate in semi-structured interviews.

In organisational research, interviews are the most widely used qualitative method (Cassell and Symon, 1994). The interviews were undertaken by one researcher (JW) and recorded on a Sony Digital Recorder, ICD-P110. The audio files were then transcribed verbatim into MS Word documents for thematic analysis to develop a coding frame (Braun and Clarke, 2006). Initial codes were generated from the transcripts and collated into themes. Interviews continued until saturation and codes and themes were checked against the raw data to ensure that they were representative of what the participants were trying to convey (Smith, 2008). Subsequent to the semi-structured interviews, a focus group was held with LEAD participants one month later by two of the researchers (JW and PRB). This was used to discuss the findings of the semi-structured interviews and to develop a set of recommendations for future leadership training programmes.

Reflexivity

Jonathan Walsh has 10 years of experience in management and leadership in a non-dental setting, but had no prior knowledge of dentistry or leadership in a clinical environment. Paul Brocklehurst is a Senior Clinical Lecturer and Honorary Consultant in Dental Public Health. Having spent 15 years in general dental practice, he was aware of the importance of leadership at a local level. Nicholas Taylor, Director of Postgraduate Education North Western Deanery with 35 years of experience in general dental practice, and Donna Hough, Head of Workforce, both are employed by Health Education North West, conceived and developed the LEAD programme, and although they contributed towards the manuscript, they did not take part in the research process.

Results

Thirteen people of a possible 35 agreed to take part in the semi-structured interviews (37.1 per cent) and a further 18 took part in the focus group. All of the participants were practice owners or were in a position of leadership within a primary care environment. The coding frame (Table I) identified 19 codes and four main themes: nature of clinical

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Table I.
Coding frame for the semi-structured interviews

Theme	Code	Example
1. Nature of clinical leadership	1. What is clinical leadership?	"[. . .] ability to influence, either up or down, the kind of, hierarchy isn't the right word, but certainly the network, the clinical network I guess. I'd probably leave it at that actually [. . .]"
	2. What are the attributes of clinical leaders?	"[. . .] values that you would have to exhibit, which are, you know, kind of honesty, patient focus, transparency and equity, I guess [. . .]"
	3. Difference between leadership and management?	"[. . .] management would be about monitoring processes or agreed KPIs, to ensure that the outcome that you're trying to deliver is reached. Leadership, I guess, would be much more about doing the right thing [. . .]"
	4. Difference between clinical leadership and leadership?	"[. . .] and in dentistry it's not just a clinical leader but a business leader as well very often. The two are enrolled in one [. . .]"
2. Challenges for clinical leaders	5. Macro/strategic bodies being out of sync with the "coal face"	"[. . .] department of Health were kind of, were almost out of sync, didn't really, they didn't really understand the objections that the average GDP would be raising to the system they were advocating. So they had a very clear vision already set up in their head that they were simply following, rather than true clinical engagement [. . .]"
	6. The impact of the NHS Dental Contract on behaviour	"[. . .] prescribing a treatment is influenced very heavily by what contract is in front of you, and what contract you're working under, and so that has always influenced what activity occurs in general practice [. . .]"
	7. Engagement across the profession	"[. . .] professional networks are great things [. . .] [. . .] because it gives an opportunity for communication [. . .]"
	8. Being prepared for the leadership role	"[. . .] there's more and more resources out there, but it's still the expectation, the norm, the default to expect people just to deal with it and learn on the job [. . .]"
	9. Performance appraisal culture	"[. . .] we do a 360 appraisal, which are anonymised, so people feel very comfortable to say exactly what they want to say. It can make difficult reading at times, but no matter how much pressure I put on the practice manager, she won't tell me who's written what [. . .]"

(*continued*)

Theme	Code	Example
	10. Channels of communication	"[...] for dentists there's not a lot of basic [information] [...] [...] I think there's a massive gap [...]"
	11. Being in the "practice bubble"	"[...] practice owners kind of bury their head in the work that they're doing themselves, rather than have a kind of look, strategically, at the work that the associates working for them are doing, or the therapists working for them are doing, or be aware of the patient experience perhaps, that those patients are kind of undergoing [...]"
3. LEAD evaluation	12. What did they want LEAD to do?	"[...] because I knew that was an issue, I kind of wanted to get more feedback on that really [...]"
	13. LEAD organisation	"[...] the size of the groups was fine, because we were broken up into smaller groups, and then brought back together for other things that could be done in larger groups, so that seemed to work okay [...]"
	14. Benefit of LEAD	"[...] some of the people on the programme on the day that we were there, were calling it as feeling quite luxurious, in terms of having time to be reflective [...]"
	15. How to improve LEAD?	"[...] i think the other that would be useful would be if we had some progression, so it's not just a matter of dealing with one topic, you almost need an annual appraisal and a PDP, so there's continual reflection [...]"
	16. Personal future direction	"[...] i was asked to be on an LPN then there might be an opportunity to do something there, if I felt strongly about it, and certainly support the process [...]"
4. Future direction	17. Future direction	"[...] just having the opportunity [[...]] to network [...] [...] to get those people together and to brainstorm and to find what works for each other [...]"

