Shaping the future of clinical leadership in primary care

Accelerated Learning Event (ALE)
2nd and 3rd December 2009
What is an accelerated learning event?

“An accelerated learning event (ALE) is not your usual conference or workshop; it is a specially designed journey that enables a depth and quality of output that would usually be unachievable in such a short time frame...”
The basis of an ALE is the scan-focus-act model

<table>
<thead>
<tr>
<th>1. Scan</th>
<th>2. Focus</th>
<th>3. Act</th>
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</thead>
<tbody>
<tr>
<td>Build foundation for high performance team</td>
<td>Focus is the first iteration</td>
<td>Create group alignment and intention to act</td>
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<tr>
<td>Engage with industry trends, industry experts and leading practices</td>
<td>Test models</td>
<td>Make definitive decisions</td>
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<tr>
<td>Create a common language</td>
<td>Rapidly prototype potential solutions</td>
<td>Engineer all aspects of the solution through parallel processing</td>
</tr>
<tr>
<td>Uncover critical assumptions and issues</td>
<td>Evaluate options</td>
<td>Establish detailed long and short-term action plans</td>
</tr>
<tr>
<td>Explore metaphors</td>
<td>Clarify expectations</td>
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<tr>
<td>Create visions of solution</td>
<td>Uncover and remove barriers to change</td>
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<tr>
<td></td>
<td>Address the situation in all its complexity</td>
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Primary care services are usually the first point of contact for a patient. They play a fundamental role in providing health services to local communities, with the majority of patient contact leading to the consumption of 80% of NHS resources.

With care being shifted away from acute to more locally-based services, primary care will play a crucial role in shaping the future of the NHS. Having strong leadership and a clear sense of direction for what the service is trying to achieve - for both staff and patients - has never been greater.

In collaboration with a variety of representatives from across primary care, the Department of Health held a two day accelerated learning event (ALE) focused on developing clinical leadership in primary care.

In order to develop an agreed vision of clinical leadership in primary care, the ALE explored the issues preventing primary care clinicians from adopting leadership roles. It also looked at learning from current good practice, creating an action plan for testing at regional events and providing feedback on outcomes and actions to the National Leadership council.

This document outlines the key outcomes of the event. It will be disseminated to participants of the ALE.
The event had six aims:

1. To articulate and agree the vision for clinical leadership in primary care.

2. To consider the issues and barriers (including how the external environment within the NHS impacts on the ability for clinical leadership to effect change) that prevent primary care clinicians taking on, or aspiring to, leadership roles.

3. To identify how we can overcome the above (by taking action both centrally and locally) including how to empower leadership beyond authority – we need to be clear this is not just about hierarchy or positional leadership.

4. To determine how we can learn from, and build on, the best of current practice and accelerate its spread to the wider community.

5. To create a set of common principles and an action plan to take forward and test out at the regional events (which will be further developed for a short vision document).

6. To provide feedback to the National Leadership Council on the outcomes and actions required to create impact in primary care.

Delegates’ hopes by the end of ALE:

- “That conclusions might make a difference.”
- “The NHS stops talking the talk and walks the walk of clinical leadership.”
- “We have a vision for the future of healthcare at primary care level.”
- “That participants have a shared vision for leading change throughout primary care working across traditional boundaries.”

“We have a vision for the future of healthcare at primary care level.”
Attendees

Individuals from the following organisations attended the event, providing a valuable balance between pathways, professions and employers’ (clinical and non clinical) views:

<table>
<thead>
<tr>
<th>Institute of Postgraduate Medicine, Brighton and Sussex Medical School</th>
<th>South West Peninsula Postgraduate Deanery</th>
<th>Dr Ellson &amp; Partners</th>
<th>Dr Sparrow &amp; Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tower Hamlets PCT</td>
<td>General Practice &amp; Primary Care Research Unit</td>
<td>NHS Institute for Innovation and Improvement</td>
<td>NAPC</td>
</tr>
<tr>
<td>South Street Surgery</td>
<td>General Practice &amp; Primary Care Research Unit</td>
<td>South Staffordshire Primary Care Trust</td>
<td>Dept of Health</td>
</tr>
</tbody>
</table>
Event outputs

The outputs from the event captured in this document have been colour-coded using the key below. Delegates worked in one of six breakout groups, which were named after the following six visionary leaders: Baird, Bell, Bhutto, Curie, Fleming and King.

<table>
<thead>
<tr>
<th>Assignment 1</th>
<th></th>
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<tbody>
<tr>
<td>Assignment 2</td>
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<td>Assignment 3</td>
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<td>Assignment 4</td>
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<tr>
<td>Assignment 5</td>
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<tr>
<td>Assignment 6</td>
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</table>
Assignment 1: scanning
Timing 10.05 am -12.00 noon: total 1 hour 55 mins

Aim
- Understanding the vision

Format

Step 1
- Delegates split into six groups
- Each group has a unique question and discussion

Step 2
- The groups have to identify a representative to represent their key learning points at a Question Time style interview to report it back in plenary
- The group should capture their key points on a hypertile

Step 3
- Plenary feedback

Questions
1. What, for you, are the most important features of the vision you have heard described?
2. Are there any additional features you would wish to see included in the vision?
3. Where are the gaps between the vision and where we are now?
4. What features of the vision are there most likely to be consensus about?
5. If the vision was a reality, what would it look like in the day-to-day life of a primary care clinical leader?
6. How would you write the vision for clinical leadership in primary care as a compelling story?
Assignment 1: what, for you, are the most important features of the vision you have heard described?

