



IS CLINICAL LEADERSHIP VITAL TO
TRANSFORMATIONAL CHANGE
MANAGEMENT?

WHO ARE WE?



- Philippa Robinson

- Robin Davis

- Char Weeks

OUR TIME TOGETHER



- What are your challenges with clinical leadership and change management?
- What do we understand about leadership?
- How do we transform services and sustain the changes, and how does leadership fit?
- What are we learning in England?
- How can we learn from each other?
- What actions can we each take to move forward?

WHAT ARE THE RULES?



JUST A FEW.....

- ❑ Listen to each other
- ❑ Be present and take part
- ❑ Confidentiality
- ❑ Commit to actions



GETTING TO KNOW EACH OTHER

Human bingo

Leadership - a brief history of research



- Definition traceable through 5 stages
- 'great man approach'
- Behavioural approach
- Situational approach

New paradigm models

- Transforming leader
- Heroic models

WHAT NEXT?

ENGAGING LEADERSHIP



- Engaging individuals
- Energising the organisation
- Moving forward together
- Personal qualities and core values

Developing Resilience – the challenge for today



- The current economic climate sees less ‘buying in’ of solutions
- Organisations are shifting focus to developing more sustainable approaches to service improvement which come from within
- The challenge lies in equipping clinicians with the leadership attributes to be resilient



WHAT ARE YOUR CHALLENGES IN
CLINICAL LEADERSHIP?

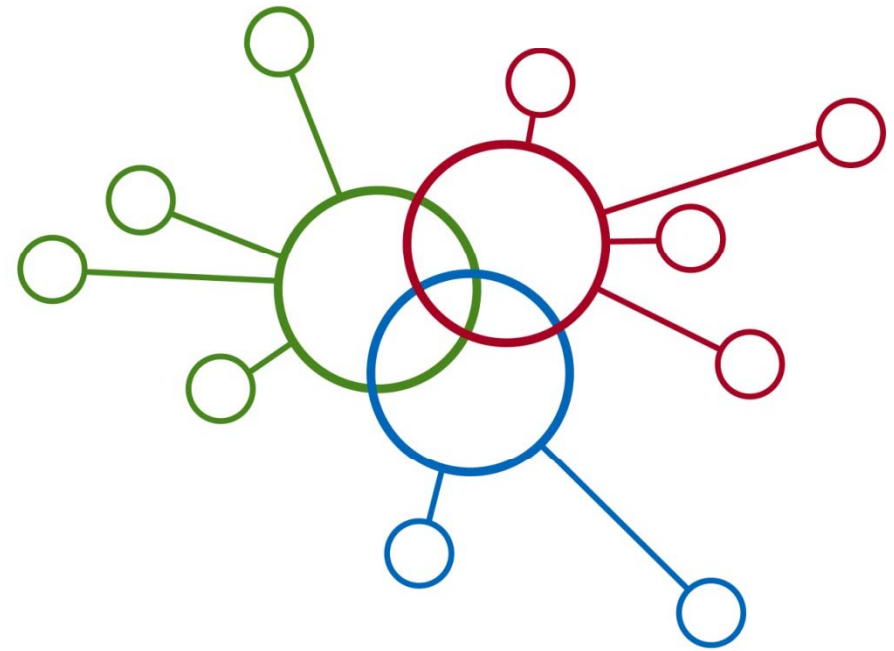
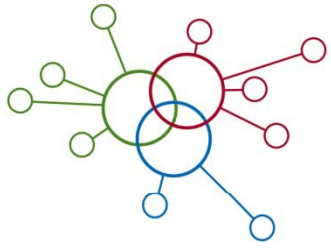


HOW DOES THIS RELATE TO SERVICE
IMPROVEMENT AND
TRANSFORMATION?

8 Steps to transforming: Kotter

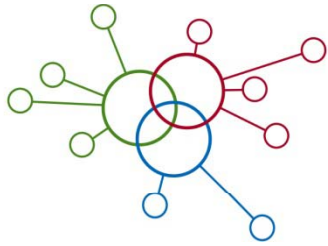


- ❖ Establish a sense of urgency
- ❖ Form a powerful guiding coalition
- ❖ Create a vision
- ❖ Communicate the vision
- ❖ Empower others to act on the vision
- ❖ Plan for and create short term wins
- ❖ Consolidate improvements and produce still more change
- ❖ Institutionalise new approaches