Table I.

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leadership, challenges for clinical leaders in dentistry, LEAD evaluation and the future direction for leadership in dentistry.

Theme 1: nature of clinical leadership

What is clinical leadership?

There were a number of definitions offered for clinical leadership and many described its use in a practice environment rather than at a strategic level:

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1.22: "[…] ability to influence, either up or down […]."

9.42: "[…] it's about being knowledgeable about clinical work, being an expert in your own field and having good professional and ethical standards […] […] always looking at what's in the best interest of the patient […]".

11.12: "[…] is about setting the tone, setting the standard of what you feel is appropriate for the patient […]".

However, it remained a diffuse concept for many and was difficult to define:

4.79: "[…] leadership is a little bit more ethereal, I suppose I view it as more having ideas, having vision, having a personality that can deliver on those or encourage other people to think like that […]".

2.55: "[…] it's clear that everyone has a different perception of what a clinical leader [is] […]".

What are the attributes of clinical leaders?

A number of qualities were attributed to being a clinical leader:

1.37: "[…] honesty, patient focus, transparency and equity […]".

2.61: "[…] mak[ing] the correct decisions most of the time […]. […] to empower and help people […]".

6.125: "[…] an open mind, flexibility, being open to other people's inputs and ideas really […]. […] not dentist knows best […]".

12.27: "[…] vision […] […] being able to articulate that vision […]. […] being able to carry that team with you […]".

Difference between leadership and management

Participants also saw a difference between leadership and management:

1.63: "[…] management would be about monitoring processes […] […] [leadership is] much more about doing the right thing, being seen to do the right thing, for the right reasons […]".

9.67: "[…] I think that leadership sets the tone more, whereas management is partly, it helps to deliver that. […]".

12.61: "[…] the key difference for me is the ability to have a vision and to develop that vision […] […] management is really about managing teams and managing individuals, so keeping them together […]".

Difference between clinical leadership and leadership

The majority of the participants saw no difference between clinical leadership and leadership in other spheres:

9.75: "[…] I think that if you're talking about excellence […] […] where as ours might be patient focused, somebody else might be customer focused, or they might be financially focused […]".

Theme 2: challenges for clinical leaders

Macro/strategic bodies being "out of sync with the coal face"

A common challenge stated by many GDPs was that decision-makers have not understood the practice environment:

> 5.245: "[…] what we do with the patient in the chair is what everyone's commissioning […] […] [yet] we have no say in it and that's really been a bug bear […]".

> 9.576: "[…] I think that most dentists would feel that they can't influence that […] […] that they are at the whim of the commissioners […]".

> 11.173: "[…] clinical leadership [should be] from within the profession, those who are still doing the job and have a degree of credibility […]".

The impact of the NHS dental contract on behaviour

The NHS dental contract was also raised as key influence on the behaviour of GDPs:

> 1.91: "[…] prescribing a treatment is influenced very heavily by what contract is in front of you […]. […] so that has always influenced what activity occurs in general practice […]".

> 7.382: "[…] they basically see the number of activities, the number of contacts, and the number of pennies at the end of the day […]".

> 12.81: "[…] working clinically with all the pressures that [the NHS] brings, and with all the issues around that, the paperwork, the red tape, the clinical governance […]".

Engagement across the profession

Engagement across the profession was seen as being important, particularly through the LPNs:

> 4.384: "[…] professional networks are great things […]. […] because it gives an opportunity for communication […]".

> 7.267: "[…] I think LPNs as such, if they're well managed and structured and led, with people who have the skills, knowledge, understanding and overview […] […] I think they have great potential to make a really positive impact […]".

> 12.219: "[…] I think clinical engagement is key in this [LPN] […] […] [so that] our vital clinical intelligence is heard where it needs to be heard […]".

