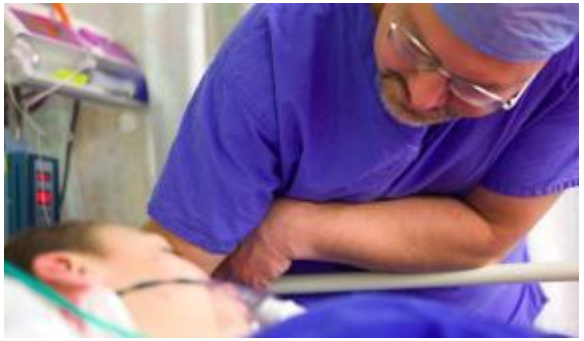
Local Professional Network Assembly









25 March 2014

THE NHS CONSTITUTION
the NHS belongs to us all

Welcome and National Update

Dr David Geddes
Head of Primary Care Commissioning
NHS England







Overview of today

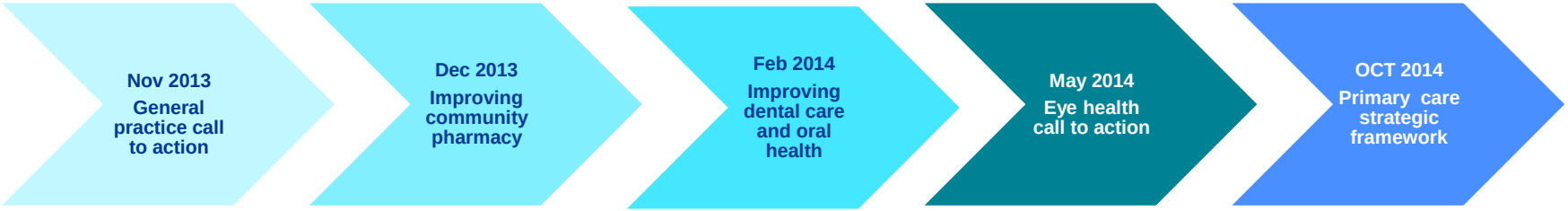
Morning

- Welcome and national update
- Clinical leadership within networks – Dr Jagan John
- Reflecting on our leadership journeys
- Morning plenary and questions

Afternoon

- Individual LPN Workshops

National Update



Primary care – a call to action

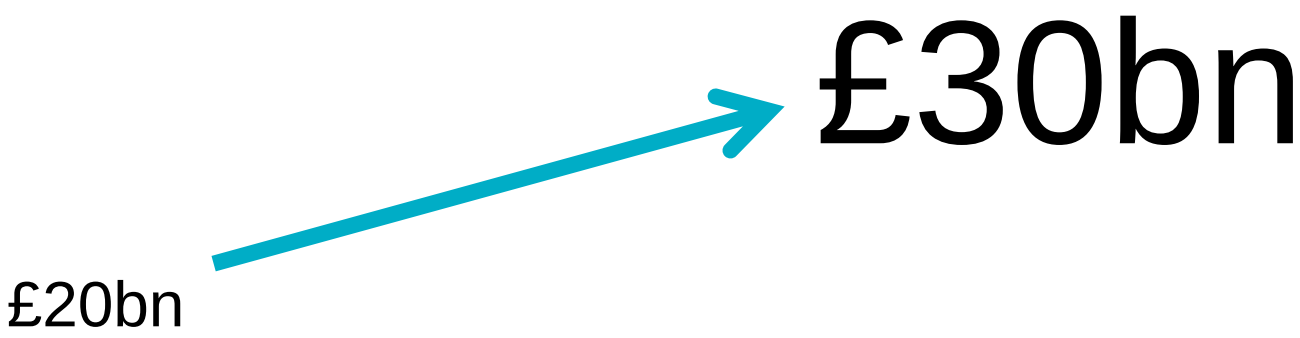
Five ambitions for primary care….

1. proactive, coordinated care
2. holistic, person-centred care
3. fast, responsive access to care
4. health-promoting care
5. consistently high-quality care

But we know this isn't what is available to all, *- - health inequalities affects outcomes*

- people from deprived backgrounds
- people from black and minority ethnic communities;
- people with physical or learning disabilities.
- people who are easy to ignore, e.g.
    - homeless people;
    - sex workers;
    - gypsies and travellers;
    - people in prisons and offender institutions.