Plenary response:

- Integration of care for uplift of quality and performance
- Integration of services that are meaningful to delivery of patient care and not necessarily whole organisation integration
- Tackle underperformance to create good standards
- Require ownership but shared responsibility for health, wellbeing, care etc.
- Provide equity of access to good quality care across the whole of primary care
- Need care and support for the whole population
Assignment 1: output from Curie group work

Integration

Engagement

Responsibility

Communication

Tackling

Under-performance

While

System

Community

Quality

Shared leadership

Accountability

Prevention

No more hierarchy

Not at the top table

LA1 Curie
Assignment 1: are there any additional features you would wish to see included in the vision?

Plenary response:

- We need to identify leaders and a process for doing so
- Equality at every level is needed between primary care and contractors
- Population health is the clinical leader’s responsibility
- Requires real, holistic patient engagement
Assignment 1: output from Baird group work

- Equality between care contractors
- Population health is my responsibility
- Real holistic patient engagement
- Leadership = day job
- Target + bonus → unintended consequences
- Timeframe?
- Aim statement
- Collaborative working
  - Collective thinking
Assignment 1: What features of the vision are there most likely to be consensus about?

Plenary response:

- Equity of access to good quality primary care – linked with this is incentivising good delivery of care
- Concentrating on health and wellbeing – the past 40 years have paid lip service to this and concentrated on illness rather than wellness
- Integrated and co-ordinated services – but only where this needs to happen
1) Equity of access to good quality of care.
   Easy delivery
   Incentivise

Concentrate on health & wellbeing

2) Integration of 1st care services
Assignment 1: where are the gaps between the vision and where we are now?

Plenary response:

- Disconnect with high level vision and what actually happens at the coalface. Frontline staff need to understand and be engaged with delivering the vision. This is compounded by policy disconnects.
- There are lots of silos - we need to get the ‘coalface’ working together.
- Inconsistency of care delivery.
- Existing culture needs to be challenged so that staff are enabled and empowered to bring about change.
- More courage and determination needed at the coalface – this can be done by empowerment/removing barriers.
Assignment 1: output from King group work

Diagram:
- Disconnect between high-level vision and the coal face.
- Morale high ground
- Patient
- Contracts
- Policy disconnect
- Culture and history impact
- Courage and determination
- Support network
- Inconsistency across all Arg
Assignment 1: how would you write the vision for clinical leadership in primary care as a compelling story?

Plenary response:

• Using the story of Robin Hood and his merry men
• Robin Hood has interlinked goals relating to patients, population and budgets
• Only by working together with his band of clinicians can he achieve these goals
• He was an inspiring leader who bucked the trends, worked outside the box and broke the rules
• He inspired the belief that ‘we can do it!’
• Questions about who is the Sherriff of Nottingham in this story? The clinicians? The trust? DH? The structure itself?

Alexander Fleming, 1881-1955
Assignment 1: output from Fleming group work
Assignment 1: if the vision was a reality, what would it look like in the day-to-day life of a primary care clinical leader?

Plenary response:

- Service would be predictable for the caregiver and patient
- Less variance in care, more ‘smoothness’, more standardisation – less risk!
- Service passes the ‘Ronseal’ test – it does what it says on the tin!
Assignment 1: output from Bell group work
“80% of cost reduction depends on clinical decisions”

Brent James
Intermountain Healthcare
Assignment 2: scanning – good practices
12.00pm -1.15pm: total 1 hour 15 mins

Aim
Sharing good practice

Format
Delegates split into six groups
Each group will attend three, 15-minute good practice micro sessions

Step One
15 mins + 5 mins travel per round
The sessions will be led by clinical leaders who will present their case studies to describe:
• Aims and impact
• Critical success factors
• Challenges
• Transferable principles

Step Two
The end of each session will be marked by music
The Flow Team will take each group to their next session

Questions
Feedback
There will be no formal feedback process for this session
Delegates will have five minutes at the end of each presentation to ask any key questions / offer thoughts and reactions
Delegates are encouraged to note any:
• reactions
• thoughts
• comments
that they wish to make/want the rest of the delegates to consider and write them on the graffiti wall in the main plenary room at the end of the session and during the lunch break.
Sharing good practice – our speakers

1. **Lis Rodgers**, GP Doncaster - led cross-boundary 18 weeks work locally

2. **Ian Trimble**, PEC Chair, Nottingham City PCT

3. **Annie Macallum**, Nurse Gloucestershire PCT - leads cardiology in primary care in Gloucestershire and in particular has developed excellent relationships with local cardiologists

4. **Stephen Foster**, pharmacist - set up a successful anticoagulation monitoring service with local GPs despite lack of support from the PCT

5. **Nikita Kanani**, GP - specialty trainee, will talk about trainee perspective on leadership

Communication is the key

Organisational culture is important

Personal commitment

The NHS needs to respond

Leaders need to want to change

Step forward

You don’t need time and money to demonstrate effective leadership

Link into networks (multi disciplinary)

Passion and perseverance are essential

You don’t need time and money to demonstrate effective leadership

Get rid of ‘hang-ups’

We need to steal good ideas and not reinvent the wheel.

It’s not exactly rocket science (but clearly beyond the wit of politicians)

We need to steal good ideas and not reinvent the wheel.

Lots of excellent examples in care. But tend to be small scale and fragmental to date.

Leaders need to want to change

no more same old/same old!! Stop moaning and do something

Graffiti wall - what can we take from the good practice sessions in our quest to unleash primary care leadership?

You don’t need time and money to demonstrate effective leadership
Graffiti wall (continued) - what can we take from the good practice sessions in our quest to unleash primary care leadership?

- Hardwired into daily practice and on the national leadership council
- Current contracts get in the way
- NHS leadership council representation very skewed versus activity
- Remove the NHS from political control!
- Collaborative working!
- Independent contractors need to remember they are mostly paid by the NHS and behave like it

Leaders need mentors and supportive environment

Idea rich, time poor.