It was also seen to be important to have the right mix of skills on the LPN:

> 10.166: "[…] I think the great thing about the LPN is because there's a mix of people […] […] I was able to discuss things with Public Health and other Specialists and Consultants […] […] it's opened my eyes and made me more aware of the bigger picture […].

Being prepared for the role

There was also a sense that many GDPs felt unprepared for a leadership role:

> 9.217: "[…] I would say communication skills and professionalism, are very poorly taught at university, and very poorly role modelled […]".

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11.227: "[…] there's more and more resources out there, but it's still the expectation, the norm, the default to expect people just to deal with it and learn on the job […]".

Performance appraisal culture

The importance and value of performance appraisal was articulated by many:

11.41: "[…] historically we used to have peer review […]. […].a very useful mechanism for improving standards and demonstrating clinical leadership […]".

6.127: "[…] the more you, kind of, realise that you don't know all the answers really and just engaging with other practitioners […] […] people with other skills that you don't have yourself […]".

Channels of communication

Communication across the profession was also seen as important:

5.199: "[…] for dentists there's not a lot of basic [information] […] […] I think there's a massive gap […]".

8.714: "[…] I don't know what's going on with the local professional networks […]".

11.387: "[…] as much as anything it's lack of guidance centrally as to what the new structure should look like […]".

Being in the "practice bubble"

Another important aspect of leadership was the need to think more strategically and take a population focus:

6.614: "[…] they tend to go into the practice, work in their practice and that's it, that's all they do […]".

8.141: "[…] you've got to step outside the bubble of the practice […]".

10.640: "[…] you're in your surgery and you don't really have that opportunity to speak to other peers […]".

11.27: "[…] dentistry has been historically a very isolating kind of profession; it's you in a surgery working on your patients […]".

Theme 3: lead evaluation

What did they want LEAD to do?

Many of the participants entered the programme with an open mind and were prepared to be actively challenged:

3.733: "[…] I went into it with an open mind […] […] I just went into it and thought, right, let's see where this goes […]".

4.872: "[…] I didn't have any expectations […]".

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10.740: "[…] let me better my skills and become a better leader […] […] that's what I went on the course for […]".

12.340: "[…] it was an opportunity to challenge myself […]".

LEAD organisation

All the participants were strongly supportive of the design of the programme:

2.829: "[…] I thought it was a really well ran and set up day […] […] but it was a real challenge, I have to say […]".

3.635: "[…] you know you have your follow-up interview […]. […] it's not just that day and then you forgot about it […]".

4.717: "[…] the feedback […] […] was so personal […] […] it almost felt like it was a one on one coaching session from the start of the day […]".

8.826: "[…] the coaching bit afterwards was really interesting […] […] I never had any coaching off anyone about anything […]".

9.800: "[…] I wouldn't say it was easy, but I found it extremely valuable, and I wouldn't have wanted it not to have been that way […]".

11.620: "[…] the opportunity to reflect on that [feedback] […] […] and then the follow-up coaching was key to it actually […]".

Benefit of LEAD

All of the participants stated how they'd benefited from LEAD:

1.435: "[…] it was interesting […]. […] [it felt] quite luxurious, in terms of having time to be reflective […]".

2.82: "[…] I think what has become apparent is increased self awareness […] […] how I deal with other people and an appreciation that everyone is different, their motivations are different […]".

3.412: "[…] understanding, that there are different people, and we all do different things differently […]".

4.409: "[…] I'd never really, kind of, taken time to think about what attributes and what parts of me might make for a good leader and what might make for a bad leader and the LEAD Programme made me think a lot more […]".

5.657: "[…] it's helped my personal development […] […] focussing on strengths that I didn't realise I had actually […]".

6.540: "[…] it's opened my mind, again, to realise that you don't have [to have] all the complete full skill set […]".

8.664: "[…] accepting that not everyone thinks the same as you and that it doesn't necessarily mean your point of view's definitely right or anything like that […]".

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9.743: "[…] made me realise that, oh, what you do bring is valued, stop trying to be somebody you're not […]".

13.168: "[…] they've helped me focus on what else, what's the next step, what I want to do […]".

How to improve LEAD?
A number of suggestions were made about how to improve LEAD, but most comments related to how it should be developed further:

1.841: "[…] I think we need a continual programme […] […] to allow us to almost build a framework against which you can progress […]".

2.912: "[…] it would be cool to go on further down this path and do more of this stuff […]".

3.649: "[…] I think it's going to have to be on-going […]".

