Publicly Engaged GP Leadership

A handbook setting out 10 principles for GPs leading programmes of commissioning change by working with their local population

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Foreword

This handbook is the distillation of work done across NHS Lincolnshire since our formation in 2006. Shaping Health for Lincolnshire indicated to people that we were setting about our role in a new way and were determined to listen and involve people in how we commissioned health care.

This document is intended to share our learning with the wider NHS community and we hope will prove useful to GP Commissioning Consortia in the coming months and years.

A wide range of people have worked hard and with great professionalism to deliver the outcomes reflected herein. It is important to acknowledge their sterling work especially Martin’s fellow Directors. A special mention must be made of Edie Butterworth who has led a small but tireless team supporting the consultations and their subsequent analysis and feedback to the Board.

As we move into a period of tremendous reform passing on our knowledge, skills and experience is one of the key objectives of the team from NHS Lincolnshire.

John McIvor
Chief Executive, NHS Lincolnshire

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i. Background and Purpose of this Handbook

A group of GPs from East Lindsey Practice Based Commissioning Cluster approached the senior management team in NHS Lincolnshire. It was the middle of 2007 and they were increasingly concerned about their local hospital, Louth, which seemed to be gradually being diminished. They had a clear vision in which the hospital played an important role in their area and had been trying to get someone to give them some support for a couple of years. This felt like a critical moment.

We in NHS Lincolnshire could see that there were a group of local GPs keen to support a programme of change in their area and the first Shaping Health commissioning programme was born – “Shaping Health for Louth Hospital”. The brand had been born a few months earlier as we had just completed a major public consultation on our high level commissioning intentions and plans across the county called “Shaping Health for Lincolnshire”.

The work in Louth was to change a small secondary care led hospital – providing A&E, 60 medical and 12 surgical beds and a range of outpatient services – in to a primary care led unit, whilst allowing the majority of patients to continue to attend; essentially to keep the same patient flow with a different clinical model.

The commissioning programme ran from July 2007 through to September 2009 – by which time the GPs’ vision had been turned in to a detailed commissioning specification together with a competency framework for all clinicians working in the new model; there had a full public consultation that had been evaluated; and a Board decision to proceed with implementation and a new service in A&E from April 2009 and on the medical wards from August 2009 had been taken. Alongside this was a programme to build an integrated IT infrastructure across A&E, the wards, Out of Hours services, community services and GP practices.

On looking back over the work at two evaluation and lessons learned workshops we soon realised that, whilst there was a lot to learn from the clinical model in Louth, it was essentially designed for a single hospital with a particular set of circumstances. The more important and transferrable learning was about the process; the way the programme was planned, undertaken and delivered.

We started programmes based on the same template in Skegness, Gainsborough and Mid Kesteven, including Grantham Hospital. As the process has rolled out and been refined, it has become clear that there is something powerful and persuasive about the elements of the approach being followed. It has delivered results way above those we could have been expected.

This handbook is a distillation of the learning in Lincolnshire from programmes of work with a common theme – commissioning change, locally led by interested GPs working closely with their local communities and supported in their work by their local PCT.

It groups the learning in to 10 Principles – 10 easy to understand steps that have been tried and tested and together can deliver transformational results.
1. There is Only One Place to Start

Principle 1
Base the work on understanding, cultivating and nurturing a local vision.

The health service has always had a tension – often healthy, but sometimes very divisive and controversial – between locally driven ideas and regionally and nationally directed ways of working.

There are clearly important developments that are carefully considered at a national level and need to be implemented across a region or area. However, too often this becomes a reason why a local vision is unnecessary or irrelevant and there is little point to it.

The first job in our programmes has been to empower; to let local clinicians and local people know that the future of services in their area is dependent on them. They need to create a local vision, unimpeded by centralised requirements, based on their view of what is required and for which they will take ownership and responsibility.

Basing the work on a local vision is as much a philosophical point, a way of thinking, a touchstone of the approach, as it is a statement of what takes primacy.