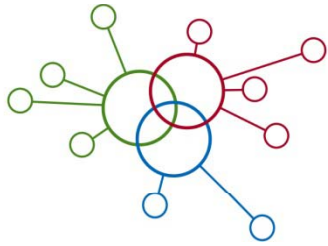


The NHS Sustainability Model

Maher, Gustafson, Evans 2003

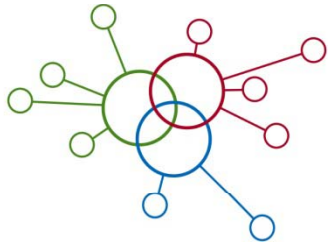


**Create a plan before,
during and after
implementation of
your improvement**



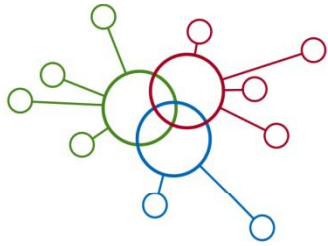
*Change is inevitable; success is not,
leadership is vital.*

- ***“Many leaders are quick to step forward as enthusiastic sponsors of change without really understanding what the role demands”***



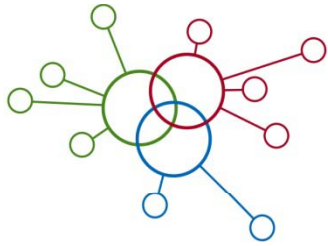
- Do staff have the level of improvement skills required to sustain the change- PDSA, Capacity and Demand, Variation?
- Is there a training & development infrastructure to identify gaps in skills & knowledge and are staff trained to take change forward?





- *“The all-too-common consequences of **poor employee engagement during change programmes** - the reduced magnitude of the benefits achieved, drawn-out timescales for their achievement, and the **failure to sustain** them beyond the immediate implementation phase - should be compelling enough to encourage the adoption of a bold new approach.”*

- *(Corven Consulting, 2005)*



Staff must be able to see that ‘they’ will benefit (WIIFM) if the scepticism is to be tackled. We tend to position improvement projects as being ‘good for patients’ we also need to spend time with staff to understand the ‘good, bad and ugly’ effects of the change on them.

WHAT ARE SOME OF THE LEADERSHIP APPROACHES IN ENGLAND?



- High political priority
- National leadership council
- Leadership structures at every level in the NHS
- Clinical leaders network/ 18 week musculo/skeletal approach

Key Elements of NHS Leadership



Our Approach to Leading Change

Lessons and challenges:

- **Role of the system** – we need to get people thinking in terms of the whole system rather than within traditional organisational boundaries; this applies particularly to improving quality
- **Role of leadership** – we need to change the nature of leadership its focus on targets to prioritising quality, taking risks, and looking out not up
- **Pace of change** – we cannot expect consistent pace of change across the system, so we must encourage innovators and not hold back the “leading edge”
- **Change not churn** – we must avoid change for change’s sake e.g. further structural reform (“messing about masquerading as action”)

Resulting principles for change:

- **Co-production** – need to work jointly with NHS / stakeholders, examples of NSR; World-Class Commissioning; quality metrics; Op Framework
- **Subsidiarity** – devolving power / decision-making as close to patients as possible e.g. Practice-based Commissioning, clinical dashboards
- **Clinical leadership** – aligning managerial and clinical priorities and leadership e.g. SHA Medical Directors, Service Line Reporting
- **System alignment** – making sure all parts of the system work together and pull in the same direction, example of National Quality Board

Overview of the Talent & Leadership Framework

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	Key purposes	Sample products
National 	<ul style="list-style-type: none"> • Ensure conditions and incentives enable leadership for quality • Set standards to ensure value for money • Lead on creating advocacy for improvement • Commission top leader programmes 	<ul style="list-style-type: none"> • National Leadership Council – Annual Report • Commission leadership development for undergraduate and postgraduate curricula and NHS top leaders • Evidence gathering on capability and capacity
Regional	<ul style="list-style-type: none"> • Facilitate regional collaboration to improve leadership capacity and capability for quality • Tailor regional standards • Commission senior development programmes 	<ul style="list-style-type: none"> • Regional talent and leadership plan • Commission development programmes (eg. for aspiring Chief Executives, Executive Directors, Senior Clinical Leaders, etc)
Employer	<ul style="list-style-type: none"> • Create and foster conditions for talent and leadership development • Align career paths with patient pathways and service delivery • Ensure that the profile of leaders reflects the communities served • Participate in regional improvement 	<ul style="list-style-type: none"> • Organisation diagnostic and improvement plans • Provision of assurance where funding has been made available • Commission and implement programmes (eg Trust Board Development, Leadership for Quality, etc.)
Individual	<ul style="list-style-type: none"> • Continuously learn and develop • Spot talent and support the development of others 	<ul style="list-style-type: none"> • Personal development plan and career portfolio • Coaching, teaching and/or mentoring others

National Leadership Council

NLC Vision

A health care system with outstanding leadership and leadership development at every level to ensure high quality care for all.