4.928: "[…] It would be nice to have something more formal than eight hours CPD […]".

13.274: "[…] I just feel that every time I get anything […] […] I feel like I need more, I want more […]".

Personal future direction
Many of the participants were keen to utilise their training from the LEAD programme, either within their practice environment or for the LPN:

6.903: "[…] changing a number of things within the practice that historically we've always tended to do […]".

11.752: "[…] I mean a long term plan is me leaving this place [practice] and I want to be able to hand it over in a way that's going to continue to be a healthy environment […]".

12.617: "[…] I've got my eyes open for opportunities that might be there to have a wider clinical leadership role. In the practice, it's about building the practice […]".

Theme 4: future direction

Future direction of LEAD
All the participants felt that there should be a formal leadership and development programme established for GDPs:

FG.619: "[…] if it was to be brought into the core aspects of CPD, may be looking at different aspects of leadership […] […] make it more available to people who are more likely to hide away […]".

FG.602: "[…] I think as a core CPD idea it's a sound one, because I know influencing people is the way it's going with the NHS […]".

Participants of the LEAD programme also felt that there should be a formal appraisal system at a local level to facilitate peer-to-peer feedback and make use of action learning sets, which has proved very successful:

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7.406: "[…] having somebody at a peer level, and somebody at an abstracted level, be able to sit and do some critique of the activities I was involved in […]".

4.299: "[…] more direct mentoring would probably be helpful at times […]".

10.640: "[…] dentist[ry] is quite an isolated kind of job. You're in your surgery, and you don't really have that opportunity to speak to other peers […]".

E-learning tools and the development of an Information Technology (IT) platform were considered to be important to move leadership training forward. This could promote greater access to resources and standardise learning content whilst also facilitating structured reflection, peer-to-peer learning and the ability to share best practice through case studies:

FG.780: "[…] something that we can revisit because you come to a course like this and you take on so much information and it isn't until maybe a couple of weeks down the line you start to process that information […]".

FG.771: "[…] facilitated by simple things like resources or communications, mechanisms, to form these little peer reviews, so a facilitative process to move it on […]".

12.596: "[…] access to resources […]. […] we should really have a website where we can build our own portfolio. Medics have it. Why we don't have it I've no idea […]".

It was also felt important that leadership development should begin at an undergraduate level and continue during the early years after graduation (foundation training):

FG.514 "[…] I think there is something about these kind of courses that could be introduced earlier on as well in the undergraduate training […]".

9.119: "[…] educated people sacrifice their emotional maturity for their intellectual development […] […] a 16 year old girl in Darwen who comes to work as a dental nurse, very often has more emotional maturity than a 23 year old dental graduate […]".

FG.662: "[…] you're talking a generational change, which is why the Foundation Training opportunity is the chance to bring it in, makes the old ones jealous and they think they won't survive, that's when you get action […] […] not so much the stick, perhaps more the carrot […]".

Participants suggested that leadership training should be developed to create a tiered learning content, relevant to the individual's roles and responsibilities. This could include "stepping stones" to allow lower level role profiles and the whole dental team to benefit:

FG.754: "[…] so many other professionals [are] now being registered not just dentists, it's really important that these sort of facilities are accessible to those other professionals as well […]".

FG.754: "[…] if we can do this as part of a team, because I'm sure that they have got a massive awry of skills and backgrounds that would just complement what we're all trying to do […]".

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Discussion

The understanding of leadership amongst the GDPs was consistent with earlier research (Brocklehurst *et al.*, 2013b). Charisma and team-oriented attributes were considered to be important; "leadership as the individual" and "leadership as the relationship" both being articulated (Day and Zaccaro, 2007; Judge and Piccolo, 2004). GDPs understanding of leadership related to transformational processes in the future, whereas management was related to transactional processes in the "now" (Alimo-Metcalfe and Alban-Metcalfe, 2005; Bass, 1990).

GDPs also identified a number of challenges for leadership in dentistry. Expressed tensions were articulated between clinicians working at the "coal-face" and decision-makers. This was manifest by the existing NHS dental contract, whose incentives appeared to dominate clinical behaviour. This concurs with earlier research, who found that dentists' views on social responsibility are dominated by economic imperatives (Dharamsi *et al.*, 2007). As highlighted by Maxwell and subsequently by Mills & Batchelor, it appears that if future services are to be responsive to need, equitable, effective, socially acceptable and efficient, the financial incentives in the new contract need to align to these qualities (Maxwell, 1984; Mills and Batchelor, 2011). Leadership on its own is unlikely to meet the principles set out in "Securing Excellence in Commissioning NHS Dental Services", the system must be designed to improve quality from the contract upwards (NHS Commissioning Board, 2013, Securing Excellence).

