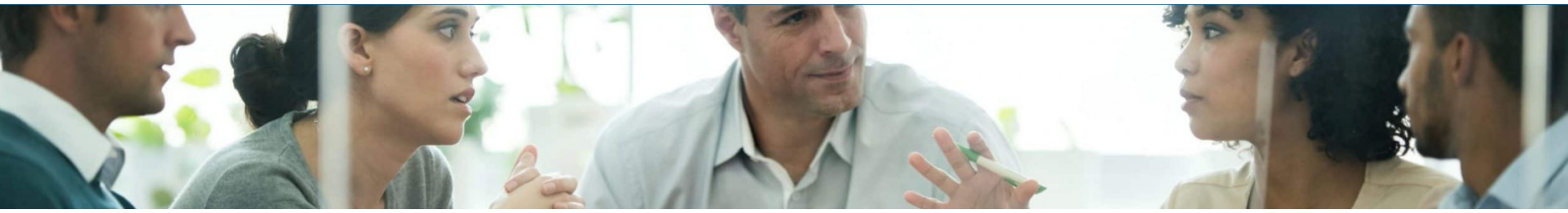
Insight

June 2020



This edition of PCC Insight is written at a time of significant change in the health service, face to face consultations in general practices have fallen significantly – we are hearing as low as 8% of consultations are face to face in some practices.

The speed of implementation of change due to less red tape – for example to enable sharing of patients records across providers have made a real impact to improve patient care and reduce risk, and reducing some functions not deemed essential at the present time – for example friends and family survey reporting has freed much needed capacity. Systems joining up to enable quick remote advice from consultants to GPs may have improved care and patient experience.

We know that some of these changes will not be sustainable, or indeed desirable, longer term, for example, where there will always be a place for on-line, video or phone consultations are these efficient in the long term, what is being missed and who isn't presenting who should? Is the new way of working right for the professionals – while some may prefer the remote consultation mode, others may now feel the essence of patient care and what they enjoyed has been taken out of traditional general practice.

Reflection across systems, recognition of achievements and agreement of the new way forward will be needed. Pathways have changed, some simply converted to the same pathway but digital, others may have stopped or removed steps. All these changes will need to be considered properly, the positives and negatives identified and what needs further transformation considered, at primary care network (PCN), place and integrated care system (ICS) level.

At PCC we have launched support to help practices and PCNs reflect and identify what they do want to keep and develop further, and this needs to be considered at place level and across ICS where appropriate. The practice, and PCN, is just the starting point. There is the opportunity now for transformation – doing different things, rather than reverting back to doing the same thing differently.

In this edition of PCC insight we include articles on teaming – where teams have been thrown together around a task, love based leadership, developing social prescribing models for the future, the strength and transferrable skills of primary care leaders in a crisis and other articles that I hope are useful too.

At PCC we are supporting PCNs, NHS England, CCGs and other clients remotely, not just by converting some of our face to face work to be managed using video conferencing technology, but we are also helping our customers hands on, where required. This has included contacting primary care professionals on behalf of commissioners, seconding members of our team to support other organisations for some of their time, and managing application processes on behalf of clients. We are providing business as usual, our helpdesk, adviser led support and facilitation for workshops and meetings (remotely of course), but we can and will do more. Do get in touch if we can help you.

Keep safe and we look forward to hearing from you. Contact us at enquiries@pcc-cic.org.uk

What's Love Got to do With It?

As humanity adapts to the post Covid-19 world, is it time to reflect on the balance of fear based as opposed to love based leadership approaches in the NHS?

The very mention of love in the context of our work will I am sure make some people uncomfortable, embarrassed or dismissive. But maybe it's time to accept that work is done by humans, 100% of the NHS workforce are human and a big part of our humanity is the need to connect, trust, communicate and feel part of something we believe in. There are huge opportunities to take the learning from recent events and the extraordinary acts of commitment and courage and build kinder, more inclusive primary care organisations in the NHS, where people can bring their whole selves to work and feel valued. Evidence shows this will improve wellbeing for staff and deliver better outcomes for patients and citizens.

