OHSEL ICS Clinical and Professional Leadership Group

2 February 2021
Synthesis Pack

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Introduction

On Tuesday 2 February 2021, the OHSEL ICS Clinical and Professional Leadership Group (CPLG) met for a workshop to discuss the next phase in the development of system clinical and professional leadership for the ICS in SEL.

The objectives of the session were to:

1. Discuss and improve the plans for developing clinical and professional leadership, creating ownership for the plans amongst the group.
2. Focus on developing plans for engagement, including who needs to be involved in the next phase.
3. Discuss elements relating to inspiration and governance, gathering views and providing insight for the project.

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Our ambition - setting the context

By April we want to be in a position to describe our shared vision/ambition for clinical and professional leadership within 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 leadership time in SEL is impactful, and helps us energise our transformation and improvement plans for SEL as a learning health and care system.

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

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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 leadership done well?

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

Covid guidelines development in the Spring. There was clarity of purpose and pace, task and finish focus to the work plan. And also a good mix of individuals on this group and shared learning.

CCG Clinical Leadership - clear roles in relation to transformation programs and close working with executive colleagues and transformation teams

Many pathway examples - these have worked best with clear leadership, an inclusive process and a shared/clear goal and objective. Those requirements with a degree of urgency have also driven pragmatism.

Recent **virtual ward** work demonstrated the benefits of Borough working with enabling SEL action. Great legacy and the chance to build on this is exceptional. Repeated conversation has led people to move from traditional opinion to rapid conversation, excitement about innovation with patients/ resident at the centre - that as motivation for change.

Coordination across primary and secondary care to help decompress pressures during second surge.

The **vaccine programme** - it's important to put energy into governance as there is a danger of too much reactive behaviour. We have done so much as a system it has been good at getting to a certain point - couldn't do it without integrated clinical leadership, leadership from Trusts and fantastic and dedicated leadership across the wider care and Pharmacy system.

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Section 1: Engagement

After this, we reflected on the group of clinical and professional leaders involved across SE London. We asked **who needs to be 'bought in'** to this development process in order for it to be successful? We also asked the group to consider 'who is not currently in the most senior clinical or professional leadership roles, but best exemplify the values we want to see in our future leaders'?

Who needs to be 'bought in'?

The group identified colleagues from across SE London who should ideally be engaged with this development process including:

- **On the ground clinicians** who must understand what the CPLG does and see the benefits it can bring to them. Promote a focus on **joint working** and an understanding on how parts of the system are **interconnected -** we want clinicians to see interactions between secondary/primary care in a constructive way where they are not fighting against the system. There should be wider engagement in pathway redesign/distributed leadership.
- Our **institutions and their representatives**, our local partnership groups, clinical teams. If we are to make a positive impact to health outcomes we need to bring our population with us.
- Important for **multi-disciplinary input** too and a focus on working together across organisational boundaries.

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.

- **Wider representation of MDT** (i.e. Pharmacy, Clinical Governance) is very helpful, and partnership agencies and programme teams add considerable value. Having a wider group of disciplines brings a richness to the conversation.
- **Clinical effectiveness team members** - many PCN CDs, leaders of networks. There are loads of clinicians and professionals leading change and improvement but not with 'positional' authority/status.
- **'Promoting' the concept of the ICS to students** - Nurses, Medical and AHP so that it is embedded early on and becomes part of aspiration to be the leaders of the future.
- **Go younger** - we see leadership as a later part of your career. Younger people have lots to offer and would diversify our leadership, bringing new ideas and new ways of working.

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

Structure and clarity

- A structured agenda, briefing and conversations ahead of sessions and clear focus on outcomes and opportunities.
- Better administrative function and support - there is too much energy spent on admin duties.
- '111 First' programme has seen a huge number of pathway changes and emergency care. The clinical leadership is clear and supported by programme management structure which allows clinicians to focus on the pathway.

Allocated time for learning and engaging with others

- Encouragement, resource & senior sponsorship with the permission to try and fail or fly. Primary care is a good example of celebrating what works and learning from what doesn't.
- Hearing voices from citizens and people with lived experience to inform where priorities for system leadership are.
- Exposure to learning and leadership outside the NHS. Helpful to understand how challenges are tackled in other sectors.
- Build spaces for listening, reflection and coaching. There needs to be protected time to think and formulate ideas away from the day job.

Clear purpose and motivation

- Connection to a higher purpose. Tapping into people's 'intrinsic' motivation and seeing change happen is so motivating.
- We need the balance of governance processes which can get in the way of this and suffocate the excitement and energy of individuals but ultimately keep us safe.
- During Covid we gave leaders autonomy to create solutions and access rapid decision making processes to embed this.

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:

The wrong members

- The busiest people in the system. We continually draw on people who are really busy in their own organisation. What we ask people to work on then leads to meeting fatigue and not progressing actions.
- No connection with the frontline. Representatives need to be representative of our colleagues and population and ensure horizontal and vertical communication

Lack of purpose and power

- Give it a lovely vague remit and hazy decision making powers.

Poor structure

- As many meetings as possible and committees for sign off. How do we not have a governance process which off-loads responsibility? We need to devolve decisions to lowest possible level as it empowers people and allows great decisions to be made on the ground.
- Long, repeated agenda without a focus on outcomes or outputs, no resources to support the group and multiple layers of sign off.

Section 4: Acting and 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.

Help us to think 'outside of the box'

Don't create another governance structure

Define 3 key areas for focusing our joint purpose, creating some support resource to help and then celebrating progress and achievement.

Keep developing relationships like tonight, keep space for slow conversations as well as fast conversations.

Focus on the 'why'. Not just to foster leadership but those with the strong motivation to lead change for a purpose that reads across.

Plan on a page..share with stakeholders..encourage engagement

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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 Shane at shane@kscopehealth.org.uk

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