PCTs should ‘let go’ clinicians to do commissioning

If we do not allow pre-reg. nurses etc. in to learn about general practice how can we grow our clinicians and future leaders. Make all practices ‘training practices’

We keep doing it then losing it: primary care collaborative, modernisation agency, NHS Networks, NPCRDC, MASC etc.
Graffiti wall ‘wordle’
Emerging themes and reflections

Dr David Colin Thome, National Director for Primary Care and Dr Johnny Marshall, NAPC Chairman

Leadership context

Find and support informal leaders. There is too great a focus on positional leadership and we need to see leadership at many different levels including:

- leadership in the public and patient arena
- leadership in local primary care environment
- leadership at national level.

A formal vehicle is needed to identify leaders.

There is value in a reflective leadership style.

There is a lack of primary care experience in senior leadership positions at present.

Accountability

Take steps to demonstrate local leadership and take control and accountability over the areas of service where you can have an immediate impact. This has to be part of personal strategy. If future leaders are to influence the external environment, they need to be accountable for how they deliver existing services and those they can influence.
Co-ordination and alignment

Find a common purpose and alignment with others across boundaries who share the same values and are working towards the same goal of delivering quality patient care. The reward is delivering improvement together. The skill here is leading across organisational boundaries and we need to encourage and give authority to those working across these boundaries. For example, it might be that we give leadership to a hospital social worker or ambulance service to act as local primary lead. Question who is the best-placed person to lead.

Challenge

Challenge some of the received wisdom – the terminology we use and our understanding of it. For example, care pathways are not necessarily useful for managing chronic diseases. Primary care has valued its independence and needs to consider what independence in clinical practice it is prepared to share. Leaders need to be vocal about the care patients receive (there is too much variation in care) and for this to be central to their leadership role.

“In summary, we need both competition and collaboration.”
Assignment 3: focus
2.20pm - 6.20pm: total 4 hours

**Aim**
Address some key issues to identify the case for change and investment

**Format**
Delegates split into 6 groups

**Step 1**
Each group has a unique question which they will address

**Step 2**
Each delegate in the group will take a panel, then share with their group. The group then identify (6) key points that they want to make

**Step 3**
The group then shift to another groups room – leaving a representative to share their work with the next group. Once the key messages are shared, the incoming group to critique and build on the previous groups work

**Step 4**
There are two rounds in this process for each group
Each group will stay in the current room, to create their proposition/”case for investment” to present in plenary

**Step 5**
Plenary Feedback in ‘Dragons’ Den’ style

**Questions**

1. How do we create the ‘right’ culture and behaviours to allow primary care leadership to flourish?

2. How do we unearth the untapped pool of leadership talent in primary care?

3. How do we make the strategy for clinical leadership ‘real’ in a local context?

4. How do we more effectively build clinical leadership into daily work in primary care?

5. Create a definition of clinical leadership. How would you recognise an effective clinical leader in primary care?

6. How can the developmental needs of clinical leaders be addressed by enabling the skills, capabilities, confidence and opportunities?
“It’s better to ask for forgiveness than permission.”
Assignment 3: how do we create the right culture and behaviours to allow primary care leadership to flourish?

Key points presented to Dragons’ Den:

- Clear policies/vehicles and implementation (not constraining/stifling)
- Clear objectives/incentives/KPIs
- Showcase real service change
- Accept different levels of engagement
- Devolve budgets/risk and hold to account
- Competency framework (developmental including leadership in curriculum)
- QIPP is delivered by good clinical leadership, which is dependent on the right culture and behaviours and an evidence-based approach
Assignment 3: how do we unearth the pool of leadership talent in primary care?

Key points presented to Dragons’ Den:

• Turn on the light – in people, in core training, by making leadership a key issue (theory, practice, development), through practice and networks

• Talent spotting – look out for select people with multiple potential at all levels (change, rigour, reflection, facilitation, see competency framework)

• Development of talent – mentoring, moderate

• Resource allocation – time, supervision, courses

• Reward and recognition – of everyone doing good work

• Challenge, share, support – give the conditions to deliver, accept risk, assume some will fail
Assignment 3: how do we more effectively build clinical leadership into daily work in primary care?

Key points presented to Dragons’ Den:

- Identify, communicate and disseminate good practice
- Infrastructure, protected time (individually and in teams), number of £ penalty network
- Mindset plus culture of reflection and challenge
- Spot ‘passion’ (may be hidden), nurture, develop and sustain over time
- Patient-centred delegation – let go
- Skills knowledge and behaviour – not rank or title
Assignment 3: how do we make the strategy for clinical leadership real in a local context?

Key points presented to Dragons’ Den:

- Start with the outcomes in mind – based on local need
- Appropriately funded, supported, valued
- Succession planning – creating the ‘talent pool’
- Develop the leaders with greatest desire and appropriate skills and talents – decommission the dead wood
- Empowering clinicians by involving them from the outset
- Leading to quality
Assignment 3: how can the developmental needs of clinical leaders be addressed by enabling the skills, capabilities, confidence and opportunities?

Key points presented to Dragons’ Den:

- Early and continuing development opportunities
- Mentoring / coaching networks
- Organisations identify, value and celebrate leaders
- Structured learning including secondments and real application of learning on projects
- Exposure to modelled good practice
- Leadership scout / champion per PCT with real budget

Alexander Fleming, 1881-1955
Assignment 3: create a definition of clinical leadership. How would you recognise an effective clinical leader in primary care?

Key points presented to Dragons’ Den:

- Clear moral compass and accountability
- Clinical perspective
- Vision
- Moving hearts, hands and minds
- Change agent – able to deliver (enabling and empowering) to others
- Flexible pragmatist

Alexander Graham Bell
1847-1922
Reflection on themes from Day 1

Dragons’ Den judges and audience

- A lot of energy and enthusiasm engendered and consensus that we do not want to be saying the same things next year

- Accountability – what does accountability really mean with devolved budgets? Is the accountability and responsibility correctly aligned?