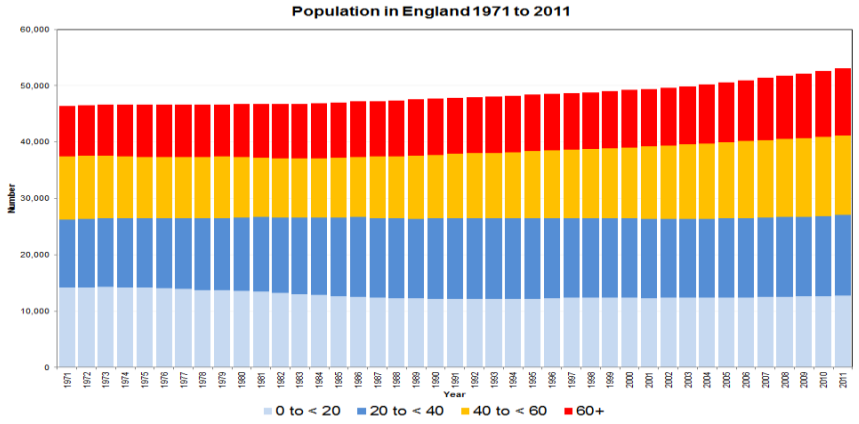
The commissioning challenge

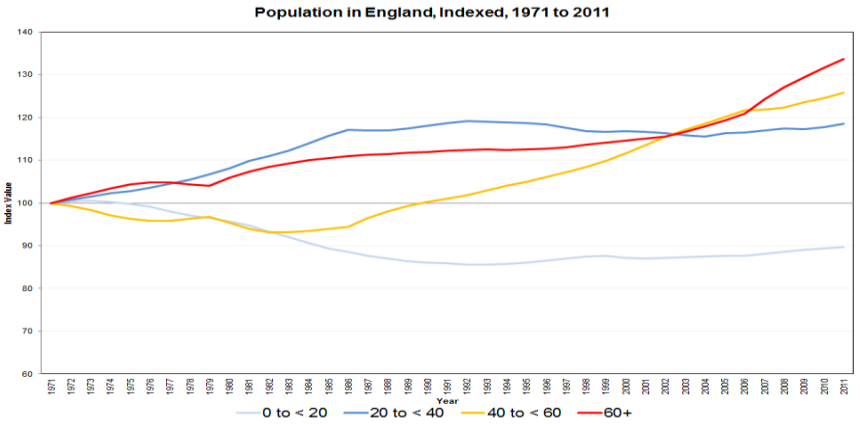


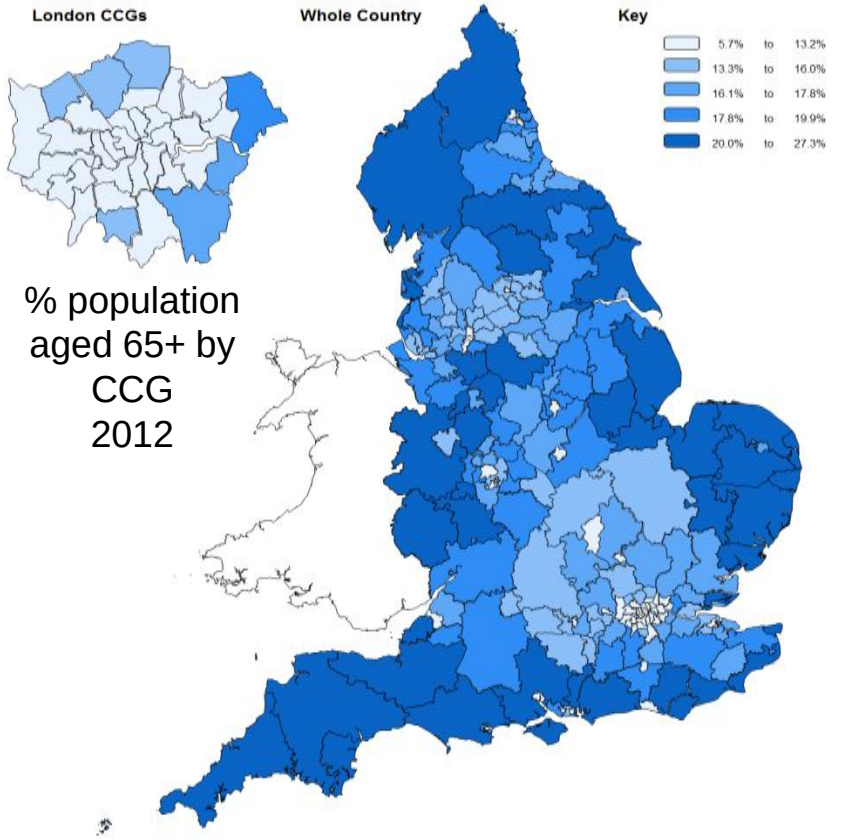
2015
Nicholson's challenge

2020

The population in England is growing



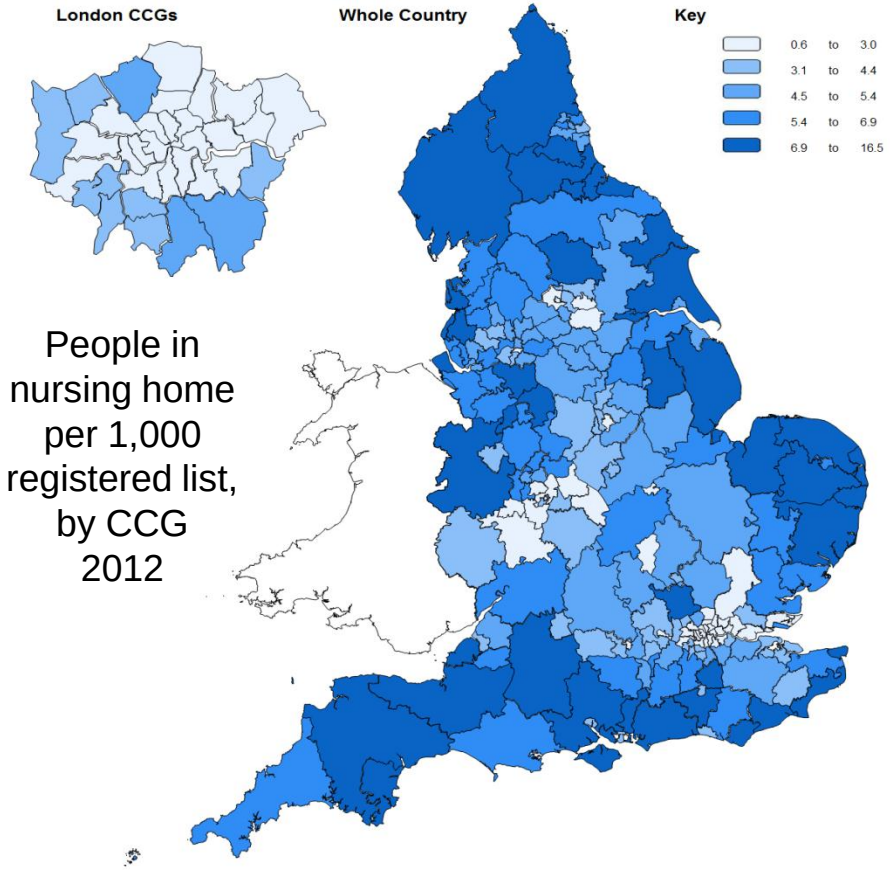




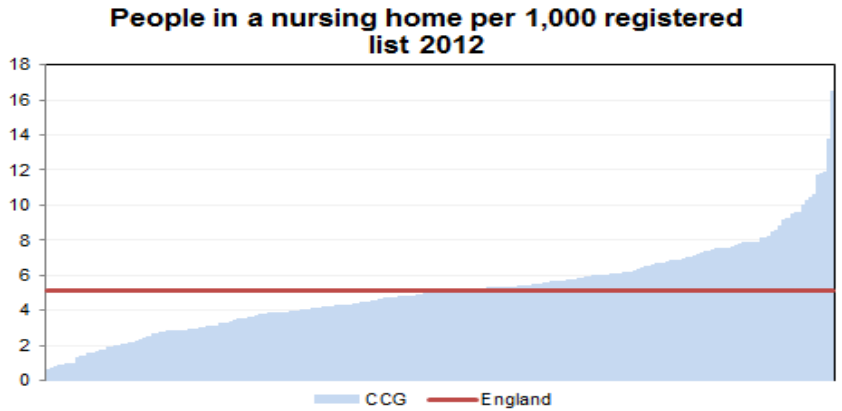
% population aged 65+ by CCG 2012

Data source/s: ONS mid-year population estimates; NHAIS

On average, 5 in every thousand people are in a nursing home



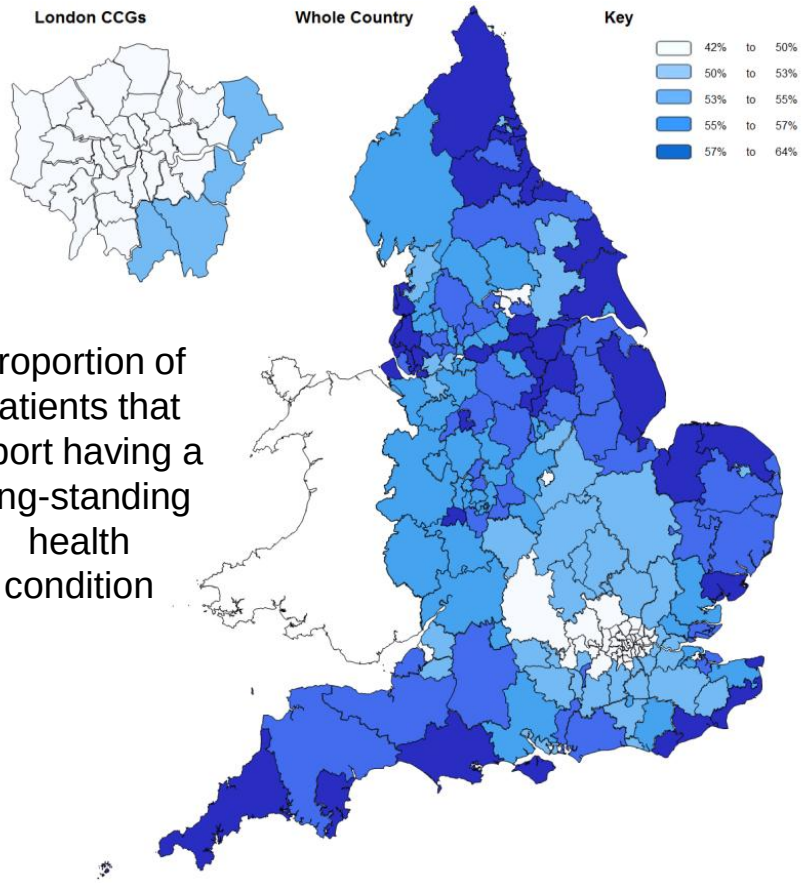
People in nursing home per 1,000 registered list, by CCG 2012



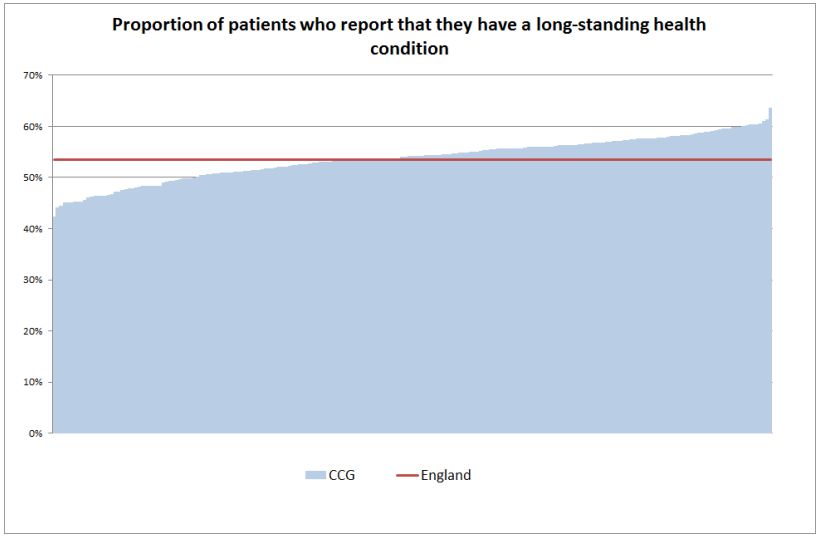
- On average, 5 in every thousand people are in a nursing home;
- Across the country, in CCGs, this ranges from a maximum of 16.5 to minimum of 0.6 people in every 1,000.

Data source/s: NHAIS mid-year extracts

53% of people report that they have a long-standing health condition



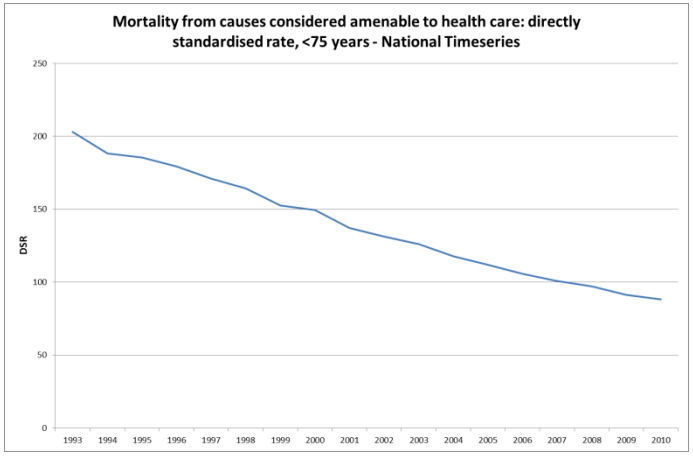
Proportion of patients that report having a long-standing health condition

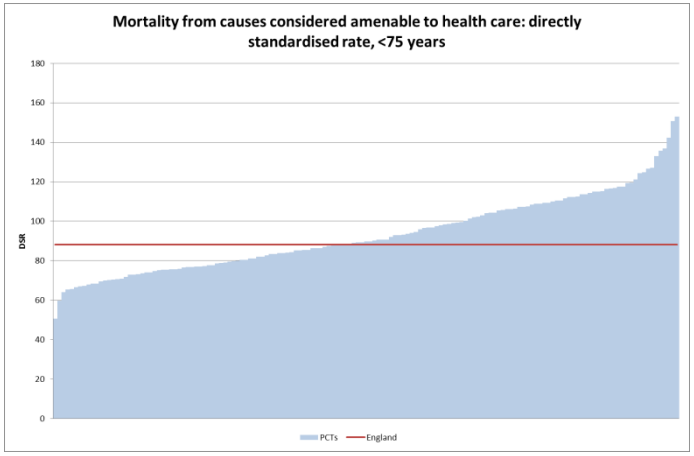


- Across the country, in CCGs, the proportion of patients that report having a long-standing health condition ranges from 42% to 64%