Morison & McMullan's study found that education was vital for developing leadership amongst GDPs (Morison and McMullan, 2013). Other theorists argue that naturalistic learning is more important (Burgoyne and Hodgson, 1983). This study highlights the real value of doing both and creating a framework to encourage GDPs to reflect. Many of the practitioners had no pre-conceived idea of leadership or what the programme would entail. However, all valued the opportunity to take a step back from their busy lives and engage with their peers. Although the LEAD programme did have specific and concrete role-play exercises to help practice leadership skills, the predominant change that GDPs reported related to a change in attitudes and behaviours, along with a better understanding of themselves. If clinical leaders in dentistry are to work for the needs of their patients and communities, community-facing values are key.

There are many opportunities for GDPs to improve themselves through Continuing Professional Development. Yet, whilst this may improve clinical proficiency, the reaction to LEAD suggests that there is also a niche for leadership development. LEAD has been a pilot initiative, yet it appears to have been very helpful at both a strategic and practice level. It appears to have gone some way to better enable GDPs to influence the world that sits outside of their "practice bubble". As LPNs continue to develop further across England, it will be important to disseminate the findings from the pilot across the new networks and via the educational structures that oversee both undergraduate and post-graduate training. All of the participants that were interviewed derived a substantive benefit from LEAD and all advocated for a formal leadership and development programme for dental professionals more generally, not just in relation to the function of the LPNs. The establishment of a strong culture of leadership development in dentistry was viewed to be paramount. It was also suggested that as some individuals can often shy away from training areas where weaknesses are

perceived, a formal leadership and development learning cycle for each practicing GDP would help to mitigate against this (Recommendation 1; Table II).

Participants also felt that there should be a formal appraisal system at a local level to facilitate peer-to-peer feedback and make use of action learning sets (Recommendation 2; Table II). GDPs reported that they had gained significant benefit from stepping away from their normal daily practice routine to attend sessions that encouraged discussion and reflection as a part of a peer group. A common comment was that the chance to reflect is often lost within hectic work schedules and participants welcomed the opportunity to gain perspectives from outside of the practice. Feedback on performance was reported to be difficult to obtain and this had left individuals feeling short on confidence to step forward to engage in LPN's and similar initiatives.

All of the participants argued for a central or a regional e-learning resource to help take leadership development forward (Recommendation 3; Table II). Comments suggest that this would promote greater access to key material, standardise learning content and enable best practice to be shared through case studies. This would not be dissimilar to the centralised resource for NHS staff in medicine via the NHS Leadership Academy (2014).

The focus on leadership was also something that the participants suggested should start at undergraduate level (Recommendation 4; Table II). Making resources available at this early stage was seen to be important, particularly as the future shape of the workforce is likely to require clinicians working in larger teams, as compared to the historical patterns of delivering care. Such initiatives have already been adopted in Europe and have proved to be effective at increasing inter-disciplinary collaboration.

Alongside mandatory modules, other components could be tailored for specific role profiles or for different members of the dental team (Recommendation 5; Table II). Creating a suite of tailored options to meet the specific development needs of the differing role profiles that sit within the profession would appear to be sensible and has been used in other areas of the NHS (NHS Leadership Academy, 2014).

Conclusion

The understanding and utilisation of leadership amongst GDPs varies considerably. There are also challenges in ensuring that financial incentives in the new NHS Dental Contract align with the principles outlined in "Securing Excellence". LEAD has enabled GDPs to practice and refine their leadership skills, but more importantly, it has been key to developing important values attributed to leadership and reflective practice.

§	Recommendation
1	There should be a formal leadership and development programme established for GDPs at a regional level
2	A formal appraisal system should be developed at a local level to facilitate peer-to-peer feedback and make use of action learning sets
3	E-learning tools and an IT platform should be utilised
4	Leadership development should begin at undergraduate level and should form part of continuing professional development
5	The leadership programme should have tiered learning content to enable the whole dental team to benefit

Table II. Recommendations from the participants of the LEAD programme for future leadership training

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Leadership development within dentistry appears to be both needed and welcomed. The opportunity to address this training need brings opportunities for the dental profession to drive up quality and deliver patient benefits.

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