



Clinical Leadership Paper for the London Clinical Cabinet

Professor Becky Malby, September 2018.

The History of Clinical Leadership – the context

A Feudal and fragmented NHS (Rudolf Klein, Patricia Day) paved the way for the Griffiths report (1983) with its iconic phrase “If Florence Nightingale were carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge.” The diagnosis was that the NHS was swamped by directives; and professionals were operating independently of need. The report recommended putting the NHS at ‘arms length’ from politicians; general managers in charge of budgets and performance, and clinicians more closely involved in management. Over time clinicians became increasingly involved in management from leadership roles in provision (directorates in hospitals) to commissioning – practice based commissioning (2005) through to clinical commissioning (2011). The ambition was to bring the doctors who committed the most resource in their day-to-day practice into an accountability framework for the wider NHS. In 2011 the Health and Social Care Act “puts clinicians at the centre of commissioning, frees up providers to innovate, empowers patients and gives a new focus to public health.” The drive to bring clinicians (now not just doctors) into the full resource decision-making process, as a means of managing the Triple Aim of Healthcare (a term coined by Berwick et al 2008) was back in the forefront of policy.

However alongside the ambition for clinicians (in the early years stage doctors, and more latterly all the clinical professions) to take responsibility for the resources that they commit through their clinical decision-making; there was also a mistrust of the professions – a concern that professionals protect their self-interest over and above the needs of the people they serve. ‘All professions are a conspiracy against the laity’ wrote George Bernard Shaw in 1906 in his play ‘The Doctors Dilemma’ and Margaret Thatcher would have agreed. Thatcher thought that the professions were self-indulgent. Her solution was the market (Evans 2004), Blair followed with the target culture, to bring professionals to account for improving access and to attempt to stop the postcode lottery. In 2002 McNulty and Ferlie wrote:

‘...health care organisations can be described as consisting of little more than ‘loose coalitions of clinicians engaged in incremental development of their own service largely on their own terms.’

When subsequent Inquiries found the failure in professional leadership to lead quality, put very directly by Bruce Keogh in the Mid Staffs Inquiry (2011) that the poor care was caused partly by a “failure of clinical leadership”, the political discomfort with the professions surfaced again.

The tension then arises between clinical professions being the cause of the problems in healthcare, against an emerging narrative of clinical professionals as the solution.

A National Inquiry into the Productive Relationship Between Management and Medicine (Kirkpatrick et al 2007) investigated the nature of the relationship in NHS organisations where collaboration between management and medicine was reaping



benefits. The Inquiry found that this critical relationship was productive where there was:

1. A shared sense of endeavor and collective responsibility.
2. Participative and open decision-making, and an inclusive approach to information.
3. A distributed collaborative model of leadership. Shared decision-making at all levels.
4. An organisational focus on quality and health, reflected in the organizational processes and metrics.

These organisations had greater capacity for collaboration, clear alignment across financial, operational, and quality decision-making, and shared responsibility for service change. Clearly bringing medicine and management together through a clinical leadership model had an impact.

Lord Darzi's review (2008) to bring quality back into the heart of the NHS recommended that 'clinicians [are] encouraged to be practitioners, partners and leaders in the NHS'. In his view the direction of travel to secure needs based quality health services could only be done in partnership with clinical leaders. His review catalyzed The Darzi Fellows Programme as a flagship for the NHS. At this stage the scepticism of the professions about going to the 'dark side' of management began to dissipate, and the concern that the professions had about 'selling out' or being the champions of quality, became an argument of the past.

The Kings Fund (2011) reported that 'One of the biggest weaknesses of the NHS has been its failure to engage clinicians – particularly, but not only doctors – in a sustained way in management and leadership.' The white paper attempted to bring clinicians of all professions into the heart of management decision-making.