NLC Purpose

The NLC will focus on improving leadership to deliver high quality care for patients. It will drive a transformation of leadership capability and capacity throughout the system

NSR Leadership Commitments

1

Establish an NHS Leadership Council to create rigour and scale in Leadership Development (NSR)

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2

Identify and support the Top 250 leaders in the NHS (NSR)

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3

Introduce the leadership for Quality Certificate (NSR)

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4

Introduce the Clinical Management for Quality Programme (NSR)

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5

Reflect leadership skills in the undergraduate curricula (NSR)

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6

Reflect leadership skills in postgraduate curricula and appraisal processes (NSR)

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7

Create Clinical Leadership Fellowships (NSR)

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8

Commission a new development programme for Trust boards (NSR)

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9

Encourage the development of Masters-level programmes (NSR)

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10

Foster leadership for quality: expect all those leading change to be clear on Vision, Method and Expectations (NSR)

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Produce Talent and Leadership Guidance to ensure a systematic approach to Talent management (Operating Framework)

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Remove the barriers to enable more leadership positions to be filled by clinicians, people with BME backgrounds, women and people with experience beyond the NHS

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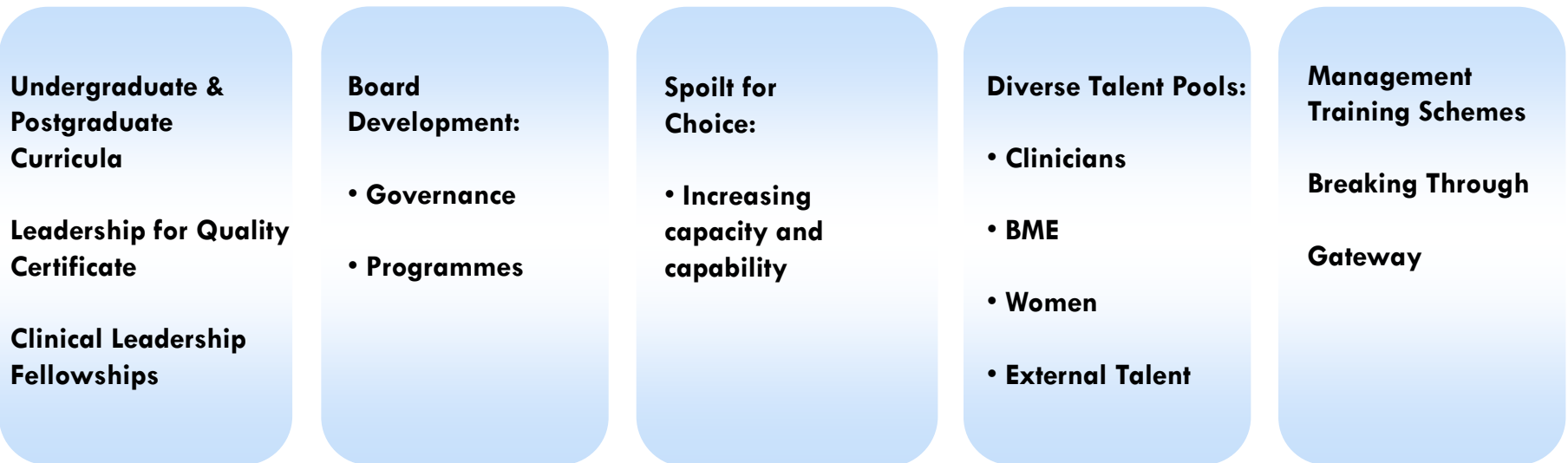
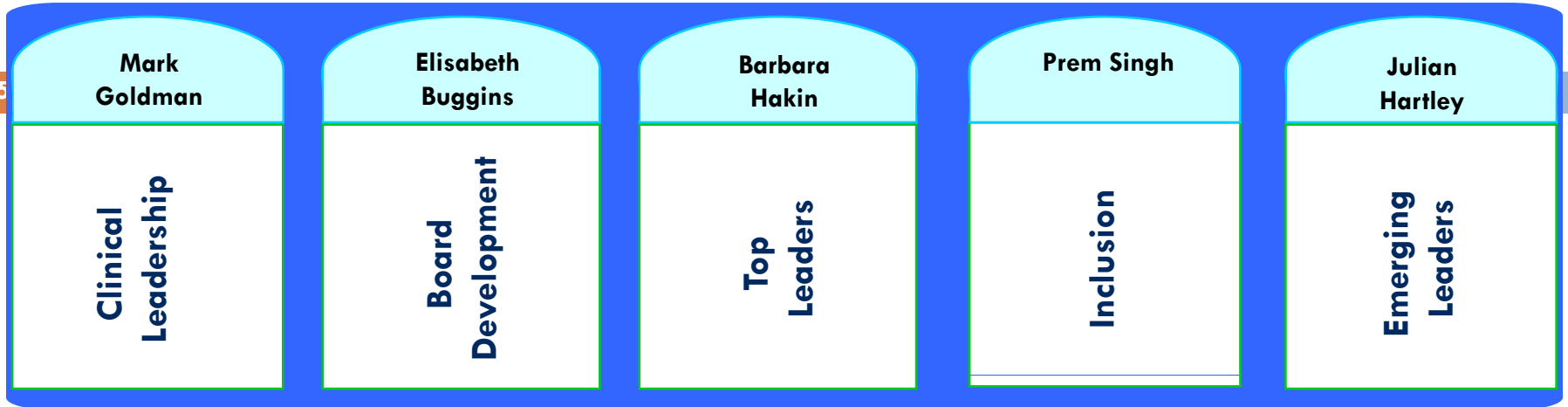
National Leadership Council