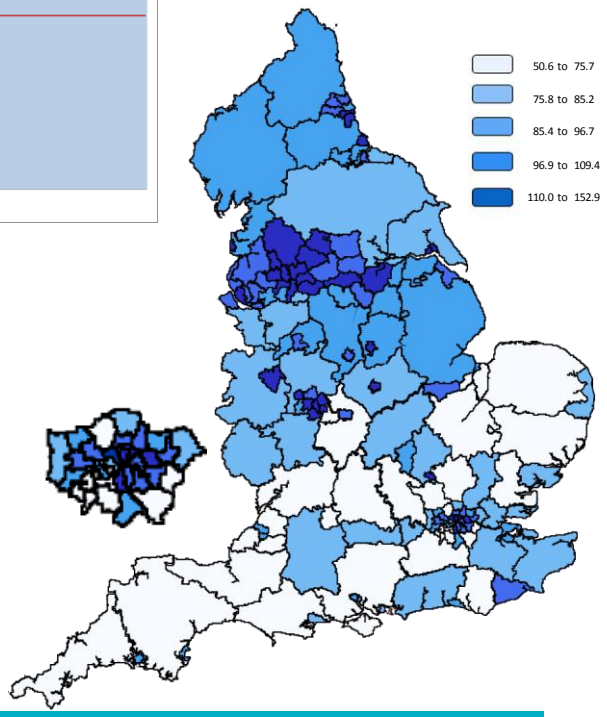
Data source/s: 2012-13 GP Patient Survey Results (http://www.gp-patient.co.uk/results/)

Mortality from causes considered amenable to health care is falling, but there is wide variation across commissioners





- Nationally this metric has fallen significantly year on year
- There is variation at a local level with the map showing mortality in Northern PCT areas generally being higher than in the South
- The area around Manchester performs particularly poorly compared to the rest of the country, with the three worst performing areas being Manchester Teaching PCT (152.9), Blackpool PCT (150.7) and Blackburn and Darwen (142.3)



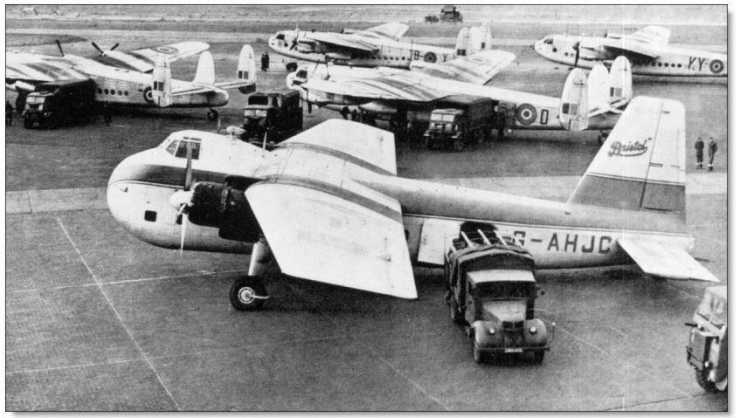
Data source: IC Indicator Portal, 1993 to 2010

The NHS is 60 yrs old…

NHS England

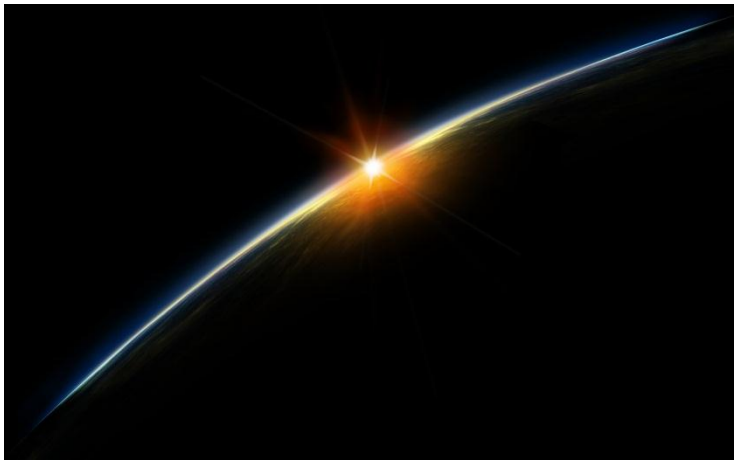






What's on the horizon for LPNs…….

- Raising the profile – ' focus on' session at the primary care oversight group.
- Networking and communication
  - NHS net accounts, with N3 capability
  - Steering groups assemblies
  - Sharepoint space
- Leadership development



What sort of leadership do we need?