The role of the wider clinical professions in leadership (beyond just medicine) has emerged alongside a recognition that complex needs require multidisciplinary teams to work collaboratively. Nurses in particular have taken the alternative career path into management in a way doctors never have (taking up management in the absence of clinical leadership roles for wider professions). The power and authority of medicine (very tangibly signaled by salaries that go above and beyond their management and clinical colleagues) remains, but there is an emerging peer based model of clinical leadership with 3-way leadership in directorates (medic, nurse, manager) and more collaborative approaches to complex needs at team level in the community.

As we move into a more collaborative model of organising in the NHS the clinical professions now fully embraced their role in leadership of the whole of the NHS agenda. This is a steady trajectory from keeping the clinical agenda completely separate from the resource agenda, to embracing a fully integrated model of organising. Whether this has been accelerated by the change in policy direction from competition to collaboration is unknown, but there is definitely a climate for collaboration that embraces both a more collegiate relationship with general management, and across the clinical professions (and now including social care in more advance models). This is particularly seen in the emerging GP leadership in clinical commissioning groups where GPs appear to be more likely to adopt collaborative over 'heroic' leadership styles (Marshall et al 2018).



Clinical Leadership – what is it?

Denis and Gestel (2016) describe clinical leaders as “professional-managerial hybrids”. They state that:

“Clinical leadership thus incorporates a variety of roles and resources that help front-lines clinicians to introduce new ways of working and to redesign care for improvements (Baker and Denis 2011). It is expected that clinical leaders will influence their peers through their professional knowledge and skills in promoting improvement of care within the context of available resources. They will also collaborate with managers in developing organizational strategies that are aligned with quality improvement (Noordegraaf 2011)”.

This is not without challenge as the clinical professions navigate the potential dilemma between corporate responsibility and accountability, and professional autonomy. This is well described in the Denis and Gestel (2016) paper.

The Impact of Clinical Leadership

The importance of clinical leadership for healthcare change has been well described (Swanwick and McKimm, 2011, Edmonstone, 2009, Wilson et al., 2013, Malby et al., 2013). The direction of travel is clear, and to an extent this has been an ideological movement (healthcare quality will be improved and costs reduced if clinicians are at the heart of decision-making). However there is emerging evidence of the beneficial impact of clinical leadership.

Kirpatrick et al (2007) conducted a national inquiry into the relationship between management and medicine. This identified that “Clinical-management engagement is often associated with a) improved productivity (through the redesign of clinical work) - Degeling et al (2003); b) enhanced capacity for change and innovation (Fitzgerald and Ferlie 2006). A number of studies have found that poor performance and clinical failure were linked in part to a ‘disconnect’ between medicine and management (Healthcare Commission 2006, Mannion et al 2005). Many have also identified a positive link between effective clinical leadership and improved patient care. There is then some evidence to suggest that improving the capacity of doctors and managers to co-produce services will add value in the system.” (p 5)

A subsequent review conducted by the Faculty of Medical Leadership and Management, The King’s Fund and the Center for Creative Leadership (West et al 2015) showed the importance of leadership in the health service. The review concluded that “there is clear evidence of the link between leadership and a range of important outcomes within health services, including patient satisfaction, patient mortality, organisational financial performance, staff well-being, engagement, turnover and absenteeism, and overall quality of care”.

Veronisi et al (2013) found a significant and positive association between a higher percentage of clinicians on boards and the quality ratings of service providers, especially where doctors are concerned. “This positive influence is also confirmed in relation to lower morbidity rates and tests to exclude the possibility of reverse causality (doctors joining boards of already successful organisations).”



In terms of effective clinical leadership the Stoery and Holti (2013) investigation for the NIHR programme into the relationship between clinical leadership and outcomes demonstrated that:

1. The obstacles to the exercise of the clinical leadership of cross-boundary service redesign within the context of the NHS are many.
2. Some significant examples of clinical leadership of service redesign which were all the more impressive because of the challenges that had to be surmounted.
3. Clinical leadership was found to occur at multiple interlocking levels and the role of clinicians in shaping national policy should not be underestimated.
4. Successful clinical leadership requires the enactment of skillful practice.
5. Clinical leaders were capable of being open to new ideas and new knowledge.
6. Implementation leadership was important; it is the essential minimum for change.
7. Most effective service redesigns were achieved when used both informal, lateral, leadership & formal project planning.