- How do we get people who could be good leaders to come forward if they are not engaged with the current agenda? How do we get rid of the dead wood?

- Having real money budgets could be a quick route to engaging and improving leadership

- The impending financial situation means we have no time to wait for structural change – we need to change clinicians’ behaviour now
Day Two
Reflection on themes from day one
Dragons’ Den judges and audience

• Need to have skilled and competent clinicians who are also ‘corporate’
• Need to explore what can be achieved within the current system and not rely on structural change
• The financial crisis can been seen as an opportunity and a driver for change
• We should be building relationships with counterparts in PCTs, not bashing each other. Shadowing, mentoring etc. We don’t understand each other’s pressures
• We need a new style of leadership in the future, one based on facilitated support not command and control. It will involve investment in relationships across the whole system
• Question about whether we all need to be singing from the same song sheet - don’t we need a diversity of talents?
Reflection on themes from day one
Dragons’ Den judges and audience

• There is a need to **create a compelling case** that persuades colleagues to move away from the current model of payment by volume

• Need to guard against the risk of people who are new to leadership roles adopting the culture they have grown up in – top down, risk averse. Leaders will need to be supported to **challenge the current culture**

• Training in leadership is not necessary – an enabling culture is

• To achieve **second order change** you need: clear incentives, aligned policy, get the metaphor for change right, get rid of the people not delivering

• Obstructions - we have no **vehicle for sharing good practice** and a lack of clear guidance in key areas

• We can influence change by making **small changes**

• We have lots of opportunities, we have the skills, motivation and desire – we just need to take on the **accountability**, cut the umbilical cord and get on with it
Assignment 4: drivers and barriers
8.55am - 11.45am: total 2 hours 50 mins

**Aim**
To surface the drivers for and barriers to primary care leadership

**Format**
Delegates split into six groups. Each group has a unique question

**Step 1**
The groups have to work together and use their creativity to answer the question and report it back in plenary

**Step 2**
Presenting back in plenary should be done as creatively as possible and props will be available

**Step 4**
Plenary feedback

**Questions**

1. What barriers do we need to overcome to delivery a strategy for clinical leadership
2. How do we incentivise clinical leaders to participate in developmental activities (within existing resources)?
3. What drivers will help in achieving the vision?
4. Who can help to deliver and support the strategy for clinical leadership?
5. How do we utilise the current system and resource support to deliver clinical leadership?
6. What additional resources might be required?
Key points

• We are juggling a lot of balls: DH, unions, other parties
• Lack of interdisciplinary working
• ‘Glass ceiling’ stops progression
• Existing contracts
• Lack of partnership working
• Lack of mentorship and support
• Need to focus on interpersonal relationships
Key points

Incentivise

• Personal and career development
• Mentor support
• We all need a mentor, money, a balanced judge, pirate to push us, a fairy godmother!

Clear pathways

• An expectation that leaders demonstrate the required leadership competency
• Develop the culture and engagement required to achieve second order change
Assignment 4: Luther King group work - what drivers will help in achieving the vision?

Key points

- Understand politics and politicians and engage them
- Use health and wellbeing outcomes to achieve large scale behavioural change
- Positive public support and public participation
- Use other government policies as a driver – e.g. regeneration / telemedicine
- Spend wisely
- Understand other agencies’ cultures and approach to risk
- Check / assess whether drivers work for all participants – Commissioners, GP practices, DH
- Call for action is a focus not on the drivers but on taking control of the ‘vehicle’
Assignment 4: Bhutto group work - Who can help to deliver and support the strategy for clinical leadership?

Key points

• Need to create a compelling story and narrative for change
• Need to act broad and deep
• Need to be prepared to be rule breakers

• Those who can help achieve the change include:
  – Peers, colleagues
  – Enthusiasts and champions
  – SHA/ DH/ PCTs can facilitate
Assignment 4: Bell group work - how do we utilise the current system and resource support to deliver clinical leadership?

Key points

- Wake up – communicate – engage – implement
- Real investment needed
- Capture and utilise the enthusiasm of clinicians
- Improve communication and engagement
Assignment 4: Fleming group work - What additional resources might be required?

Key points

• Overarching principle is to see things through the eyes of patients
• Need resources to free up leaders to be creative
• Use existing resources differently – e.g. resource self care management by patients
• Need to act as role models
• Demonstrate the change of behaviour we want to see as leaders
Quote from the conference

“A journey of 1,000 miles starts with a single step.”
Assignment 5: Planning for action and creating the manifesto
11.45am – 4.00pm: total 4 hours and 15 mins

Aim
To develop the 7-day and 30 day high impact action plans to deliver the vision for primary care leadership

Format

Step 1
Part of Plenary
Before lunch
Key themes (optimum 6/8) from the event to be posted in the plenary room. Groups to self-select depending on where their energies and interests lie

Including a working lunch
Groups to work to produce their high impact 7 and 30-day action plans

Step 2
Step 3
Creating the compelling manifesto
Each group to create their declaration of key principles and intentions to act as the compelling and binding ‘mission’ for delivery

Plenary feedback & manifesto sign-up
Groups to feedback in plenary

Themes

The themes for action planning captured as they emerged over the two days:

1. A campaign for primary care!
2. What will we do to identify and support a future leader in our local system?
3. How do we take the ‘primary care home’ forward?
4. Greater accountability leads to greater influence: an action plan for accountability
5. Relationship with the National Leadership Council and the NHS ‘infrastructure’
6. How do we take the themes from this event forward to the regional events and how do we support local leaders?
7. How do we turn some of the outputs of this event into a compelling vision to mobilise people?
Assignment 5: Baird group work – manifesto
Supporting future leaders

Manifesto

“We will secure the future of the NHS by developing primary care leaders to deliver health and wellbeing for all.”
Assignment 5: Baird group work – 7-day action plan
What will we do to identify and support a future leader in our local system?