Visionary



Knowledgeable





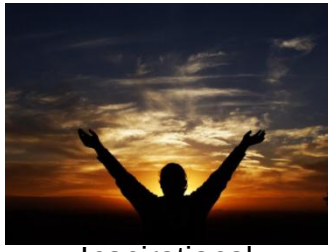
Goal Oriented



Encourage Growth



Catalyst for Change



Inspirational



Reflective



Practice Shared Leadership



Flexible



Motivational



Charismatic

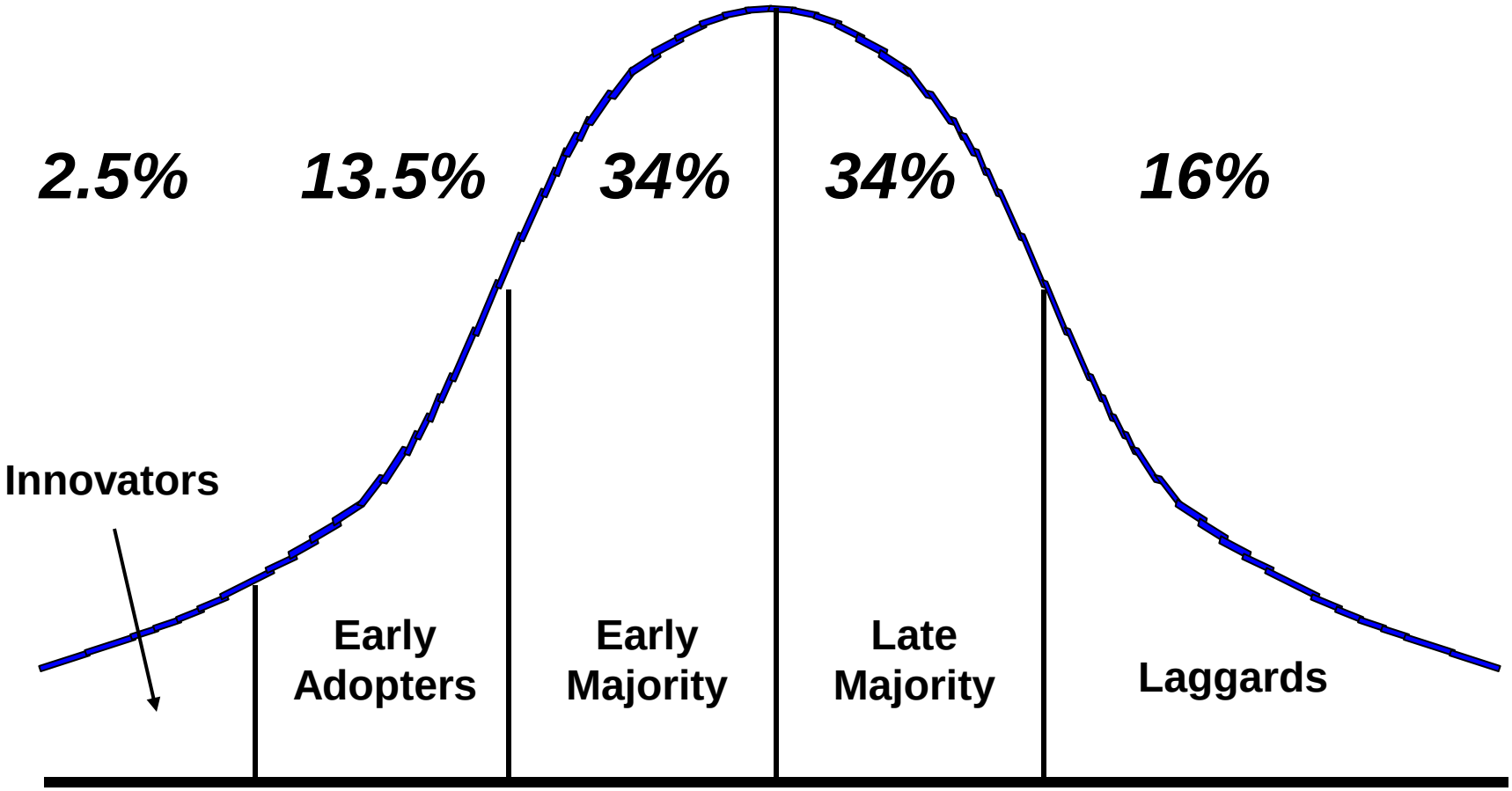


Authentic



Expertise

Encouraging followers – *'adopter categories'*

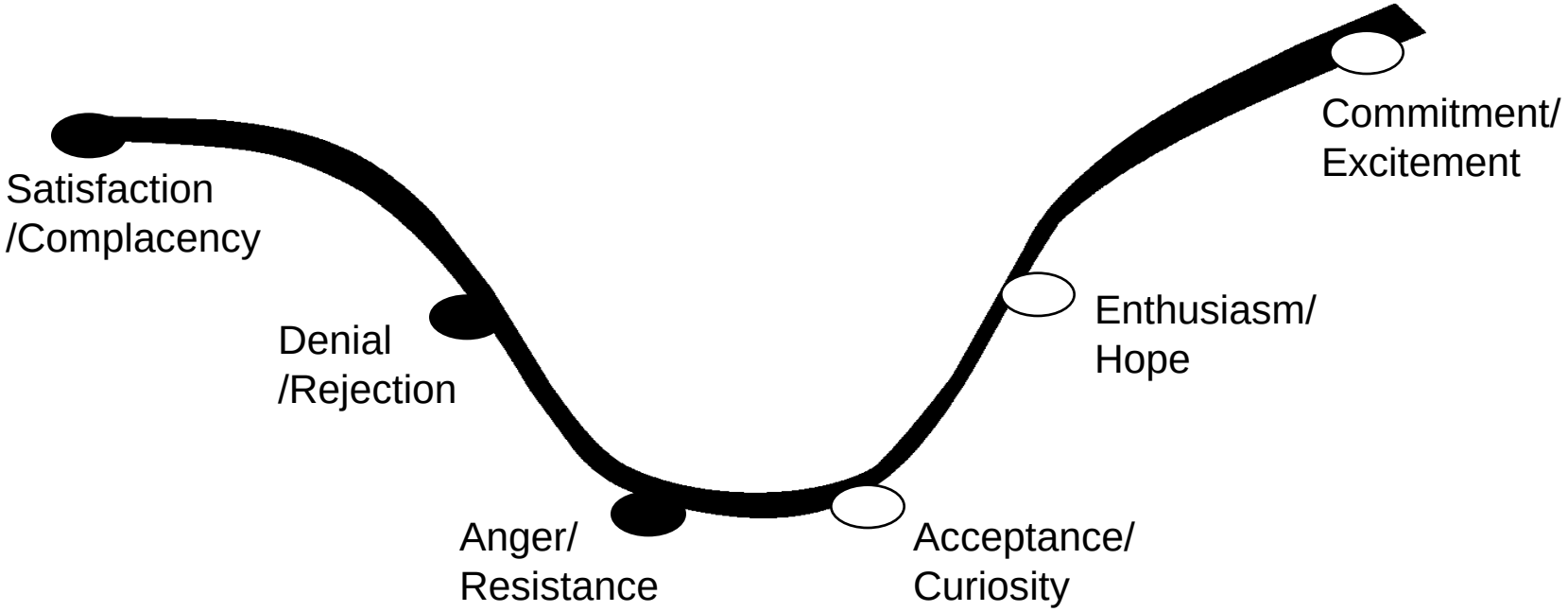


Source: Rogers

Encouraging followers



Communication and resistance

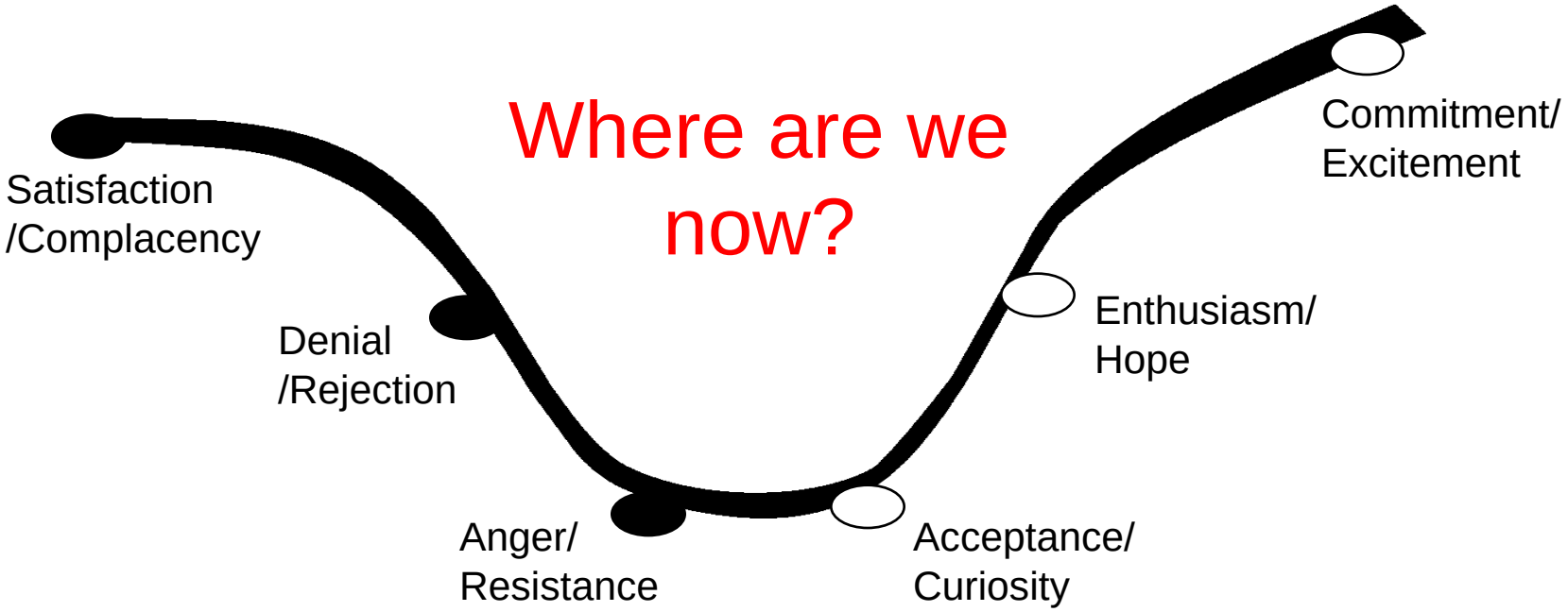


OPPOSED → → → → → **ENGAGED**

• Convey urgency • Give facts • Provide evidence • Convey big picture	• Listen • Show concern • Restate facts	• Listen • Demonstrate concern • Restate facts • Convey commitment	• Restate big picture • Communicate vision • Ask for help	• Involve • Celebrate wins • Inspire	• Feedback success • Inspire • Create Champions

Communication Priorities

Communication and resistance

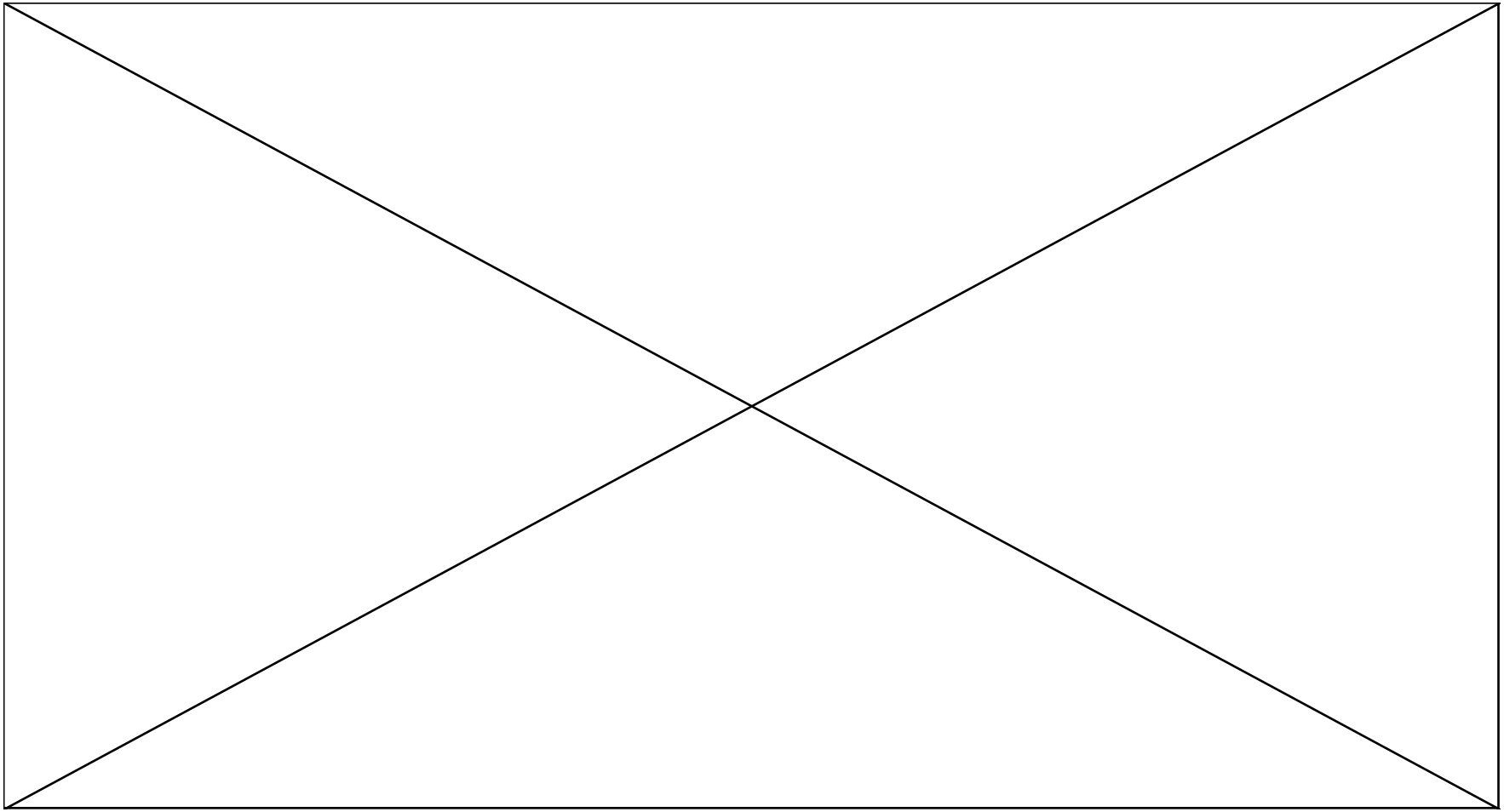


OPPOSED → → → → → **ENGAGED**

• Convey urgency • Give facts • Provide evidence • Convey big picture	• Listen • Show concern • Restate facts	• Listen • Demonstrate concern • Restate facts • Convey commitment	• Restate big picture • Communicate vision • Ask for help	• Involve • Celebrate wins • Inspire	• Feedback success • Inspire • Create Champions