Overall it is now clear that high organisational performance results when good clinical engagement occurs, and higher quality care results from strong clinical leadership (Dellve et al., 2018; Reinstern et al 2008, NICS 2003).

Clinical Leadership Development

Having recognized the need for and benefits of clinical leadership, the next issue has been the readiness of the clinical professions to take on these roles. Whilst the attitude to leadership has changed, and whilst clinicians are taking up roles that embrace leadership, their development for these roles is less robust.

Leadership development and management development has long been embedded in nursing career development, and is increasingly common in medical careers (with intercalated degrees that include management). However many hospitals have little or no management or leadership development for their consultants, or directorate leads, and that is mirrored in primary care where opportunities for GPs to develop these skills has been sparse. The readiness of medicine mirrors the early ambivalence, and sometimes vociferous opposition of the profession to integrating management into its practice. As attitudes changes the development of the profession in terms of management and leadership skills has fallen behind. This is partly because the profession has taken time to realize that management and leadership isn't straightforward 'common sense'. Many stories of the early days of CCGs are told where GPs believed that running their own small business was adequate preparation for committing public resources through commissioning.

No matter what the causalities the reality remains that:

'...consultants rarely receive leadership training and might experience problems with the transition into management roles, particularly in relation to conflicts with their other responsibilities to patients, colleagues and life outside work.' Lewis 2013



‘Successful reshaping of local health systems depends heavily on the leadership of clinicians, working with partners in social care. But clinicians are rarely trained in the major change management skills they need for the task. Moreover, they get little career support for challenging perceived boundaries between clinical and management roles. Consequently the systems leadership roles where clinicians can make such a big difference may not appear to them as attractive or feasible career opportunities.’ NHS 2016

In fact according to Edmonstone (2009) ‘no systematic and structured national leadership development provision for doctors existed prior to 2001-2002’ (p 210).

The Darzi Fellowship programme (resulting from the 2008 Darzi review) originally for doctors and now for all the clinical professions, in its 10th year, is the longest standing programme for developing clinical leaders in London. The impact of the programme is described below but it demonstrates the value of investing in clinical leadership development.

Leadership in high performing health systems is distributed (Denis et al 2011) and therefore in focusing on clinical leadership development for the future, the model of development should not just be for senior leaders but for the full range of clinical leaders, working at multiple levels and in multidisciplinary teams contributing to securing quality healthcare for all. This is supported by West et al (2015) report on leadership in the NHS which states that successful organisations are “leader-ful” not just “well led”.

In addressing clinical leadership effectiveness organisations need to provide clinical leadership in an integrated multidisciplinary model across all levels of organizational decision-making.

Effective Clinical Leadership Development Programmes

Of course effective clinical leadership development has many of the characteristics of any effective leadership development programme. The difference is the context in which clinical professionals join a leadership programme (the dominant role of expertise in the profession; the lack of prior leadership and management development in training).

At its heart any clinical leadership development programme needs to be based on the best intelligence about adult learning. This is the bedrock.

Adult Learning

Adult learners require far more than just information; they require a myriad of teaching technologies. These adult learning principles to the design of our programme (Knowles 1984):

- Adults need to know why they are learning something
- Adults learn through doing
- Adults are problem-solvers
- Adults learn best when the subject is of immediate use

Effective adult learning programs use double loop learning methodology based on for example Kolb’s experiential learning framework (Kolb 1984), and support continued learning and development through learning communities such as action learning sets



so that participants 'learn how to learn', and have a deeper sets of alternative ideas and behaviours from which to choose to act (Schön 1983).