The second step in the process is to understand what regional, national, legislative and regulatory frameworks and policies impact on the local situation and ensure that these are clearly understood.

And then the local and central views need to be reconciled – again the standpoint is the important issue; how to reconcile potentially conflicting views from the perspective of maintaining and supporting the local position. How do the pieces fit together, whilst retaining the essence what is being sought by the community and its clinical leaders?

This requires an ability to retain flexibility in approach and clear and well-developed communication and reasoning skills.
Flexibility can come from understanding clearly, not only the issue – “we want to keep and A&E” – but also what is significant about it. Asking the question “What’s important to you about [that]?” helps to elicit higher order objectives, such as – “so that we can have a service here that is available 24 hours a day 7 days a week”.

Alternatively, the same question posed to the other, more centralised position – “We can’t have a local A&E service”
“What’s important to you about shutting the A&E service?”
“Services need to be safe and we can’t staff the A&E in that unit”

The reconciliation in this example, that started as true opposites - A&E or no A&E standpoints - turns out to be about a service available 24 hours a day 7 days a week and something that is safe and can be staffed. This is much more straightforward and the chance of finding a resolution are many times greater.

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Position 1
Understand, cultivate and nurture a local vision for services
The default position
A touchstone for the programme

Position 2
The national, regional, legislative and regulatory framework
2. A Cunning Plan

Principle 2
It is important to have robust programme and project management arrangements in place and people with enough capacity to lead them effectively.

Of all of the principles, this one does seem to be the most simple and may have people chorusing “of course” and bemoaning the statement of the blindingly obvious.

Nevertheless it was commented on through all of our lessons learned processes and given that there can be huge variations in the rigour of programme and project management, it is worth setting out those issues that were critical to our success.

A plan at the right level of detail

We have found programme and project planning to be key elements in our work. The key step for us was ensuring that the information presented was at the right level of detail for the audience. Our key Programme Boards were all multi-stakeholder Boards with members of the public, local community representatives, local authority members and officers, GPs and other clinicians and NHS management staff.

We maintained programme reporting at a high, summary level that allowed an informed discussion without introducing levels of complexity that were off putting for a lay reader.
All the Boards were constituted through formal terms of reference and each programme had a formal Programme Initiation Document. We have found that adopting this approach ensures that programme management is core to the work of the Boards. We produce monthly update reports that assess progress against the set timeline and formally review a risk register (again at a high level with 5-10 items for the whole programme).

Within each of the workstreams we establish formal projects where necessary, but limit these to the minimum number we can work with.

**Programme Leadership**

We recognised the need to ensure that there was significant and dedicated support for major programmes of work and we have used external support to good effect on some of our most major programmes.

It is important that there is on-the-ground leadership at a suitably high level, but the simple truth is that Directors at NHS Lincolnshire do not have the time to dedicate to the number of programmes involved.

The job is about the timeline, plans and documentation, but as importantly it involves managing stakeholders, political awareness and problem solving. We have benefitted from speed of response, quality of paperwork and reports, consistency of process and a real focus on delivery to timescales. Notably, these programmes have been about hitting milestones – what are the options? What do we need to accelerate? What might we have to accept in order to achieve a deadline – rather than the reasons we need to delay?

No solution is perfect and the answer is not simply that external support is the best approach, but that we need to find ways to give people space, free from distraction and multiple demands, if we want to have successful programmes and projects.

**Phases and Delivery**

We have found that it has been important to break our programmes down in to phases that help to define the purpose of the current part of a long-term programme. For example a vision creation phase, a consultation phase and an implementation phase. Initially this was driven by our processes for contracting external support, but has become fundamental to driving success.

This establishes key dates for delivery for all partners involved in the programme and for our external support. It gives us good definition and allows real focus. It means that we have key points to refresh the programme plan and to reconstitute Programme Boards and project structures.