Communication Priorities

Developing followers…



Maximizing Clinical Leadership in Clinical Networks

Local Professional Network Assembly

Manchester 25th March 2014

Dr Jagan John
GP/GPWSI in Cardiology
Chair LMC (BDH)/BDCCG Clinical Director
London Clinical Senate Board Member (NHS E)

My Journey- Some Years ago

- Monday morning GP clinic
- Patient X with many issues- CCF, Hypertension, COPD, multiple medications,Depressed, Lives alone,
- Not coping, medications not optimised,...
- Wanted to bring her help, and i need help to manage her.....
- Started asking questions.....

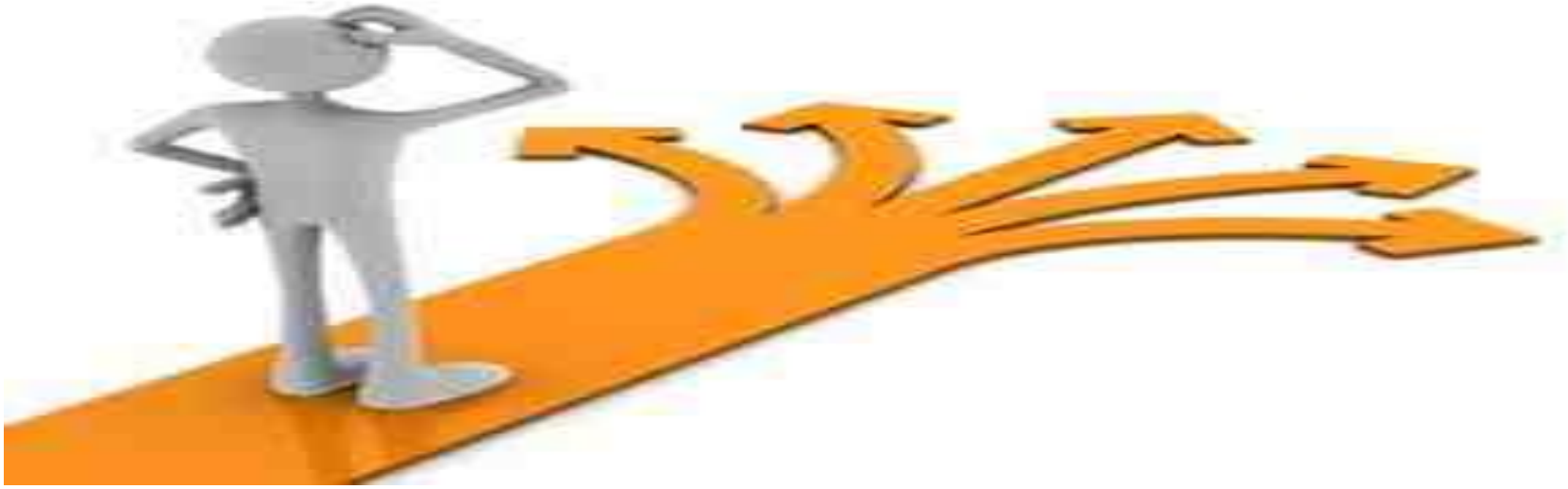
The NHS



What do I do first?

Real knowledge is to know the extent of one's ignorance.

Confucius



Evidence: Using the Patient Story

- Video – Experience Based Design
- Captures patient experience
- Provides valuable feedback to ALL staff
- Powerful message to teams
- Distils the essence of why we're all here
- Reality check
- Make it everyone's problems, and allowing all teams to work on it

The systems perspective

- Too many admissions & readmissions
- Too much activity in secondary care
- Too much reactivity/not enough proactivity
- Need more integration between services



The patient perspective

- High Anxiety
- Low levels of confidence in managing own health
- Low levels of health literacy
- Confusing system to navigate
- Reliance on system in times of real or perceived need



The Vision in North East London



- Coordinated care for patients and carers in the community
- Optimal patient experience and clinical outcomes
- Lower cost, better productivity
- Whole system change (1,000,000 patients)

What do we do next?

Without knowledge action is useless and knowledge without action is futile.

Abu Bakr



Getting involved: QIPP LTC Workstream/ Networks

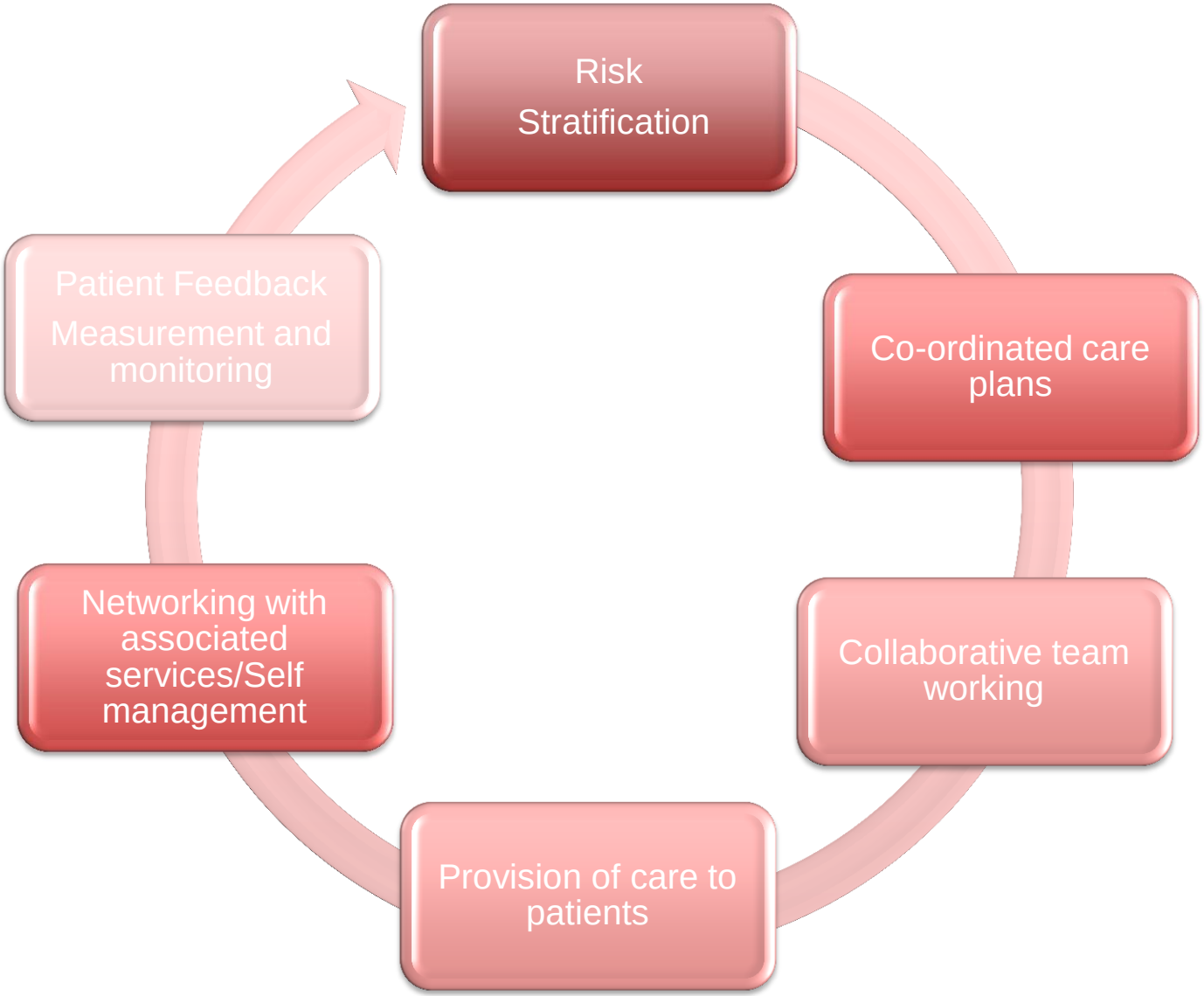
Primary drivers:

