OHSEL ICS Clinical and Professional Leadership: Primary Care Recovery Group

17 February 2021
Synthesis Pack

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Introduction

On Wednesday 17 February 2021, the OHSEL ICS Primary Care Recovery Group met for a workshop to discuss the next phase in the project set up to develop clinical and professional system leadership for the ICS in SEL.

The objectives of the session were to:

1. Discuss and improve the plans for developing clinical and professional system leadership.
2. Focus on developing plans for engagement, including who needs to be involved in the next phase of this strategy and development support work.
3. Discuss elements relating to inspiration and governance, gathering views and providing insight for the project.

Our ambition - setting the context

By April we want to be in a position to describe our shared vision/ambition for clinical and professional system leadership for the ICS and its role within the governance of the ICS.

But beyond that – how we will ensure that system leadership is supported, so that the ~100 days a week we currently spend on clinical and professional system leadership time in SEL is impactful, and helps us energise our transformation and improvement plans for SEL as a health and care system.

This will enable us to identify the support we need for system leadership for the coming year to ensure that we are ready for any organisational or legislative changes emerging as a result of the current consultation on ICSs by 2022.

Agenda

The agenda was organised around the 3 work-streams for the planned programme of work over the next 3 months:

1. **Engagement** - Who needs to be part of this work? What opportunities does this programme present to leaders? What is working well now, and why? What is inhibiting, or reducing the impact, of system leadership? What do you need to maximise the time in system wide leadership?
2. **Inspiration** - What does world class leadership look like? How can we draw upon inspiration and ideas outside of healthcare to generate ideas for what the future of clinical and professional system leadership for SEL could be?
3. **Governance** - While we don't want to be constrained by traditional ideas around governance, how can we develop a structure which fulfills our obligations and keeps us focused and grounded?

Where is clinical and professional system leadership done well?

We started the session asking the group to reflect on where you have seen clinical and professional system leadership been most effective. When was it, and what made it work? Below are a selection of responses.

GP Federation in Bexley brought together strong leaders with a shared vision and no preconceived agenda**.** The chairman is respected locally and has a clear and evolving vision.

Covid response - the development of borough Covid pathways/hot hubs gave permission to clinicians to be innovative and empowered, with the right support at south east London level.

Working to a single goal during Covid - we set up primary care taskforce meeting on a weekly basis and took a collective approach of working with public health and LA partners, all working to do the best they could to address COVID. We broke down barriers which shows how effectively we can work together and build relationships.

A 'resplendent' group working across Bexley, Greenwich, Oxleas and LGT. As a group of professionals across health and social care working together they have been very good at problem solving with the common goal of improving patient care.

Rolling out the Covid vaccination programme including the PCN response to vaccination.

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Section 1: Engagement

After this, we reflected on the group of clinical and professional system leaders involved across SE London. We asked **who needs to be 'bought in'** to this development process in order for it to be successful?

Who needs to be 'bought in'?

The group identified colleagues from across SE London who should ideally be engaged with this development process and how we could best engage them:

- **A range of professions -** in terms of clinical and professional input we can often be quite 'doctor-centric' but recently we have made positive change in increasing and broadening clinical input and leadership. We should prioritise involving nursing but also ARS who are becoming significant members of teams. We must also not forget non-clinical professionals.
- **Take a broad approach**, including PCN CDs, acute trusts CDs, social services and social leaders, the voluntary sector and our patients. We need a range of people involved ensuring we can represent and understand all important issues.. Local care partnerships are important as we need to have the breadth of responsibility.
- **Working from the bottom up -** We need to ensure our approach is not top down, and it must have local ownership. If we are to tackle neighbourhood inequalities we need local leaders, we still need to workout how to have the interface between local communities and South East London as a whole.

We then asked the group to consider 'who is not currently in the most senior clinical or professional system leadership roles, but best exemplify the values we want to see in our future leaders'?

Who is not currently in the senior clinical or professional leadership group whom we should engage?