It may sound cumbersome, but we have found that respecifying membership and purpose of Boards and groups has had a profound effect on how well they work.
3. Patience is a Virtue

Principle 3
Place real emphasis early in a programme on creating the environment for change, building relationships, establishing the right Board membership and gaining confidence; focus less on deliverables and obvious signs of progress, but lay the foundations for long-term success.

There is usually a great deal of energy surrounding the start of a major programme. A lot of discussions will have taken place, agreements reached, expectations raised and accountability and responsibility established. Then, quite rightly, people want to see some rapid and visible movement towards the goal as it is no doubt critical or at least important to the organisation.

However, we have found that there is real benefit is taking some time to build the environment for the programme and have adopted a policy of taking steps in the programme only when we know they will be successful.

Essentially for us this has been about placing more emphasis on the relationships within the programme than the tasks we need to achieve – we have no problem with task, we are very focussed on achievement – we need to understand that relationships are also critical.

And we do this, not only because it is right - if we invite someone to be part of a programme we are running, we ought to give them the time and information to allow them to play a full and active role – but also because we have found that it is the fastest way to get to the outcome.

We have worked so positively with some stakeholder groups that they became fierce advocates for the changes being proposed by the local GPs, who demonstrated an ability to listen to any concerns being raised and adapt their ideas.

The public consultation was then an incredible success with such significant local backing and we were able to move through to implementation without having to deal with any major problems or setbacks.
Principle 4
Leadership is key: find local GPs and clinicians to lead local health service changes.

The direction of travel of national policy is clear: GPs will be at the forefront of planning and delivering changes to the NHS and health services over the next few years. To take on that role they need to be comfortable with leadership of the health system in lots of different ways – there is a lot of responsibility.

We have recognised that leadership development is not something that many of our GPs are exposed to and is not a skill that occurs naturally with the nature of their jobs.

But we also have seen the power of GPs leading change and are real advocates for this role. So the question is not whether GPs should lead programmes (the next section gives more on why this is the right approach), but what that means and how to make it happen.

Where to focus GP Leadership

GP leadership is key, but it is not the whole answer by any stretch of the imagination. We have provided a huge amount of support to allow the leadership to maximise its impact. We don’t ask GPs to do programme management, to create risk registers, to write project documentation, to co-ordinate activities, to liaise with the media, to structure work on data analysis, to prepare presentations or to check minutes.

Accepting that this isn’t where they add most value allows them to provide real leadership where it is needed – they do chair multi-agency Programme Boards, give presentations, discuss programmes with the media, undertake audit and analysis, construct clinical pathways (that we will write up) and most of all, have clinical debates with colleagues about the best vision for services.

A silence fell over the group again in stark contrast to the lively and intense conversation that had characterised the rest of the workshop.

The reason? We had just asked the question again “Which one of you GPs would like to chair the Programme Board?” No takers.

We were asking the wrong question, with a group who didn’t understand what that would involve. When we broke it down, we found we had leaders comfortable in a variety of areas – one happy to talk to the press, one who would present the vision to hospital colleagues and one who would discuss it with the PEC.

We also gave them support too, coaching and development as well as managerial.

And then there was a GP who, when he understood that it was just chairing, was happy to do that within a programme with such strong process and relationship management.
The most important aspect of this leadership is trust and consistency. We support GPs feel confident to put forward their ideas consistently to different audiences and we work closely to ensure that we build trust between the clinical and managerial community – trust that the support we promise will be there when we need it and that they will stick to an agreed message when challenged.

The next section – Principle 5 – explores the reason why GP leadership is especially powerful and necessary when discussing changes with the local population.

The Responsibilities of GP Leadership

We have an expectation that GPs provide leadership through all aspects of the programme, from the inception of a vision through public consultation to guiding the implementation phase as commissioners.

We explain this clearly to the local GP community at the outset and we have found that the most common comment and refusal lies in the notion that they would be asked to stand up in public and advocate for something that they didn’t believe in – “I’m not standing up at the WI and telling them I think it’s a great idea to close the day hospital”.