Risk Profiling

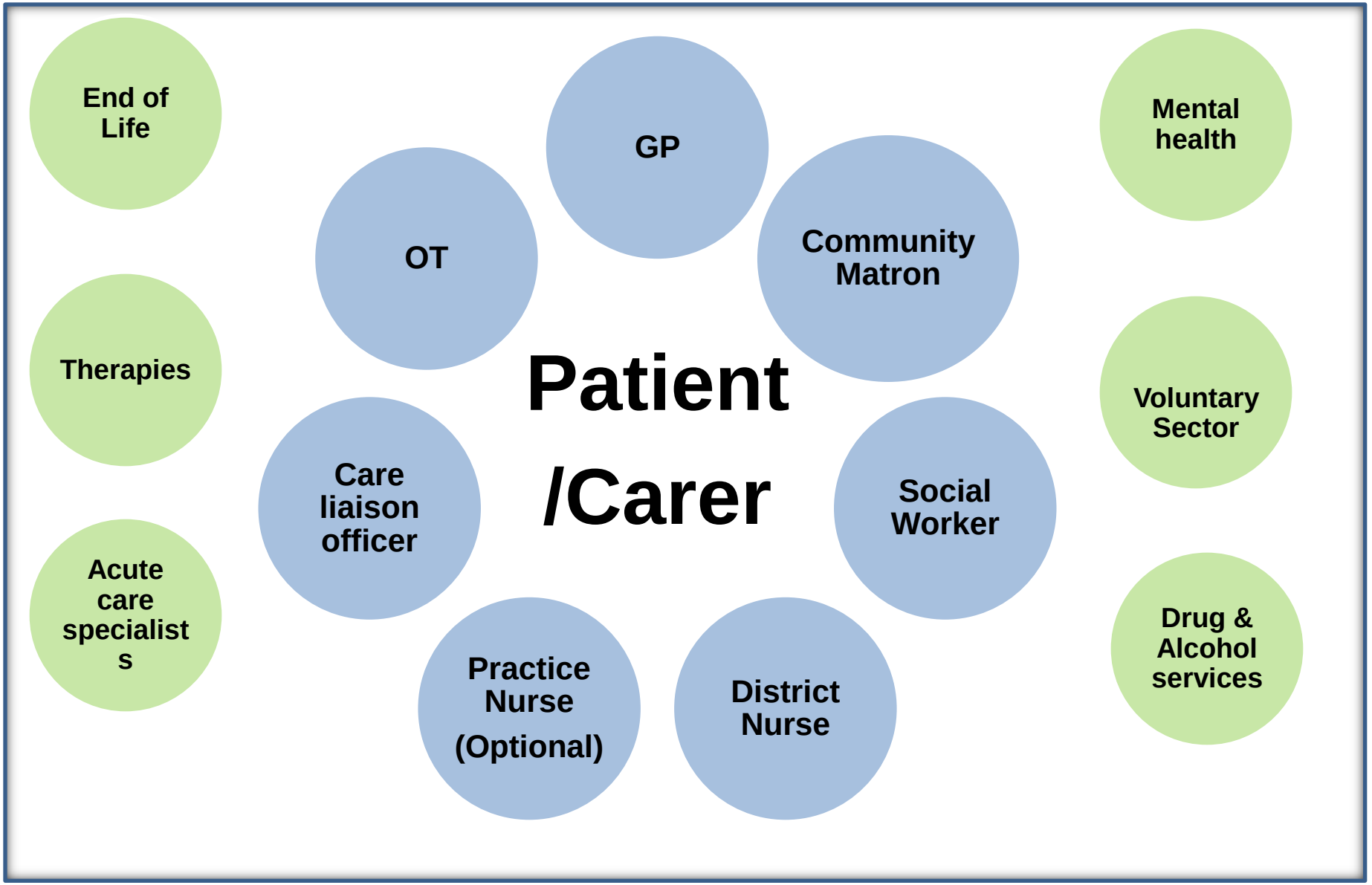
Integrated care teams at locality level

Systematic empowerment of patients to self manage

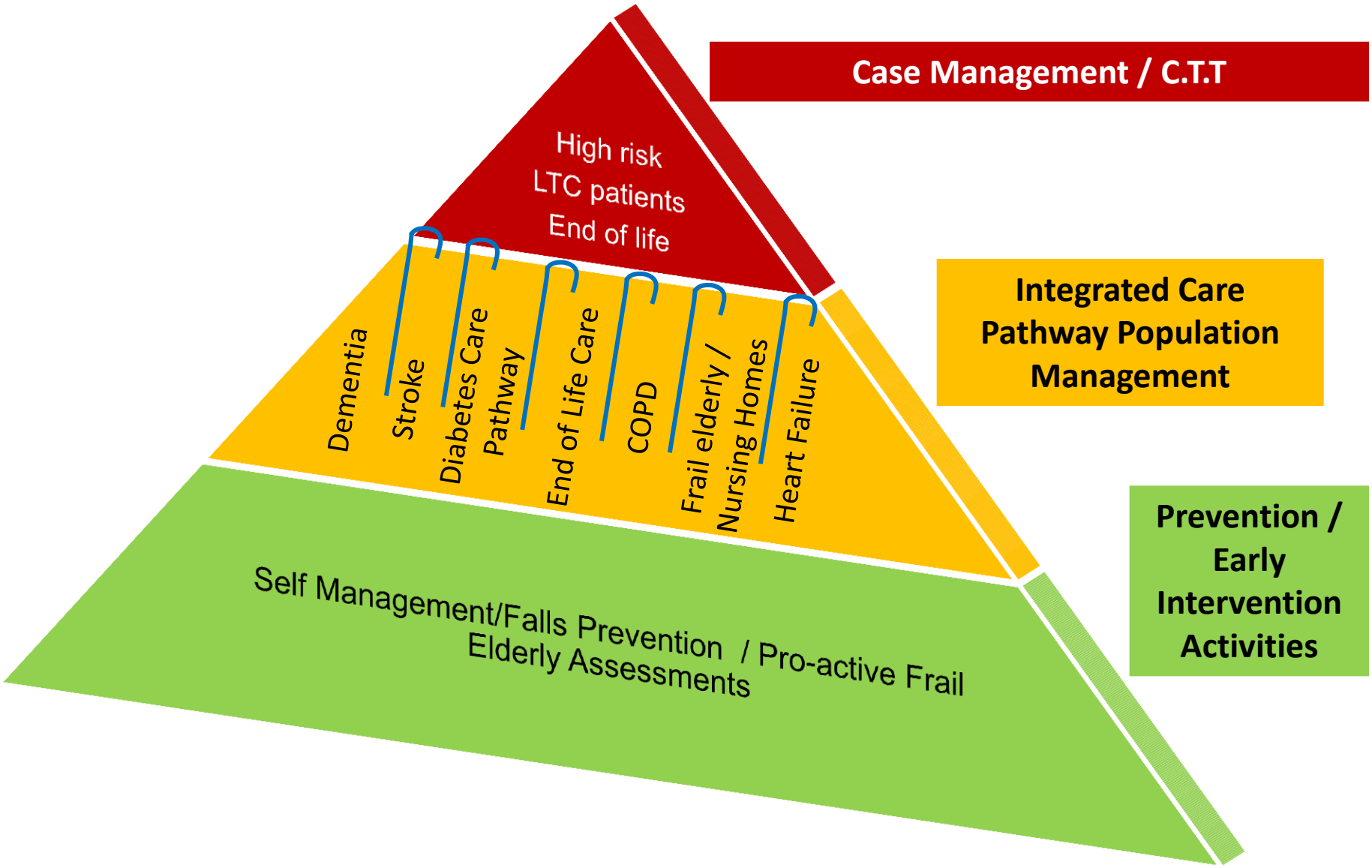
Design a methodology



Design A Co-produced ,Co-ordinated Care Team



Design A Whole System Approach



The Target changed

- Realisation -work could not be done alone
- To implement change in a system / primary care/ Community landscape needed to influence central decisions
- Needed to use Clinical Networks to align for common goals to support project
- Through the QIPP/LTC team under Sir John Oldham needed drivers centrally to implemented/ DES

Overall Outcomes

Quality Outcomes

- Over 6000 patients with MDT care plans in place- now Virtual (so all professionals can update/ patients/carers can view this)
- 300 GP practices, 4 local authorities, 2 acute trusts and 1 community provider delivering the model of care (Integrated Care Coalition)
- Improved co-ordinated care by multi-disciplinary teams and reduced duplication
- Every patient has a nominated and dedicated coordinator to coordinate personalised care
- Rapid access to social care as needed through direct referral to social care
- Transformation in the workforce and retention
- Reductions in admission by 14% in B and D 2013/2014

My Journey- The outcome

- Monday morning GP clinic
- Patient X come backs
- Coping, has carers and medical support, managing her illness better, medications optimised,...
- She phones one person to get all help- Need based.....Happier
- BUT what could we do better.....

What has/had to change?

- Believing in the same vision and upskilling- Improving Quality
- Understanding what patients were experiencing, constant feedback from patients. Making it everyone's problem
- All organisations and teams being proactive, and coproducing solutions and designing the data resource even if it was radical.
- Respecting and supporting each other's views and Strong Shared Leadership
- Creating an Environment: Being able to be ambitious, and doing an all or nothing approach.
- Allowing localised changes, and the ability the system to innovate and teams to take ownership, alignment with bigger strategic models

Leadership: The Challenge

Population

- Mixed population profile; deprivation, age, ethnicity and Health Inequalities, increased expectations
- Inadequate patient satisfaction and some poor outcomes
- Rising unplanned hospital admissions
- Variation in quality,
- Reducing investment

Organisational change

- NHS restructure ,Clinical Commissioning Groups
- Further Clustering of groups.CQC, Monitor
- Community and Acute Provider Mergers

Local Authority and Social care restructures

Organisational form

- Organisational boundaries
- Evidence of Gaps, duplication and silos
- Resource rationalisation
- Can the system cope with more in the community
- Different Data Systems that could not merge



Cost pressures	Quality	Tracking costs v tariff	Contracting Model	Stakeholder Engagement	Data Analysis
Patient experience	Safety	Innovation	leadership	Health economy	Data Collection

Servant Leadership



Key Characteristics

Listening; Commitment to growth, community	•listening effectively to others and,is responsible for serving the need of others
Empathy and Healing	•understand others' feelings and perspectives •foster each person's emotional and spiritual health and wholeness
Awareness	•understands his or her own values and feelings, strengths and weaknesses
Persuasion and Stewardship	•influences others through their persuasiveness. •is a steward who holds an organization's resources in trust for the greater good
Conceptualization and Foresight	•needs to integrate present realities and future possibilities •needs to have a well developed sense of intuition about how the past, present, and future are connected.