<table>
<thead>
<tr>
<th>What</th>
<th>Who</th>
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<tbody>
<tr>
<td>1 day: letter from DH to COGPEP to direct deaneries to establish</td>
<td>DH / James Parsons</td>
</tr>
<tr>
<td>regional leadership forums</td>
<td></td>
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<tr>
<td>Shared leadership for all</td>
<td>Richard Emms</td>
</tr>
<tr>
<td>Identify a mentorship training programme (RCGP / Pharms / PMs)</td>
<td>Dominic Horne, Nigel Sparrow, Sam Clark (PM’s)</td>
</tr>
<tr>
<td>Identify mentorship training network</td>
<td>Catherine Baraniak</td>
</tr>
<tr>
<td>Find two trainees in each VTS that have clinical leadership</td>
<td>Mike Deighan</td>
</tr>
<tr>
<td>potential</td>
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<tr>
<td>RCN PNA to scope opportunities for the mentorship/leadership</td>
<td>Sue Nutbrown/ Suzie Clements</td>
</tr>
<tr>
<td>programme</td>
<td></td>
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<tr>
<td>Put clinical leadership onto the agenda of dental programme board</td>
<td>Peter Bateman/ Sue Gregory</td>
</tr>
<tr>
<td>of Modernising Medical Careers</td>
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**Assignment 5: Baird group work – 30-day action plan**

What will we do to identify and support a future leader in our local system?

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<tr>
<th>What</th>
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<tbody>
<tr>
<td>Report back to the group the success and problems arising from the 7-day action plans</td>
<td>All</td>
</tr>
<tr>
<td>Identify a successor!</td>
<td>All</td>
</tr>
<tr>
<td>Identify a date to share MCLF with the dental board</td>
<td>Mike Deighan</td>
</tr>
<tr>
<td>Instigate acting up plan for assistant directors in three areas neglected at present</td>
<td>Catherine Baraniak / Sue Nutbrown</td>
</tr>
<tr>
<td>Develop plan to have a leadership network</td>
<td>Peter Bateman / Richard Emms</td>
</tr>
<tr>
<td>Identify / scope opportunities in dentistry</td>
<td></td>
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</tbody>
</table>
Manifesto

“Primary care, population-based organisation with contract to deliver measurable improvement in health and healthcare.”

Signed: single responsible care provider
### Assignment 5: Fleming group work – 7-day action plan
How do we take the ‘primary care home’ forward?

<table>
<thead>
<tr>
<th>What</th>
<th>Who</th>
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<tbody>
<tr>
<td>Collate and share outputs from the conference with PCT</td>
<td>Tim Richardson</td>
</tr>
<tr>
<td>Discuss and shape with colleagues from dentistry, optometry and pharmacy (including contractors)</td>
<td>John Milne, Sue Blakeney, Dhiren Bhatt, Liz Stafford</td>
</tr>
<tr>
<td>Explore opportunities for working across community care provision, social care and hospitals</td>
<td>Sheinaz Stansfield</td>
</tr>
<tr>
<td>Feed in a précis to pharmacy white paper</td>
<td>Liz Stafford</td>
</tr>
<tr>
<td>Determine scope including: social care, partnership working, patient involvement and prevention.</td>
<td>ALL</td>
</tr>
<tr>
<td>Identify credible management partner</td>
<td>Tim Richardson</td>
</tr>
</tbody>
</table>
Assignment 5: Fleming group work – 30-day action plan
How do we take the ‘primary care home’ forward?

<table>
<thead>
<tr>
<th>What</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address technical transactional issues including data and PBRA</td>
<td>Ian Trimble</td>
</tr>
<tr>
<td>Other technical issues relating to risk, finance/ audit and governance</td>
<td>David Colin-Thome</td>
</tr>
<tr>
<td>Discuss with potential local partners</td>
<td>ALL</td>
</tr>
</tbody>
</table>
Manifesto

“Unleash the potential of healthcare professionals in primary care to improve the health of the nation.”
# Assignment 5: Curie group work – 7-day action plan

A campaign for primary care

<table>
<thead>
<tr>
<th>What</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raise the issue / idea with RCN, PNA, ANP</td>
<td>Eileen Munson</td>
</tr>
<tr>
<td>Discuss with DCT to endorse our manifesto and arrange meeting with Andy Burnham</td>
<td>Eileen Munson</td>
</tr>
<tr>
<td>Discuss with Johnny Marshall (NAPC) and arrange stakeholders for a NAPC meeting</td>
<td>Debra Sprague</td>
</tr>
<tr>
<td>Exploit networks in BMA to raise the issue</td>
<td>Sam Everington</td>
</tr>
</tbody>
</table>
# Assignment 5: Curie group work – 30-day action plan
## A campaign for primary care

<table>
<thead>
<tr>
<th>What</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face-to-face meeting with Chair, NAPC and influencing stakeholders</td>
<td>Debra Sprague</td>
</tr>
<tr>
<td>Put together evidence-based ‘fact list’ for use in campaign</td>
<td>Eileen Munson to collate</td>
</tr>
<tr>
<td>Draft letter for DCT to inform Andy Burnham and for CNO</td>
<td>Debra Sprague and team</td>
</tr>
</tbody>
</table>
Manifesto