Effective Leadership Development

West et al. (2015, p 3) found that across levels of leadership development programmes - individual, task-based, team, organisational, national "...there is little robust evidence for the effectiveness of specific leadership development programmes". However there are reappearing themes such as self-awareness and personal reflection, communication, teamwork, leadership styles, a support network, duration of one year and experiential learning, in studies of the learning impact of Leadership Development (LD) programmes. (Strawn et al., 2017; Tsyganenko, 2014, Pradarelli et al., 2016,).

In a review of Leadership development programmes Edmonstone (2013 p 537) proposed the following common design principles for effective leadership development programmes:

- **“Starting with ‘what is’:** This implies a need for shared agreement about the reality of the local situation between the programme participants, the key stakeholders and the coaches/facilitators working on a programme.
- **Focusing on the end-point:** Explicitly linking a programme to desired service improvements and what can be learned from them—thus, demonstrating an impact that benefits service users.
- **Real time, real work, real people:** Programmes would be co-designed in close collaboration with participating organisations and their current work effort and priorities, together with programme participants.
- **Explicitness about underlying values:** The values underlying the programme would be clear and shared. Participants would be encouraged to reflect upon their own value-set and ‘theory-in-use’ through critical reflection.
- **Addressing system-wide issues:** Sharing and comparing across professions, organisations and sectors would be a key element of such a programme. This would help leaders to understand and work across a whole system, rather than a localised part.
- **Embedding development with core business:** Programmes would be seen as vehicles for addressing key policy issues..
- **Embracing diversity:** Recognising that learning comes from understanding difference and so encouraging participants to ‘step into each others’ shoes’ both within and between organisations
- **Addressing sustainability:** Actively considering how gains in personal and system effectiveness can endure and extend beyond a programme’s duration.”

Lessons from Clinical Leadership Programmes

Please see the Case Studies in Section 2.

Successful Fellowship/ Clinical Leadership programmes are designed based on the principles proposed by Edmonstone (above) along with those of Swanwick and McKimm (2014) who summarize a set of principles for design of leadership development namely that they should be:



- **Practical:** through the incorporation of the development of key skills such as coaching, change management, and negotiation
- **Work oriented:** by including project work as a key component supported by action learning sets
- **Supportive of individual development:** through 360° feedback, coaching, and mentoring
- **Link theory to practice:** through the provision of selected leadership and management literature, relevant to the educational context
- **Build networks:** through action learning, coaching, and social networking.

Whilst it is possible to provide the 'structure' of any clinical leadership programme, this doesn't provide insight into the underlying pedagogy or organisation.

Effective Leadership Development Principles and Practices

Overall the evidence suggests that any Clinical Leadership Programme needs to include the following:

1. Adult learning methods in understanding distributed leadership, systems and how they work, power, approaches to quality, change management, collaborative decision-making. This means an inclusive, collaborative approach to learning events (workshops) with little didactic learning.
2. Skills development in working with diversity and conflict, negotiation, personal resilience, change practices for wicked and tame problems, inquiry, critical analysis, reflection, learning to live with uncertainty, and working with people and communities as assets.
3. Organisational application – a real piece of leadership change work where the clinical leader can practice their new knowledge and skills, and learn through doing and reflection, and peer review with colleagues in an action-learning approach.
4. Clear mentorship of the clinical leader in their own organisation as they learn to apply their new learning in practice, providing air cover for the clinical leader to experiment with new skills and practices.
5. Leading as peers – using the clinical leadership learning group as the case material for understanding how to work as clinical peers in a distributed leadership model.
6. Personal Leadership application – knowledge development supported in its application by coaching.
7. System mentorship to support ongoing careers and sustainability of the programme learning.
8. Opportunities to build networks for personal development and support beyond the programme, and in support of the organizational change effort they are leading.