And we have got clearer about our answer – “It will need to be you standing up, but only to talk about what you think should happen and do believe in”. The course of the programme will expose the clinical leaders to all the issues that need to be resolved and we support them to come to their own conclusion about the right proposals for the future – these will need to be affordable, sustainable, safe and efficient.

And we have learnt to have faith that GPs are very good at weighing up the evidence (if it is all collected and presented effectively) and will come to the best solutions if they are given the support, resources and time to do so. So rather than trying to corral wary clinicians to stand up for something they don’t believe in we spend the time to allow them to come to a view they are aligned with.
5. Trust Me, I’m a Doctor

Principle 5
When GPs stand up and provide a vision they believe in, their ability to persuade is almost irresistible.

The place of GPs in society has changed a lot over the years and over recent times there has been a significant number of comments about a public who don’t quite hold them in the same regard as we used to – following many stories about their earnings and business practices as well as about the standard of care offered.

However, our experience is entirely that GPs are incredibly powerful as leaders in their own community, especially, (following the thrust of the last section) where they are able to lead a process that they both believe in and are engaged in.

This is true whether they are working with community stakeholders and members of the public in Board meetings or at coffee mornings or when they are presenting at major public consultation events.

We judge this by observing GPs in action and watching the public reaction, but mostly by results – our consultation outcomes in Louth and Skegness have been exceptional (see boxes).

Shaping Health for Skegness Hospital – Consultation Results

The key proposal at Skegness was:

“We want to have an urgent care service that is available for patients 24 hours a day, seven days a week at Skegness Hospital. This would bring together in Skegness Hospital care that is currently provided by the A&E Department in Skegness and the Out-of-Hours service based in Boston.

We propose it is time to formally rename the unit as an “Urgent Care Centre”. We would change the signs to reflect this.”

The public support for this proposal was an incredible 96%.

This figure was repeated across five commitments we made relating to a Hospital Advisory Board, inpatient services, palliative care, outpatient services and routine testing.
Of particular note would be the 96% public support in Skegness for removing the name A&E from their local hospital and calling it an “Urgent Care Service” in a town that is as fiercely loyal to protecting its local hospital, and emergency services in particular, as anywhere. Whilst many processes and actions during the programme contributed to this success, the actions of the key GP Chair of the Programme Board cannot be overstated.

GPs and clinicians have played many roles in our programmes and it is important to ensure each gets to use their strengths. We are fortunate to have GPs who are skilled in writing protocols, procedures and models. There is little doubt that the quality (and therefore the trustworthiness) of the clinical model in Louth and then the competency framework for all clinicians who would work in Louth were key documents.

They first gain professional trust, sometimes hard won, and are hugely persuasive with the public. It is not always that the issues are particularly radical, just that the GP who is advocating for them understands them and believes they are right for the local population.
6. We’re in this Together

Principle 6
Cherish your partners and community stakeholders. Work openly and transparently from the outset ensuring that all programme processes are designed to allow full participation and involvement.

These pictures formed the starting point for our public consultation in Skegness – the starting point for a continually changing and developing hospital. They were accompanied by a detailed history that included the remarkable event of the installation of the new operating theatre and x-ray department in 1931 … and the fact that the machine wasn’t used until 1932 when electricity arrived in the town!

The pictures and story are not remarkable, but the way in which they become part of the programme of work in Skegness is. Skegness Hospital Watch are a very active group in Skegness with a remit to protect services at the hospital. Over the years they had shown an ability to mobilise against changes that were a concern and to attract political and media interest.

We involved them fully in the programme from the outset. We set up meetings with local GPs and consultants so that they were fully informed. We attended their meetings with the GP Chair and A&E Consultant to discuss the issues. Two of their key members were on the Programme Board, fully involved in the open and frank discussions, able to question the motives, clinical models, data and evidence. They were interviewed as part of the Office for Government Commerce Gateway Review.
And at the end of that we had built up huge trust between us. This led to unanimous support for the consultation proposals from the whole Programme Board – this was the outcome we had been seeking – which meant that key local groups with an interest in the hospital were in favour of the direction that we had worked on for over a year.