“We will build and sustain relationships at every level of the NHS leadership infrastructure to create momentum, passion and delivery for improvements in primary care, patient experience, health and wellbeing through primary care clinical leadership.”
<table>
<thead>
<tr>
<th>What</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circle of influence (value of leadership, talent spot, swaps,</td>
<td>Everyone in the room</td>
</tr>
<tr>
<td>emerging clinicians at training grades and graduate trainee</td>
<td></td>
</tr>
<tr>
<td>managers</td>
<td></td>
</tr>
<tr>
<td>Profiling of senior leadership and create a map of primary care</td>
<td>‘Bhutto group’ Dominic Slowie,</td>
</tr>
<tr>
<td>clinicians in SHAs</td>
<td>JM, Jim O’ Connell, SG, Lis</td>
</tr>
<tr>
<td>Showcase this event and outputs through primary care media</td>
<td>Rodgers)</td>
</tr>
<tr>
<td></td>
<td>Dominic Slowie and JM</td>
</tr>
<tr>
<td>What</td>
<td>Who</td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>Regional events SHA dates and links</td>
<td>JM and SHA rep from the audience</td>
</tr>
<tr>
<td>Raise the profile of primary care leadership with national leadership leads at regional events</td>
<td>SG and Jim O’Connell</td>
</tr>
<tr>
<td>Offer a pitch to NLC</td>
<td>Jim O’Connell, JM and the team</td>
</tr>
<tr>
<td>Regional leads for L and TM about to meet to feedback and increase profile</td>
<td>Jim O’Connell and SG</td>
</tr>
</tbody>
</table>
Manifesto

“We will deliver a series of events that will support and develop clinical leaders within primary care across the NHS.”
### Assignment 5: King group work – 1 and 7-day action plans
Taking themes forward and supporting local leaders

<table>
<thead>
<tr>
<th>What</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1-day actions</strong></td>
<td></td>
</tr>
<tr>
<td>• Volunteers for local contact for regional? (During manifesto pitch)</td>
<td>Nav Chana</td>
</tr>
<tr>
<td>• DCT video clip to others “watch this space”</td>
<td>Louise Jarvis</td>
</tr>
<tr>
<td>• NWSHA Working across boundaries learns – talk to Liz Stafford – <strong>done!</strong></td>
<td>Sean Fenelon</td>
</tr>
<tr>
<td>• Talk to DCT re: photo on flyer – <strong>done!</strong></td>
<td>Sean Fenelon</td>
</tr>
<tr>
<td>• Talk to DH pharmacy team re: PH showcase/leadership planned events – <strong>done!</strong></td>
<td>Mike Holden</td>
</tr>
<tr>
<td><strong>7-day actions</strong></td>
<td></td>
</tr>
<tr>
<td>• Can we go beyond March 2010?</td>
<td>Claire</td>
</tr>
<tr>
<td>• Agree two regions to pilot- East of England, West Midlands</td>
<td>Sean Fenelon</td>
</tr>
<tr>
<td>• Kick off</td>
<td>Carol Marston</td>
</tr>
<tr>
<td>• Planning and feasibility</td>
<td>All</td>
</tr>
<tr>
<td>• Names to Maggie to support the events and ID delegates</td>
<td>Claire</td>
</tr>
<tr>
<td>• Planning meeting Tuesday 8th December – invite team members from regions</td>
<td>Claire / Louise Jarvis</td>
</tr>
<tr>
<td>• Feedback to group post meeting and arrange telecon within 30 days</td>
<td></td>
</tr>
<tr>
<td>What</td>
<td>Who</td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>• Design and action planning of the days/sessions</td>
<td>NAPC / DH / PCC</td>
</tr>
<tr>
<td>• Whole group telecon to soundboard current planning</td>
<td>Claire</td>
</tr>
<tr>
<td>• Rope in ‘contextual leaders’ from the regions to assist</td>
<td>Maggie Marum</td>
</tr>
<tr>
<td>• Construct draft flyer</td>
<td>NAPC / PCC / DH</td>
</tr>
<tr>
<td>• Put the invite letter together to ‘personalise it’</td>
<td>NAPC / PCC / DH</td>
</tr>
</tbody>
</table>
Assignment 5: Bell group work – manifesto
An action plan for accountability

Manifesto

“High quality managed care for all.
Risk – reward – accountability.”
### Assignment 5: Bell group work – 7-day action plan

An action plan for accountability

<table>
<thead>
<tr>
<th>What</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Buy in from the group:</td>
<td>Presenters Team</td>
</tr>
<tr>
<td>• DLT</td>
<td>Fin McCaul</td>
</tr>
<tr>
<td>• Pharmacists</td>
<td>Fin McCaul</td>
</tr>
<tr>
<td>• Dentists</td>
<td>Sarah Banham</td>
</tr>
<tr>
<td>• Optometrists</td>
<td>Niti Pall</td>
</tr>
<tr>
<td>• Communicate to policy makers via</td>
<td>Sarah Banham</td>
</tr>
<tr>
<td>• Campaign</td>
<td>Chandra Kanneganti</td>
</tr>
<tr>
<td>• Story</td>
<td>All</td>
</tr>
<tr>
<td>• Regional</td>
<td>Niti Pall</td>
</tr>
<tr>
<td>• Communicate manifesto back home</td>
<td></td>
</tr>
<tr>
<td>• Explore idea</td>
<td></td>
</tr>
<tr>
<td>• Metrics – health credits on in investment</td>
<td></td>
</tr>
</tbody>
</table>
### Assignment 5: Bell group work – 30-day action plan
An action plan for accountability