NLC Activities

1. Ensure the delivery of the NSR leadership commitments
2. Provide an Annual Report on the condition of leadership in the system
3. Gather and analyse evidence and intelligence and share best practice
4. Set objectives, make recommendations, check progress and coherence
5. Set coherent standards for leadership and leadership development, including accreditation of provider programmes when appropriate
6. Commission development programmes
7. Make recommendations for policy
8. Develop high level partnerships with the private and third sectors

National Leadership Council Priorities (incorporating NSR Leadership Commitments)

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Leadership Model: Vision, Method & Behaviours: Lead – Clare Chapman

Talent and Leadership Planning: Lead – Clare Chapman

Manager Regulation including Masters Programmes: Lead: Ian Dalton



National Leadership Council

LeadershipCouncil@dh.gsi.gov.uk

Clinical leaders network



Principles

- Support clinical leadership engagement
- Improve clinical service delivery
- Enable clinicians to influence policy implementation

Approach

- Plenary sessions by NHS influencers
- Action learning
- Networking and sharing experiences

BENEFITS

Patients

- Informed practitioners
- Motivated clinical staff focussing on latest high quality care to improve their experience
- Clinicians sensitive to and understanding importance of the impact of their actions

Organisations

- Increased quality and safety through clinically service led improvements
- Accelerated implementation of service developments
- Increased clinical ownership of health economy performance
- Opportunity to capture and share innovation and achievement

Clinicians

- Support to improve leadership skills
- Peer support and evaluation time for clinical leaders with responsibility to deliver reform
- Access to clinical innovation from across country
- Ability to engage with local and national service and policy leads
- Opportunity to address concerns in their work areas in a safe, supportive environment

NHS INSTITUTE OF INNOVATION & IMPROVEMENT & ACADEMY OF MEDICAL ROYAL COLLEGES

'Rather than the doctor's frequent role as head of the healthcare team and commander of considerable clinical resource, there is now a requirement to pay greater attention to management and leadership skills regardless of specialism. An acknowledgement of the leadership role of medicine is increasingly evident.

Role acknowledgement and aspiration to enhanced roles, be they in subspeciality practice, management or research are likely to facilitate greater clinical engagement'

(Aspiring to Excellence, Prof John Tooke, 2008)

Medical Leaders Competency Framework

- **Personal qualities**
 - Self awareness
 - Self management
 - Self development
 - Acting with integrity
- **Working with others**
 - Developing networks
 - Building and maintaining relationships
 - Encouraging contribution
 - Working within teams
- **Setting direction**
 - Identifying contexts for change
 - Applying knowledge and evidence
 - Making decisions
 - Evaluating impact
- **Improving services**
 - Ensuring patient safety
 - Critically evaluating
 - Encouraging innovation
 - Facilitating transformation
- **Managing services**
 - Planning
 - Managing resources , people and performance

Tools and Techniques



- Human Bingo
- Dice Feedback
- 2 x 2 – Stakeholder Mapping
- Facilitated Discussion
- Positive / Delta



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What will you do differently?



Thanks & keep in touch

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