Project - Patient Experience and Empowerment Evaluator for Integrated Care (IC) and Continuing Health Care (CHC)

- Issue - no recognised means of collecting and linking patient experience measures across a whole patient pathway

- Proposed solution- an automated, technological prototype linked with activity and financial cost

- Expected Benefits/ Outcomes
  i. patient experience intelligence about the integration of services within a pathway
  ii. basis for measuring experience

- Goals
  i. Support people to take a more active role in their own health and care

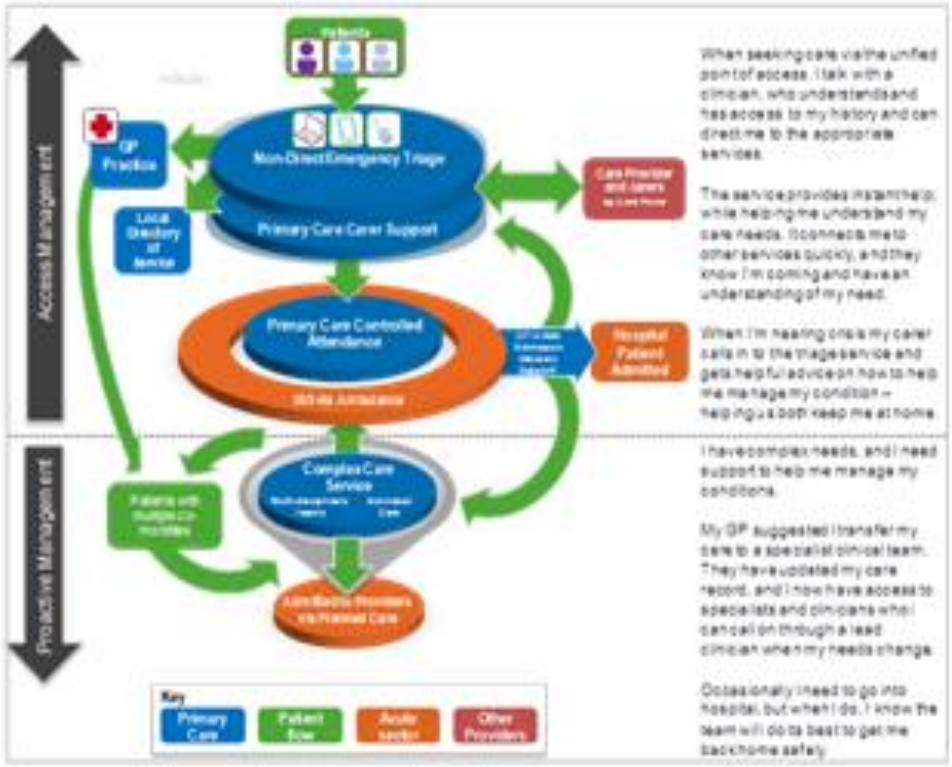


Figure 5.5: Primary care co-ordinating the service throughout the health economy

Lastly

- It is the responsibility of leadership to provide opportunity, the responsibility of individuals to contribute

» William Pollard

My Leadership Journey









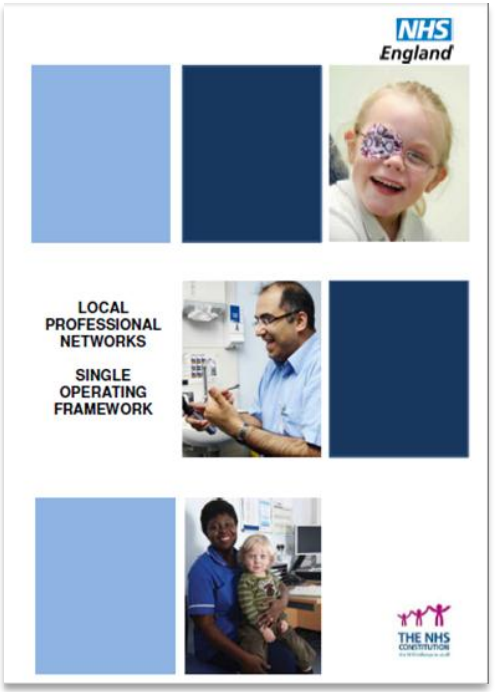
Amit Rai

NHS England

THE NHS CONSTITUTION
the NHS belongs to us all

Core Functions

- Robust clinical input
- Provide clinical leadership
- To support reducing health inequality
- Drive improvement in outcomes
- Support patient involvement




Democratic
Involve
Influence
Inspire
Vision
Leadership
Common goals
Collaboration
Trust
Empowerment
Effective communication
Values
Engagement

Distributed Leadership

- Not a recipe
- Mobilising leadership at all levels in the organisation
- Emphasis on leadership practice, not leadership functions
- Based upon the interactions between many leaders rather than the actions of one
- Engaging the many not the few



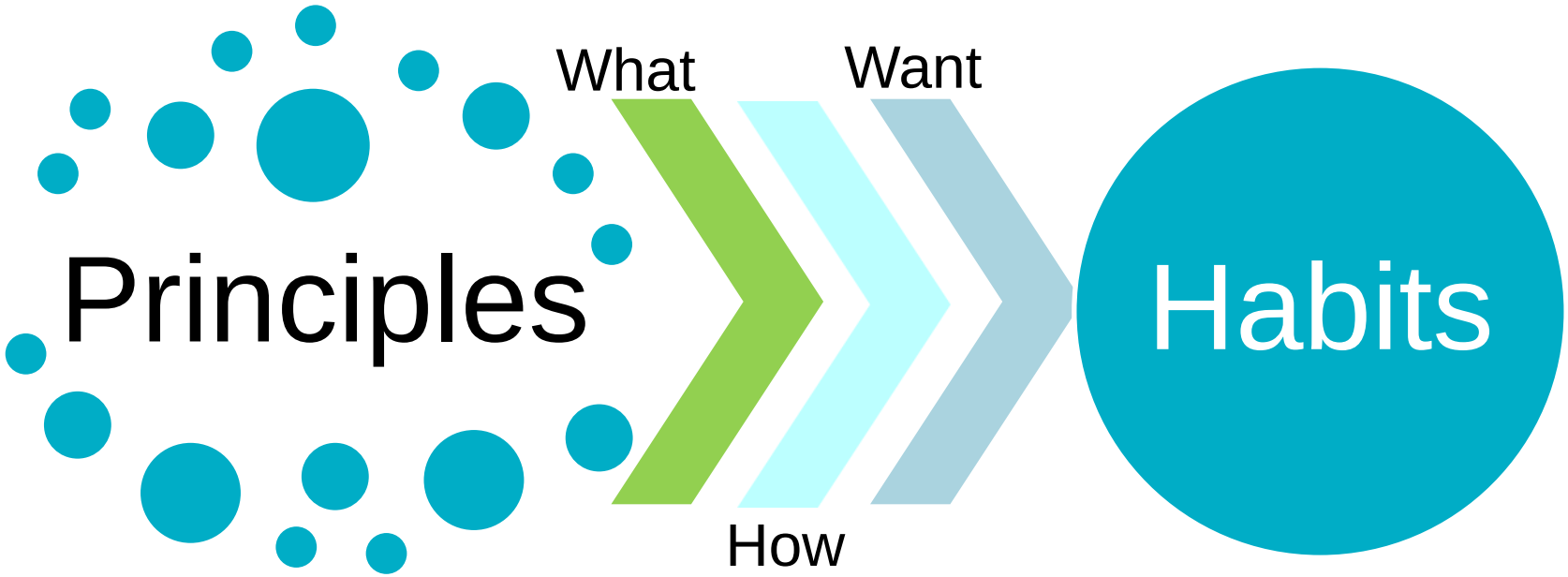
Performance = potential – interference

- Resistance
- Political intent
- Representative opinion
- Cynicism



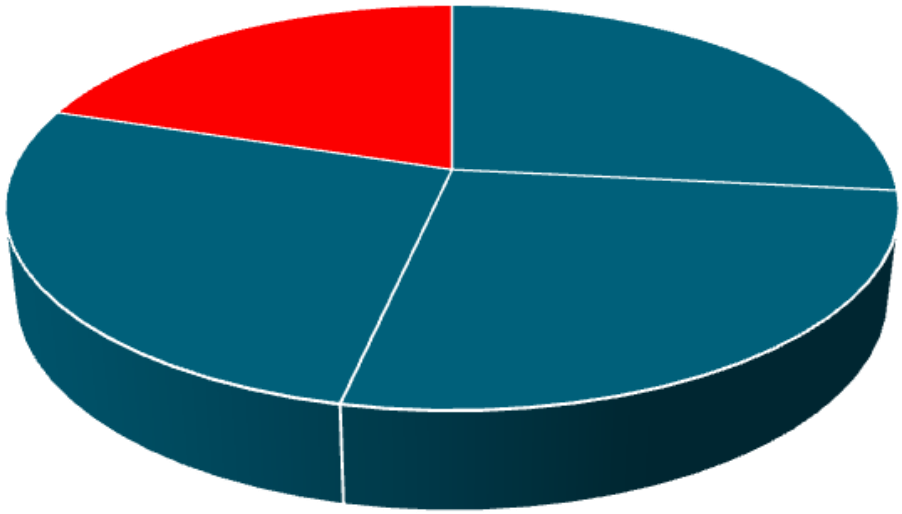
Gallwey, WT, 2000, The inner game of work, London