Skegness Hospital Watch members turned up to every consultation event and led some presentations on behalf of their Board. In short, they played a lead role in the change process. And as a result they came up with the storyboard theme for the consultation material and found the pictures and stories from their archives – a real sign of our work together.

The story shows the benefits of the approach, but the key point is about valuing stakeholders for what they bring to the process – challenges as well as support. We have realised that we need to work individually with each stakeholder to ensure they have what they need to be involved in complex programmes of change in the NHS. So with some we will set down and spend a couple of hours explaining the financial system, with others how a particular care pathway works.

A high trust environment has been critical too. We chose to operate in this way from the outset and have found that stakeholders – even those who have previously been very critical of the NHS – have universally responded positively to the trust that has been invested in them.

We have encouraged all staff to be open and honest and to answer direct questions directly and for everyone to understand why there is a need for sensitivity around some of the discussions.

Our experience has reaffirmed for us that we are better when we work through issues with those who are going to be affected by any decisions or changes. On the whole people do have the ability to understand difficult choices and to rationalise the right way to proceed.
7. Prove it

Principle 7

*Ensure there is the evidence to support the vision – it matters to people that you know the numbers and have the proof; anecdote alone will not carry public opinion.*

Analysing 2,900 lines of inpatient admission data may not seem like the most thrilling task, but it was critical to the work undertaken at Louth Hospital; this represented a full year of admission information. In fact, it was so important that a GP with managerial support and nursing input, went over inpatient data on three separate occasions. This helped to form the view in the consultation proposal that 85% of people would continue to be admitted to the hospital after it had shifted from a secondary care to a primary care led unit.

But this wasn’t enough!

Quite rightly, clinicians pointed out that this data was about discharge diagnosis not the presenting condition and these may be very different things. So an audit was undertaken of 50 sets of A&E notes and any corresponding admissions.

Following that it was important to understand the future so a prospective audit was undertaken on the wards for two months to understand how each patient who was admitted would have been treated in the new system.

And finally we went back to the beginning and revisited the data analysis for a different time period to ensure that nothing had changed and that our assumptions that we had used in consultation were still valid as we got towards implementation – the same exercise, over 630 lines of data.

<table>
<thead>
<tr>
<th>Conditions Excluded From Louth HRG Chapter</th>
<th>Admissions</th>
<th>Occupied bed days</th>
</tr>
</thead>
<tbody>
<tr>
<td>A19 Haemorrhagic Cerebrovascular Disorders</td>
<td>3</td>
<td>81</td>
</tr>
<tr>
<td>A20 Transient Ischaemic Attack &gt;60 or with CC</td>
<td>7</td>
<td>56</td>
</tr>
<tr>
<td>A21 Transient Ischaemic Attack &lt;70 or without CC</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>A22 Non-transient Stroke of Cerebrovascular accident &gt; 69 or with CC</td>
<td>9</td>
<td>120</td>
</tr>
<tr>
<td>A99 Complex Elderly with a Nervous System Primary Diagnosis (cerebral infarction, stroke, unspecified)</td>
<td>6</td>
<td>113</td>
</tr>
<tr>
<td>C26, 27 Major Medical: Head &amp; Neck or Ear Diagnoses with or without CC</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>D44 Inhalation Lung Injury or Foreign Body with CC (pneumonitis)</td>
<td>2</td>
<td>23</td>
</tr>
<tr>
<td>E11 Acute Myocardial Infarction with CC</td>
<td>6</td>
<td>47</td>
</tr>
<tr>
<td>E12 Acute Myocardial Infarction without CC</td>
<td>15</td>
<td>106</td>
</tr>
<tr>
<td>S12 Septicaemia</td>
<td>3</td>
<td>57</td>
</tr>
<tr>
<td>Others</td>
<td>15</td>
<td>76</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>70</strong></td>
<td><strong>692</strong></td>
</tr>
</tbody>
</table>
In Skegness the issues were different, but the Programme Board did review different slices from the A&E dataset over different time periods, looking at a range of issues. We matched this data with Out-of-Hours information to get an understanding of the demand for an integrated service.