<table>
<thead>
<tr>
<th>What</th>
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</tr>
</thead>
<tbody>
<tr>
<td>• Create feedback mechanism to track actions have occurred</td>
<td>DCT</td>
</tr>
<tr>
<td>• Check on response to various communications in 7-day plan</td>
<td>Niti Pall / Fin McCaul/ Sarah Banham / Chandra Kanneganti</td>
</tr>
<tr>
<td>• ‘Oiling the wheels’ – feed ideas into future discussions with David Nicholson/RCGP/NHS Alliance/DH</td>
<td>Johnny / DLT / Jim O’Connell / Jill Matthews</td>
</tr>
<tr>
<td>• Report to RCGP West Midlands</td>
<td>Chandra Kanneganti</td>
</tr>
<tr>
<td>• Report to professional affairs network – West Midlands</td>
<td>Niti Pall</td>
</tr>
</tbody>
</table>
1. Case for change

- Primary care has the majority of patient contact
- Quality of care delivered varies
- Too much risk is passed off to secondary care
- Systems are broken down and not delivering:
  - Outcomes (health)
  - Value for money
  - Professional reward
2. The vision

Imagine primary care that is:

- Integrated
- Population-based
- Proactive about wellness
- Empowers system delivery:
  - Health outcomes
  - Better use of resources
Assignment 5: Colin-Thome group work
Turning ALE outputs into a compelling vision to mobilise people

Vision

- Cascade communication
- Buddy/mentor
- Set up a new service
- Meet coalface and engage
- Spread good practice now
- Succession plan through juniors
- Identify and mentor
- Incentivise (£) and save
- Use juniors
- Be infections and ‘play it’
3. The problem

- Historically primary care leadership has been underdeveloped
- Dispersed market
- Fragmented voice

4. The solution

- Social movement:
  - At all levels
  - Targeted and differentiated
- Challenge self
- Drive system change
Assignment 5: Colin-Thome group work
Turning ALE outputs into a compelling vision to mobilise people

Just do it!

“Today at 2pm I put our vision into practice. I phoned my business partner and asked if I could make change for my organisation (practice) by taking the lead in a new concept in the community involving ourselves and other organisations.

The change for me was not having to waiting for approval from the PCT and not having to ask for a budget, but making a change for our patients or any person who wishes to be a patient.”

Jo Medhurst
The Pledge

J. D. I

1. I will tell clinicians when they are doing a good job and celebrate them to others.
2. I will produce a list of metrics on quality in general practice (with others) - 2nd draft in 30 days.
3. I will communicate with and support other clinical leaders.
4. I will take more care of my personal possessions on a course.

J. P. I

1. I will empower my VTS to join the pledge on the next week - real junior making real changes.
2. I will encourage second year registrars in the rotation to be the main contact to make sure their voice is heard.
3. I will work with the National Junior Doctors' Association to make sure the voice of junior doctors is heard.
4. I will make sure the junior doctor's voice is heard in the rotation.

I will ensure that the junior doctor's voice is heard in the rotation.

J. P. I

1. I will take on the role of leadership.
2. I will encourage second-year registrars in the rotation to be the main contact to make sure their voice is heard.
3. I will work with the National Junior Doctors' Association to make sure the voice of junior doctors is heard.
4. I will make sure the junior doctor's voice is heard in the rotation.

I will ensure that the junior doctor's voice is heard in the rotation.
J.D.L.  THE PLEDGE

I WILL SUPPORT MY MANAGERS TO OPEN UP NEW RELATIONSHIPS WITH CLINICIANS THROUGH "BUDDYING" EXCHANGES AND TO HAVE SET THIS UP IN 30 DAYS. TODAY

I will invite primary colleagues to the experimental "Camp Obama"-type approach to accelerating change. It's on 4th & 5th March at University of Warwick, Helen B.

I will 'swap' people in the system with my team + me to create learning & leadership opportunities.

I will commit to making the workshop happen in our organisation.

I will talk to the GP about having a dedicated/standardised approach to PC leadership development.

I will support the delivery of the regional events. Sean
Supplementary information from assignment 3

Address some key issues to identify the case for change and investment
From assignment 3: address some key issues to identify the case for change and investment

1. How do we create the ‘right’ culture and behaviours to allow primary care leadership to flourish?
2. How do we unearth the untapped pool of leadership talent in primary care?
3. How do we make the strategy for clinical leadership ‘real’ in a local context?
4. How do we more effectively build clinical leadership into daily work in primary care?
5. Create a definition of clinical leadership? How would you recognise an effective clinical leader in primary care?
6. How can the developmental needs of clinical leaders be addressed by enabling the skills, capabilities, confidence and opportunities?
Fleming group work
How can the developmental needs of clinical leaders be addressed by enabling the skills, capabilities, confidence and opportunities?

• Leadership scout/champion
• Opportunity to demonstrate one has leadership attributes
• Grow your own – there are people in all organisations
• Recognise limitations and address them
• Create a career path definition
• Networking and exposure to experts
• A ‘polyphony of interventions’ – mentoring, work-based, apprenticeships etc.
• A safe environment to try it out and practice leadership skills
• Celebrate successes

Further thought…
“The question is framed in a way that implies a need to invest in human capital. For effective distributed leadership, we also need to attend to social capital, i.e. opportunities, ‘vehicles’, removing barriers, creating effective structures etc.”
Bell group work
Create a definition of clinical leadership. How would you recognise an effective clinical leader in primary care?

- A clinician who works through others to effect beneficial change
- Be the change you wish to see
- The ability to challenge current assumptions and activity
- A person who is focused, not afraid to speak up, will work hard and get the job done. Make change because it is needed, not because it is written down
- Understands self-limitations
- Patient-centred
- Create a shared and aligned vision, supported by a clear methodology for improvement, where the ‘gives and the gets’ are well understood
Curie group work
How do we create the ‘right’ culture and behaviours to allow primary care leadership to flourish?

- Focus on patients and population
- Role models
- Devolution of power/accountability
- Acceptance of risk/consequence
- Operational ethos and vocational ethos
- Get DH attention and NHS attention
- Political acumen and business acumen
- Career plan/development as part of contract
- Make it a training ‘fundamental’ – next generation
Bhutto group work
How do we more effectively build clinical leadership into daily work in primary care?