Much of recent NHS management has been driven by a rational paradigm, with its roots in the concept of scientific management created over one hundred years ago. We focus on planning, return on investment and counting, and I have certainly lost count of the number of strategy documents and plans I wrote in my time in the NHS.

With this comes a strong culture of performance management around delivery; one that has undoubtedly led to improvements but also creates perverse incentives, encourages a focus on the short term and skews priorities. Research I did in 2011 also concluded that a low tolerance of mistakes rather than a learning culture exacerbates the negative effects.

Arguably this approach encourages fear based responses. A fear based culture is one where people don't feel heard, there is a culture of blame, secrecy, control or competition and the courageous conversations don't happen. We know from research on effective teams that fear based approaches do not deliver. Lencioni's model 'the five dysfunctions of teams' highlights this, with vulnerability based trust being seen as the foundation for effective team working.

So is our operating model outdated? Maybe much more relevant to the multi-faceted health and care system we operate in is the concept of complex adaptive systems and the fact that through human interaction and networks we achieve change and innovation. In these environments leadership is emergent and distributed and if we are brave enough to accept it, can pop up from unexpected places.

Rita Symons is an associate of PCC. She spent over 20 years in the NHS, ending her career as a CCG Accountable Officer. She is now a senior practitioner coach and leadership consultant, mainly still working in the NHS, including on national programmes such as the Nye Bevan programme. She is also currently the UK President of the European Coaching and Mentoring Council (EMCC).

Rita is currently leading the Becoming a team workshops for PCC.

So what does this mean for primary care and the implementation of Primary Care Networks (PCNs)? Primary care has undoubtedly made progress in breaking down boundaries between professional tribes, but there is still a long way to go if we want to achieve a distributed leadership model. It is reassuring to see offers such as coaching being made into the system and it remains imperative we pay attention to the human dynamic in PCNs as well as the structural and contractual factors. The Buurtzorg Model has been viewed with interest and adopted in parts in the UK as a solution to PCNs. This was developed originally to redesign care provided in neighbourhoods in the Netherlands.

One of their catchphrases is 'humanity over bureaucracy' and they create a culture where individuals in a team feel a high level of personal agency and control.

There are also lessons from wider sociological tools. Marshall Rosenburg in introducing the concept of 'non-violent communication' talks about moving from 'power over' to 'power with'. If we include activated patients in this, is there an appetite to move to a leadership model in our new primary care organisations where we encourage members of the team to truly lead with compassion and vulnerability?

The leaders of the future need to recognise that getting to know colleagues, accepting we are all imperfect, valuing diversity and taking time to communicate are important. They are not add-ons to the work of leadership: they are the work of leadership. This needs to be genuine and authentic. People can almost always tell if you are asking them how they are and you are not really interested in the answer. In addition, leaders need to be comfortable having difficult conversations and holding others to account. Leading with love is not about being soft and fluffy; it is about supporting individuals to take responsibility and fulfil their potential. And, it works.

Natural leaders in a crisis

By Helen Ellis

Much is written about leading in the time of Covid-19 and much is being achieved in these unprecedented times. Primary care leaders may feel they don't have all the relevant experience because this has quite simply never happened before.

What we do have in primary care though, are natural leaders who have the experience and expertise built on leading businesses, and can use their skills to:

- Have the ability to create 'new normal' out of rapid change, being fleet of foot and open to new ways of working
- Are adept at working through plan, do, study, act (PDSA) cycles, even if they don't realise it, and reflecting on how could we do things differently
- Remember to look after themselves so that they can be available to others
- Lead with empathy and compassion – real active listening to find and make connections
- Are skilled at tackling difficult conversations

These are leaders who have the emotional intelligence to make a difference, and after the crisis has past to make positive change stick.

We've seen leaders in primary care step up and engage with and involve their teams in a way which Dr Jonathan Leach, Joint Hon Secretary RCGP and PCC governing body member says is admirable. "There is no them and us, it's just us", and maintains that it's the way that you deal with people that will yield the results. Dr Leach goes on to say that "in a crisis we need to allow people to think about what the overall strategic intent is and then go on and make their own decision, rather than waiting to be told".