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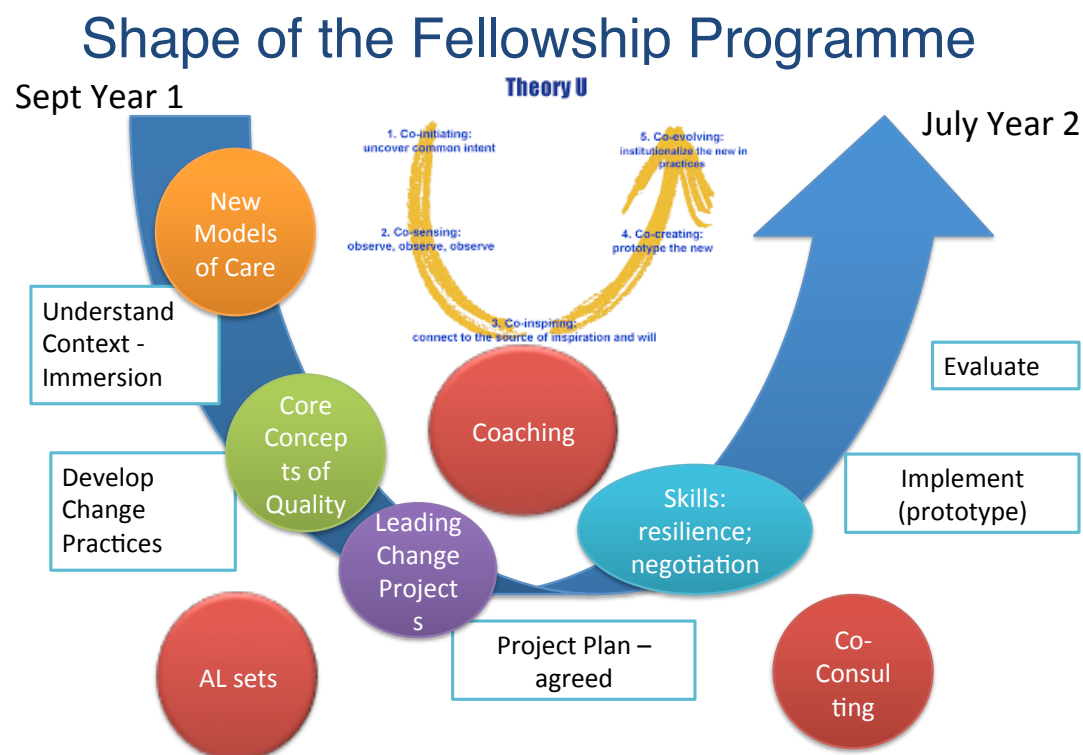
Section 2: Case Studies

Case Study 1: The London Darzi Fellowship Programme

The Darzi Fellowship is a case study in best practice for clinical leadership development.

The Fellowship is a 1-year Postgraduate Certificate combining leadership development, and organisational change. Fellows take a year out of training (doctors) or their clinical roles, working on a change project for an NHS organization. The programme was designed with an expert advisory group alongside Fellows from previous years, and is renewed annually. Each year is fully evaluated with Fellows showing significant progress in their ability to lead change, manage projects, work with citizens and communities, evaluate impact and collaborate across organisations.

The Fellowship intake varies annually from 1 to 3 cohorts of 25-28 Fellows, with half usually being medics. The fellows come from, and work in primary, secondary care and commissioning. The annual cost of the Leadership Programme is 10K per head.



The evaluation of the London Darzi Fellowship programme carried out by Stoll et al., (2010) describes the value of the fundamental relationship between workplace and programme learning, described in the following diagram:

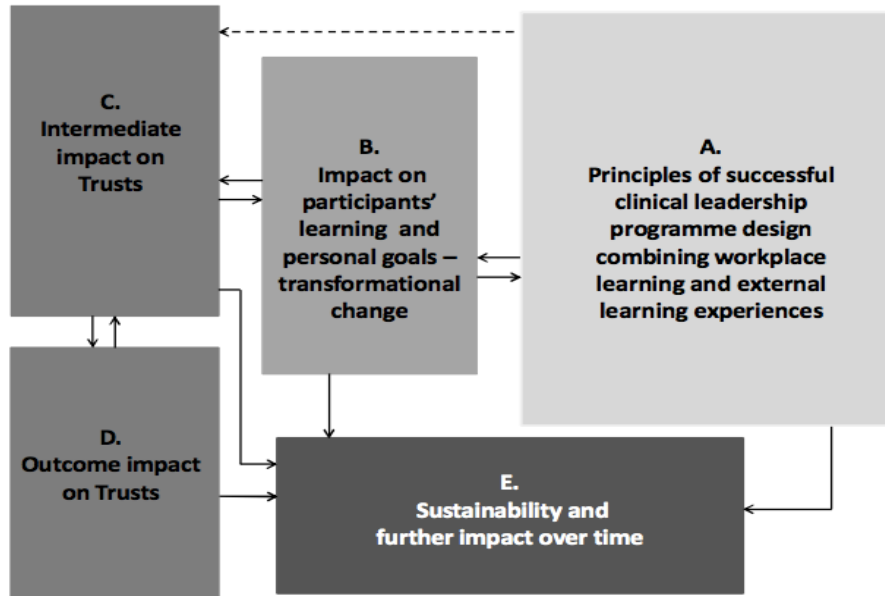


Figure 1: A model of successful programme design, impact and sustainability for clinical leadership development that combines workplace and external learning (Stoll et al., 2010: p67)

The report by Stoll and colleagues attributes the success of the programme (which at this stage was for doctors only) to:

- Committed and learning oriented MD
- Supportive Trust culture
- Working on ‘ambitious but appropriate’ live projects
- High quality mentoring
- Learning programme that targets transformational change
- Combining workplace and external learning
- Network of support – from formal to informal social learning

As the Fellowship developed into a clinical leadership programme, and the context in which the Fellowship operated change, the design of the fellowship was iterated, and the impact remained. Conn et al., (2016). In their survey of Darzi Fellows found 94% of their 90% survey return rate reported the programme as worthwhile. 85% felt more empowered to improve health care systems, particularly through developing collaborative clinical networks.

Overall a Longitudinal study of the Darzi fellowship (Mervyn & Malby 2017) demonstrates its effectiveness in securing clinical leadership who can contribute too and lead the Triple Aim - ensuring high quality healthcare, securing overall community health and managing costs.

Case Study 2. UCL Partners' Leadership development programme for emerging leaders in primary care

Preeti Sud, Head of Programmes, Population Health, Primary & Community Care, Sep 2018

This paper supplements the evidence submitted by Prof Becky Malby from LSBU on Clinical Leadership to the London Clinical Cabinet and presents one example of how the principles and practices highlighted in the evidence review are being used in practice across North Central and North East London boroughs. Since 2013, GPs have taken on clinical leadership role as commissioners in CCGs. To support new models of primary care development e.g. localities, networks; GPs and wider primary care staff are expected to undertake leadership roles with little or no prior leadership experience or support. Local CCGs in North Central and North East London identified this capability development need for primary care leaders that led to the development of this programme.

Leadership development programme for emerging leaders in primary care

Using clinical and academic expertise available within UCLPartners and through conversations with CCGs, local primary care network and national/regional leadership programmes, the following needs were identified for the primary care emerging leaders:

- Primary care leaders feel isolated
- Taking time out of busy clinical days to receive training is becoming more and more difficult
- Training/education should be delivered in bite-sized modules
- Need to develop self as well as understand how to work in new teams and structures especially 'system leadership' and
- A wider understanding of the current NHS environment is needed

Designing the leadership programme

Clinical and academic experts from the leadership area as well as primary care were brought together as an expert faculty group to support the design and development of this unique programme. This included:

- Professor Mike Roberts, Programme Director Education & Academic Lead Population Health at UCLPartners, Deputy Director North Thames CLAHRC, Professor of Medical Education for Clinical Practice at Queen Mary University of London, Assoc. Director CEEU Royal College of Physicians
- Professor Martin Marshall, Martin Marshall, Programme Director for Primary care at UCLPartners, Professor of Healthcare Improvement, Primary Care and Population Health at UCL and Vice Chair of Royal College of General Practitioners