The group suggested the following whom exemplify the values they want to see in future SEL system leaders.

- **Staff on the ground**, people who really understand patients' needs should start to flow up and inform decision making. They bring a wealth of knowledge and are at the forefront of what we're trying to do. We need to always be as inclusive as we can to involve staff when we're making these decisions. There will be pockets of good practice across the ICS that we can learn from in engaging frontline staff.
- **Voluntary sector and link workers.** We want to involve who can bring the patient and community voice and social value to the table. VCSE representatives bring a lot to healthcare within local communities and set the standards of values we should be seeking in future leaders. Link workers bridge across a lot of different services including voluntary sector and are more closely linked to the communities they are working in.
- **Public involvement** using pre-existing channels in the system to engage the public e.g. GPs have PPGs who can gather relevant information.
- **Early career leaders.** Many people in training or early roles who are heading towards leadership should be involved in system level thinking.

Section 2: Inspiration

In the next part of the session we asked the group to individually reflect on the best support they had seen to **support leaders flourish -** regardless of sector. Below is a selection of key themes.

Best support to leaders

Supporting leaders

- We need to recognise that leaders need to be supported too and often that support is quite simple e.g. the 6 streams of positivity (including sleep, nutrition and connections) are basic but are often forgotten in times where leadership can be overwhelming. We need to remind and support leaders to look after themselves.
- Leaders thrive with support from their seniors. For example Gregor Townsend's support of Stewart Hogg as Scotland's Rugby captain - as a young captain he has thrived and management has had faith and stuck with him through difficult times.

Grounded in the community

- The Scouts is an interesting example of how volunteers become effective leaders. The Scout system is built on the contributions of parents and volunteers who are then supported to take up leadership positions. It is a novel way to set up an organisation and ensure leaders come from the ground up.

What programmes outside of health can we learn from?

- Notable examples of leadership programmes outside of healthcare include; the DHL connected for excellence programme, Ashridge Business School - Aspiring Senior Leaders and the military.

Section 3: Governance

We then we asked the group to consider how we could create an approach to Governance which would be **as ineffective as possible.**

'Anti-governance'

The group shared that the most ineffective approach to governance would include:

Poor structure

- For clinicians it can be hard to contribute mindfully to meetings as they are often scheduled early or late in the day to fit in with heavy workloads. This needs to be discussed with whoever is setting the meetings and ensure we give people the time to be able to contribute to these conversations.
- Throughout the pandemic we've reduced the length of meetings to squeeze more in, but now how do we give people more time to talk and think rather than just "transmit"?

Tokenistic attendance

- Sometimes no one knows why they are at a meeting or are just attending tokenistically to be seen.
- The scale of meetings can be too large or too small and exclusive, and we are failing to connect with those not in group. At the minute if you're not in the meeting you can't influence, but if we get the governance right people should know how they can influence.
- We often rely on the same people and need more succession planning to scout out 'emerging leaders'.

Ineffective discussion

- Virtual meetings on MS Teams have often led to two simultaneous discussions; there is one meeting in the virtual place and one in the chat. Some of our behaviour has deteriorated during the last year as people are putting things into chat they wouldn't say out of loud. As a chair it's incredibly difficult to manage and it leads to an ineffective meeting.

Section 4: Final reflections

To close, we asked each group member to share **one piece of advice** they would you give us in taking this work forward.

Here are a selection of responses.

Value bottom up and local, and build on the success of our Covid response.

Look after the people who are looking after the people. Accelerating trust and transparency and strong relationships.

Keep connected outside and between meetings.

Engage as broadly as possible.

Bring together people with different perspectives.

Show value to others, ultimately benefiting population and workforce.

Value those on the receiving end. Value the opinion of those delivering the majority of the service.

Co-production with wide audience inc local population and voluntary sector.

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Thank you

Thank you for such constructive input to the session - we really appreciate it. If you have any further questions contact Chloe at chloe@kscopehealth.org.uk

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