Leading purpose and possibility



Formula for Change

D x V x F > R



- Dissatisfaction with current state
- Vision of future state
- First Steps
- Resistance

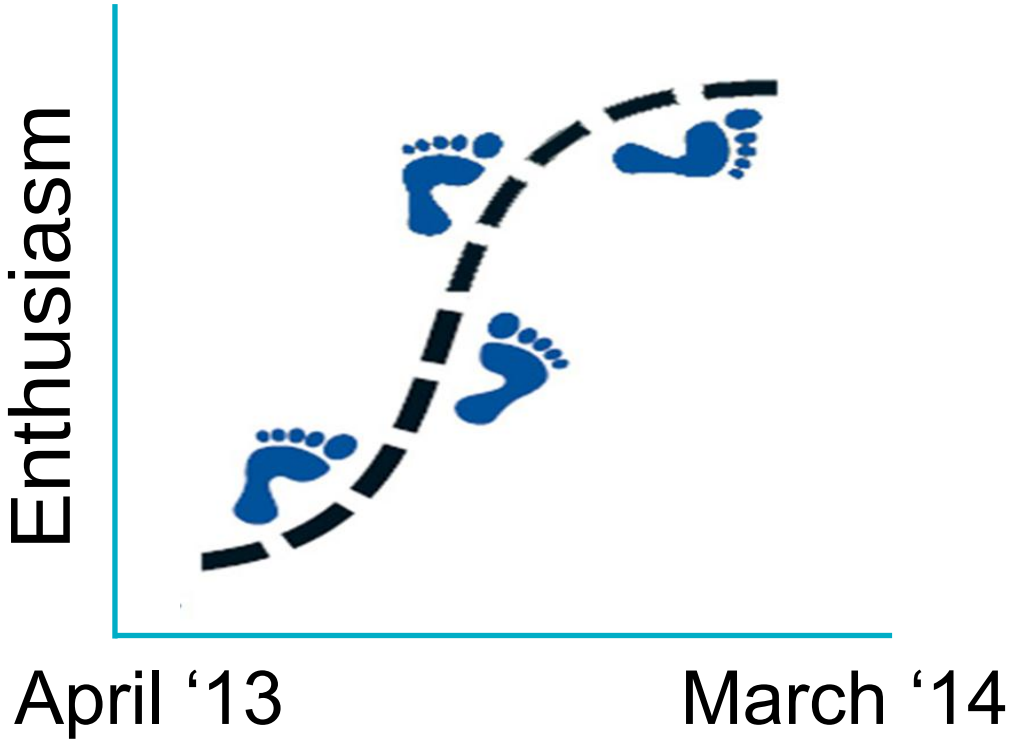
Beckhard R and Gleicher D

The '*Ground up*' Approach

Ensuring the involvement of the 'local clinical voice' at a grassroots level to contribute to distributed leadership



Achievements



Achievements

- Effective involvement of all (esp. the altruistic)
- Inter-professional working
- Feeding up the network – Steering Group
- Project on ‘Caring for the Carers’

The NHS belongs to the people
A CALL TO ACTION

Thank You

Surrey & Sussex Dental
Local Professional Network

NHS England

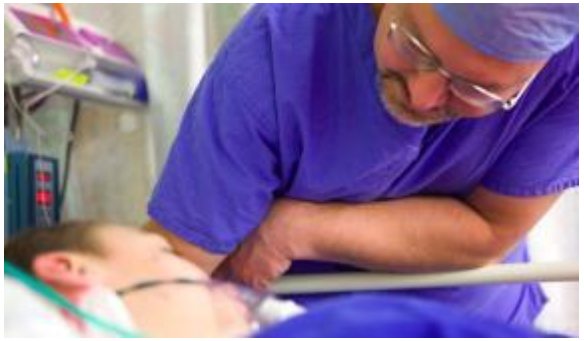


@SS_Dental_LPN

Leadership Journey

Lyn Price
LEHN Chair Essex and East Anglia









LPN Assembly March 2014

THE NHS CONSTITUTION
the NHS belongs to us all

I got the job!

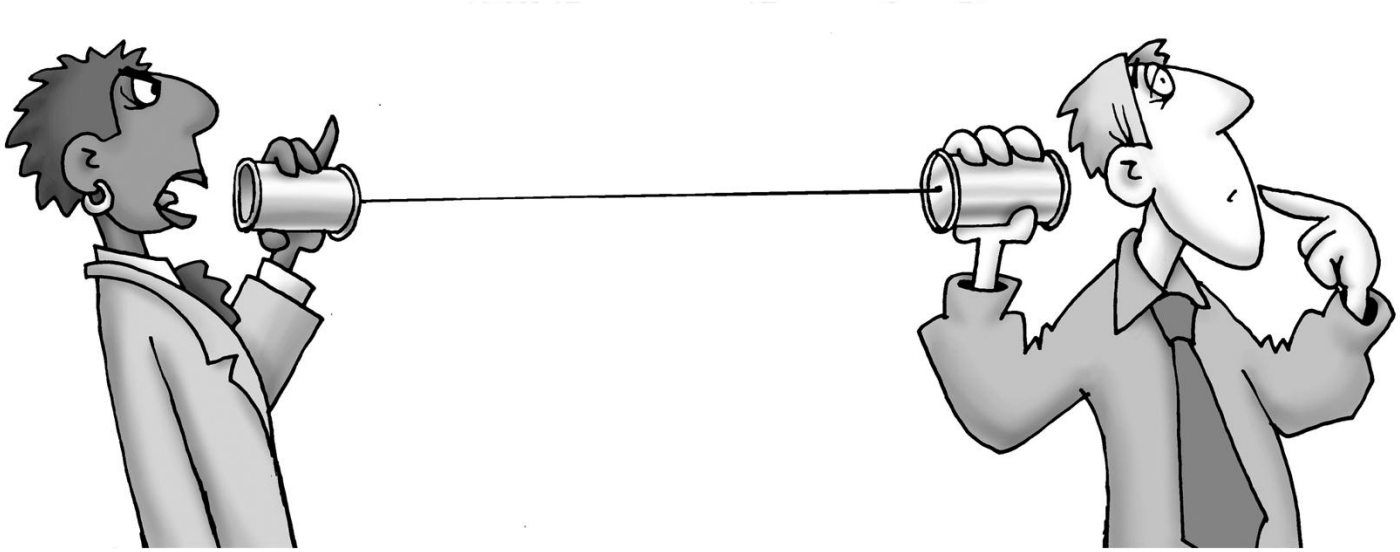


Used with permission of Management Pocketbooks

The Vision



Starting to set up the network



The Core Group



Getting Support



To What End? or Where are we going?



Used with permission of Management Pocketbooks

Unnecessary Hurdles



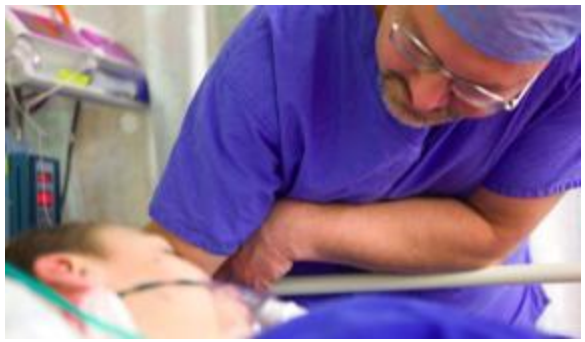
Coping with my frustration



Used with permission of Management Pocketbooks

Personal Concerns

- Variable managerial support
- Lack of accessibility to budget.
- Lack of decision making autonomy and parameters
- Networks – top down or bottom up?


Give me a chance to do the job – please!



Used with permission of Management Pocketbooks

Inspiring Future Pharmacy Leaders

Linda Bracewell
Lancashire LPN-Pharmacy





Leadership :

"Leaders must be seen to be up front, up to date, up to their job and up early in the morning"

Lord Sieff 1970

(chairman M&S)



Where I am now……

"If you don't know where you are going, how will you know when you get there?" Anon.

- Chair LPN pharmacy
- Member of Lancashire MMB
- Member of EL Interface Group
- CPPE Associate
- Lancashire LPC associate etc.



Where I was in last 5 years….

- East Lancashire PCT PEC
- East Lancashire PCT Clinical lead for education and training
- ELPCT organisational transformation board
- ELPCT pharmacy services development e.g. HLP, NHS Healthchecks etc etc.



How did I get there?

- East Lancashire PCT - PEC
- CPPE for 15 years (stopped when PEC etc just got too much)
- Local branch (now LPF???
- Projects e.g. Lancaster UNI leadership course, pre reg training and development etc.



How did I get here?

"I didn't get here by dreaming about it or thinking about it-

I got here by doing it"

Estee Lauder

The “day job”



Images of leadership



Leadership style





Key leadership traits :

- Enthusiasm
- Commitment
- Toughness
- Fairness
- Humility
- Confidence
- Integrity

Leadership may start here





…get loads of practice here





Developing leadership skills

- Don’t become task focussed
- Delegation not “passing the book”
- Effective communication
- Feedback
- Create an “agile” team



And furthermore:

"Your legacy should be that you made it better than it was when you got it"

L. Iaccoca 1924

chair Chrysler Corporation