- UCLPartners team involved in delivering mental health and cancer leadership programmes
- UCLPartners' innovation experts
- The Staff College: Leadership in Healthcare (Staff College) - an independent charity dedicated to developing healthcare leaders and helping them to deliver better outcomes. Their experienced and well-regarded faculty draws extensively from the NHS, military, business and education perspectives and experience, producing a rich collective wisdom on leadership.
- The Dartmouth Institute - the health services research and education centre at Dartmouth College, USA. They have contributed heavily to the US policy formulation which led to passage of the Affordable Care Act (ACA) in 2010. Key elements of the ACA shaped by Dartmouth research included emphasis on providers assuming accountability for quality and costs of services in Accountable Care Organisations (ACOs), and patients engaging in shared decisions and care management in Patient Centred Medical Homes (PCMHs) and other new care models at the frontlines of service. For more than a decade now, Dartmouth has been involved in bidirectional learning with NHS to bring learnings from US based accountable care systems to UK and take NHS based tools to US to accelerate learning for transformation and sustainability on both sides of the Atlantic.
- The Care City - an innovation test bed that brings health and social care organisations together to collaborate with researchers and the technology sector to pioneer and evaluate the use of novel combinations of interconnected devices such as wearable monitors, data analysis and ways of working to help patients stay well and monitor their conditions themselves at home.
- Coaching and Action Learning set expertise

This led to the final programme specifically designed for primary care, using primary care, population health and system leadership expertise that met the identified needs of emerging leaders. The design was iterative, and a robust evaluation was built into the programme delivery to capture the learning from and impact of this unique programme.

The programme:

The UCLPartners Leadership Development Programme for Emerging Leaders in Primary Care aims to equip staff in general practice with the skills and understanding they need to act as local leaders in the changing healthcare system. The programme is a carefully designed learning and development initiative specific to primary care emerging leaders. It is based on established peer-reviewed evidence and is delivered by some of the leaders in the field. The programme for each cohort lasts around 10 months and blends formal teaching modules with action learning sets and one-to-one coaching.

During 2017-18, 38 individuals from 6 CCGs in North East and North Central London participated in the programme. They attended cohorts of 10 to 15 participants each. Most of the group were GPs who had recently been appointed to leadership positions e.g. Network chairs or who were aspiring to apply for leadership posts in their borough. The cohorts, also included practice managers, federation managers,

practice nurses and CCG commissioners who were involved in primary care development.

To help maximise the learning from the programme and achieve immediate impacts in the local area, each participant agreed a project with their CCG that they could work on as part of the programme. Examples included work on social prescribing, workflow optimization to increase GP capacity and bringing the Atrial Fibrillation pathway into the community.

The programme was evaluated through a mix of participant feedback, independent evaluation by City University and an external accreditation assessment by the RCGP.

The evaluation results showed that participants met their overall development goals and gave positive feedback on the individual modules and coaching support. They also reported a wide range of things they would do differently as a result of being on the programme, including improved self-reflection, more effective interactions with their teams and greater investment in engaging patients in service improvement.

The City University evaluation found that those that seemed to benefit the most from the programme were individuals who have:

- been recently appointed in new roles or in positions of responsibility and who felt they lacked the skills and experience to carry out the new tasks required of them
- a supportive work environment which encouraged them in their learning.

The RCGP Assessor Panel undertaking the external validation stated “the programme presents an amazing opportunity for GPs” and would certainly justify the time to participate in.

Beyond these immediate evaluation results, the local population benefits from the outcomes of the individual improvement projects. The leadership participants from various cohorts continued to engage with each other as a primary care leadership community through informal networks using WhatsApp and have cited examples of supporting each other as a group. 16/17 participants in one leadership cohort have successfully applied and are working in a local leadership role.

For more information on the programme please contact: Preeti.sud@uclpartners.com