A consultant, GP and A&E nurse then reviewed patient notes for four separate day’s A&E activity for the hospital (allowing for different days of the week and crucially seasonal variation).

When we came to talk to the public we had clear evidence that the integrated service, medically led, but with greater flexibility over the type of doctor on shift at any time, would be able to treat over 99% of the current A&E patients and other patients would be able to be treated locally: data analysis said so and so did a thorough audit.

“That's all fine, but what are you going to do when a group of 5 youths turn up drunk and injured at 3 o'clock in the morning?”

“I am not saying it could never happen, but it just doesn’t happen now. We need protocols in place to cover all eventualities, but the reality is that we don’t get that kind of issue here.”

“But we do have a number of drunks turning up at A&E don’t we.”

“No, from looking at the data we have analysed, there are an average of 6 attendances per night at A&E between midnight and 8am.”

It is really important to be able to challenge stereotypes. Simple data analysis (fronted by GPs) is key.
Principle 8
Decide on a consultation approach early; it sets the tone for the whole way of working.

Consultation can seem like a remarkably complex affair, littered with potential pitfalls, the chance of being called to review, breakdown of local relationships or worse. There are statutory duties that need to be adhered to as well as local networks to involve and work with.

We decided to look at this in a different way and look at our consultation mechanism as the logical extension of the points we made in Principle 6 around working together with community stakeholders.

Early in each of our programmes we fully explain to the Programme Board the relevant duties placed on NHS bodies and the circumstances in which we would need to take different approaches. We then lay out the costs involved, such as the costs of a full 13-week public consultation, which are not insignificant. And we invite the Board to make an outline decision about the process they want to follow.

The key here is that we have this discussion before we know whether there will be any significant changes proposed or not, so the debate is an open discussion, not based on the finer points of our duty or obligation. In every case, perhaps unsurprisingly, the Board has set a path towards a full consultation.

In both Louth and Skegness we believe we could have argued that the changes were not of sufficient scale to need a full consultation, but this is a purely academic point, as we believe completely in the benefits of this approach. For example:

- The process establishes local direction for the future of local health services – it is less about the scale of change and more about how to use programmes of work to drive engagement of local GPs and the public in the future of services.
- The programme works in a different way form day 1 – in all of the work, whether it be data analysis or vision, the knowledge that eventually the work will have to be public facing ensures a rigour, depth and enthusiasm.
- It helps to drive the timeline – consultations need to be planned and agreed locally, therefore there is a necessity to complete the work required.
- It places even greater emphasis on stakeholder and community relationships and gives a focus on working with local groups throughout the programme.
- There will need to be effort applied to local authority relationships and with the Health Scrutiny Committee.
- It is a useful for GPs to have the notion of public consultation as an endpoint for their leadership work.
We have also left in place public involvement mechanisms as a result of the consultation and engagement processes – for example, we have Hospital Advisory Boards in place to give community stakeholders an ongoing input in to their local hospital and commissioning GPs a need to maintain involvement.

We have refined an approach to consultation through the Shaping Health programmes which we now believe works well. It includes:

- Pre consultation work with community stakeholders and the Programme Board as detailed earlier in the handbook.
- A pre-consultation deliberative consultation event where invited community stakeholders review the outline consultation proposals and help to improve.
- A clear, concise and easy to read consultation document
- A series of public consultation events based on a drop in format – we have a range of “storyboards” that people can browse and then sit down and discuss informally with staff present.
- GPs and clinicians at every consultation event
- Offer to present at organisational meetings
- Independent analysis of consultation outcomes
- Post consultation deliberative event – to consider the consultation results and messages that stakeholders would like the PCT Board to bear in mind when deciding on the next step.
- Board decision on implementation

It is undoubtedly a significant resource commitment from the PCT staff in particular with some of the drop-in information events lasting up to 8 hours, but we have found the results – 87% and 95% approval for the way forward give such a firm and unequivocal platform for delivery as to justify the time invested.
9. A Helping Hand

Principle 9
It is important that local people take on responsibility for their services; it is then crucial to provide them with all the support they need to deliver.