• Having clear expectations and understanding of clinical leader role
• Delegate or appoint clinical leadership to the most appropriate person irrespective of title or position. Conveying the message that clinical leadership is not only the ‘top level’. The leader changes dependent on the task or job to be done. No one is ‘leader of it all’
• Maslow hierarchy of leadership
• Adequate infrastructure for dispersed workforce
• Appropriate remuneration for time spent in clinical leadership role
• Know the mechanism to deal with under performance
• Ability to have an effective team in which each team member adopted appropriate role
• Empower those who are already doing it (without realising that they are doing it)
• Do not pull all clinical leaders out of the clinical environment
• Greater opportunities for nurses to be involved (and supported) in clinical steering groups
**Bhutto group work (continued…)**

**Time**
- Allocated time to undertake work/attend meetings etc.
- Protected time to attend learning events to improve knowledge and skills as a leader

**Bring back organisation development**
- Build leadership into GP appraisals
- Develop a career path that allows clinical leaders to function effectively at a level that suits them and retain them

**Mechanisms in place to develop colleagues and support**
- Enable people to develop leadership skills in a supported environment
- Put in place tools that enable leaders to develop and flourish
- Mentoring and support provided
- Allow stability in the system to enable leaders to learn and reflect
- Fixed time set aside in daily work and its protected
- Support leaders in the leadership style that suits the task that needs to be undertaken
- Develop tools for peer reviews

**Share good practice**
- Greater communication and dissemination of the work already being done
- Enable networking for shared learning and reflection
How do we unearth the pool of leadership talent in primary care?

- Stress importance/benefits of clinical leadership at college/university – start them young, get them thinking about it early
- Include clinical leaders as part of personal development plans
- Give incentives for people to become clinical leaders – financial, proof of recognition
- Headhunt potential clinical leaders
- Enable part-time practice/clinical leader duties - clinicians like seeing patients, helps encourage peer respect
- Someone without vested interests who is expected to talent spot and network in and outside the organisation e.g. Queen’s nursing, clinical leads
- Leadership tailored to specific stage/post and prior learning
- Bring out talents in all
Baird group work (continued…)

- Create opportunities against the norms
- Start with own immediate environment
- Network – take time to talk with other professions and share
- Build relationships
- Give time to mentor and support – skills/time – champion and grow
- Give permission to take risks. Manage risk – whether at part-time level, managerial or national
- Manage expectations

Move resources

↓

Change paradigm

↓

Challenge thinking
Baird group work (continued…)

- Change mindsets
  - Vision
  - Change
  - Maintain
- Create ‘tools’
- Create change agents
- Signpost opportunities
- Create different route maps
- Be brave enough to ask people what they think will help not just what current leads say
- Make it ok to experiment and take risks
- Don’t look in the same and traditional plans for leaders
- Create a way to learn together
- Dare to be different – value differences
- Focus attention on the informal as well as the formal – unsung leaders could emerge
Questions

• Not integrated into job plan
• Training pre – new role adoption
  
  Mentoring + supported
  
  Shadowing + tasters

• Turn on the light but let it glow for a while…
• Will it be part of the responsibility of existing leaders?
• How can we change thinking?
• Do we need a headhunting model?
King group work
How do we make the strategy for clinical leadership ‘real’ in a local context?

Local clinical leader

- Engages others within a team
- Others follow
- Lead by example
- Start with the end in mind
- Practice what you preach
- Develops and leads the vision
- Inspirational
- Respected & chosen by your colleagues
- Others follow

Practice what you preach

Start with the end in mind

Lead by example

Develops and leads the vision

Inspiration

Respected & chosen by your colleagues

Engages others within a team

Others follow
King group work (continued…)
Local needs?

- What needs to change? What will the benefits be?
- All levels should be involved?
- What barriers are there?

What lessons can be learnt?

No point re-inventing the wheel!

- Examples of good practice can be re-used/recycled
Engaging all staff in clinical service
  Monitoring and service revision

Horizon-scanning – taking ideas from all clinical disciplines

Strong culture of safer care – risk management, professional support of clinical staff

Devolved budgets for clinical training/development/acquisition – from practice core funds

Twinning and peer group support from other practices
King group work (continued…)
How do we make the strategy for clinical leadership ‘real’ in a local context?

• Within a local context, identify the local leaders in each profession e.g. PCT/PBC locality, SHA region/health economy
• Enable them to work together in a local network:
  o With a shared vision and agreed outcomes
  o Redesign services to achieve this including the public
  o Agree right incentives to all clinical groups – to ‘buy in’
• Clinical lead for each professional group is accountable for cascading this to their group and setting up a project management function to make sure implementation happens
• Succession planning/others to lead on specific services
• Multi-disciplinary budgets for learning and research
King group work (continued…)

- Describe it in a local language
- Create passion and enthusiasm for it
- Engage others to deliver it
- Do stuff
- Get it wrong → do it again → get it right
- Tell people what you do and keep telling the story
- Support individuals
- Challenge ideas and behaviours
- Build confidence as well as competence
- Need a clear **definition** of what clinical leadership is that can be **understood** by all primary care teams
- **Culture** – that fosters change and embraces differences
- **Enablers** – in place to **allow** clinicians to develop skills within their areas.
- **Knowledge and appreciation** of all the differences/competing clinical leaders and areas.
King group work (continued…)

- Identify who current leaders are
- Identify the most important areas local stakeholders want to be changed or protected
- Formulate a plan with outcomes and timelines
- ‘Owned’ by senior team
- Shared across disciplines
- Ambitious but achievable
- Field and forum-based development
- Appropriately funded
- Multi-layered
- There for a purpose not an end in itself