We have recognised through the course of the programmes we have run the crucial importance of support, both internal and external, to ensure that they run successfully.

We have had to resolve some difficult problems within our organisation where in many cases the resources we have needed for the programmes – such as finance, patient and public involvement, informatics, Public Health and communications – have been fully committed to the very many competing priorities of running the organisation on a day to day basis, let alone the development of practice based commissioning, the transforming community services process or the many assurance processes we face.

We have noticed the implication on our work when we haven’t had the right resource in place at the right time and can point to many things that we should have and could have done better; some with significant costs or consequences. However, we have increasingly specified the need for support much more clearly at the outset and then worked harder to get the assistance we need, rather than expect it to happen. Essentially applying the same skills and process internally that we have to external stakeholders.

The important decision we made – philosophical as much as changing how we work – was to ensure that we worked in a way that supported those working locally, and in doing so amplifying Principle 1 about the location of the change being local not regional. However, this point is subtly different. We commissioned external support to our Shaping Health Programmes with a remit to work in whatever way to achieve the Programme Goals, but with clear direction to work locally and report centrally.

This has meant, at times, that we have paid for external support to argue with us about the best way to proceed, advocate for a local approach that conflicts with some of the crucial projects that we are trying to deliver. As counterintuitive as this seems, we see this as a key strength of our approach and those who have taken steps in to local leadership, perhaps tentative and without full commitment, have really valued having some highly experienced, senior support so clearly and obviously standing alongside them.
And the support we commissioned has been as much about coaching and behavioural understanding as it has been about Gantt charts and timelines. Both are crucial, but our work has been marked by a far greater emphasis on the relationship skills than we place on other work we do or that we see in other organisations.

And over the time we have seen our local leaders develop (we have done other things too, such as a clinical leadership programme) alongside the delivery and implementation of change. Watching GPs with far greater confidence in their leadership working alongside empowered stakeholders has been a highly cherished outcome and one that we believe sets us up well for the future. This is the kind for work that the emerging Consortia will need to be undertaking – developing their Executive teams at the same time as defining a commissioning plan; a vision for local health services.
Principle 10

*There are many hurdles when committing to publicly engaged GP leadership as we have described, a fundamental commitment and belief in the approach is crucial when things get tough.*

We have had many moments when it seemed easier to revert to central control, managerial leadership and to face up to the shortcomings of the approach. And each and every time we have remembered why we believe this is the right way to go forward and our fundamental values.

This, of course, is the first and most important principle, placed last to emphasise that for everything we have got right in terms of empowering local leadership and stakeholder engagement, the difference between success and failure still fell to us individually in many instances and it was our personal and demonstrable commitment that made the difference.

Whether it was difficult newspaper stories with quotes from those involved in the programme, costs increasing or hugely differing opinions of the safety of the clinical models proposed, belief that well supported local leadership would win out was key.

And so a very brief, but key message: Don't start if you don't believe, as you will find many moments that will justify that you were right and the approach was wrong.

But it does get easier, success breeds success, and for every problem there is a solution…..
ii. Conclusions, Contacts and Further Information

We are proud of what we have achieved in Lincolnshire. The purpose of capturing the learning at this time is as much for us to remember locally as we move in to Consortia commissioning.

But we do believe there are lesions that are relevant beyond Lincolnshire and hope that many will benefit from our learning and our mistakes.

If you want to find out more about our work, please contact Martin McShane, Director of Strategy and Health Improvement, NHS Lincolnshire:

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External support to programmes in Louth, Skegness and Grantham has been provided by Atlyric Limited. You can contact Jerry Clough, Managing Director of Atlyric Limited using the details below.

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