What leaders may need to brush up on are the less well-rehearsed elements, for instance:

- Managing abnormal bereavement
- Many primary care colleagues and teams are dealing with more personal and organisational bereavement than usual. Tap into local and national support resources and allowing the space to talk and process feelings.
- Maintaining their own personal resilience and that of their teams and communities.
  In the face of bad news and ever-changing guidance it's really important not to panic and to try to create a culture that avoids negativity
- Communicating – a lot and well
  There are so many mixed messages and no clear end date so it's important to keep talking, openly and honestly, whilst making good clear decisions and remaining flexible.

Remembering the notion of not missing the opportunity of a crisis, now is the time to take stock and look at what's been achieved and reflect on our leadership behaviours, learning and the gaps to address.

Helen Ellis
Head of development, PCC

PCC leadership training

The Covid-19 crisis has led to the emergence of new leaders across health and social care. At PCC we have listened to these leaders in designing our current programme offer. We have developed support that can be delivered virtually and welcome discussions with you to understand how best to meet your needs.

Contact us at: enquiries@pcc-cic.org.uk

Making an impact – social prescribing evolves to cope with rising demand

Enabling the development of social prescribing models to cope with the rising demand for community support; capitalising on emerging new roles to support primary care was at the heart of the new model recommended when PCC recently supported NHS Halton CCG .

We reviewed the existing social prescribing service and helped formulate a new model which would allow the incorporation of the requirements from the network contract DES and ensure the range of interventions supporting the Halton health system were aligned through a single vision for social prescribing.

Background

Primary care networks will be the base from which the Integrated Care System (ICS) is built, around both people and place. Significant importance is being placed around the expectations for ICS's, as illustrated by the significant investment by NHS England through the £43.5m commitment of recurrent funding.

NHS England's Long-Term Plan (NHS LTP) highlighted Social Prescribing as a key element in the prevention workstream, and the Network Contract DES for 2020/21 has stated its commitment for expanding social prescribing services across Primary Care Networks (PCNs), so, it is not surprising that Social Prescribing is one of six development support domains for PCNs.

Clearly the COVID19 pandemic has significantly impacted the health and social care system and primary care is no exception. General practices were forced to implement telephone triage at scale almost overnight, and there is now perhaps greater recognition of the importance of connectivity and coordination of support-based activities during this crisis and for the future.

What we did

PCC supported NHS Halton CCG and the two PCNs of Runcorn and Widnes in crystallising a social prescribing strategy to ensure the future service was accessible to all, and formulated a delivery model which met the particular needs of the population of Halton.

This comprised of a series of engagement events across the all the key stakeholders across Halton, to understand the developments that were taking place, what had been working well, and what the present challenges were. We used a combination of interviews, group interactions and workshops to ensure service users, commissioners, providers, general practitioners and practice staff had the opportunity to contribute.

Through building on existing policy and the ICS strategy together with interweaving the specification requirements from the DES, we developed a consensus for a future definition for social prescribing and a service model.

We completed our support providing a series of supporting documents around quality standards; link worker training programmes; service specification, together with recommendation for implementation.

Andrew Paterson
Associate, PCC

who led the work in Halton

https://www.england.nhs.uk/long-term-plan/

Future needs and opportunities

The review published in February by the Institute of Health Equity concluded that in England health is getting worse for people living in more deprived localities and regions, health inequalities are increasing and, for the population as a whole, health is declining. As a consequence, if we do not address this decline, the ambition of the NHS LTP may not be realised.

Through PCNs exploring opportunities to develop partnerships with Local Authorities/Councils and other local agencies, this could contribute to how the system can address some of the challenges faced by their local populations relating to the wider determinants of health, and close the gap in health inequalities.

PCNs have the opportunity to utilise the Additional Roles Reimbursement Scheme (ARRS) to fund any of the 'new roles' including the health and wellbeing coach and care coordinators. Both roles would logically fit as part of the social prescribing 'family'. Health coaches will focus their skills on helping those patients with low initial patient activation measure (PAM) scores or with complex or multiple issues. Care coordinators, given they are more junior in grade, will provide a more supportive function, focusing on patients likely to require more straightforward signposting to community groups.

PCNs may also wish to consider delivery models which allow link workers (and future roles) to work for the PCN collectively, as part of a social prescribing team, receiving referrals from each practice which undergo a triage

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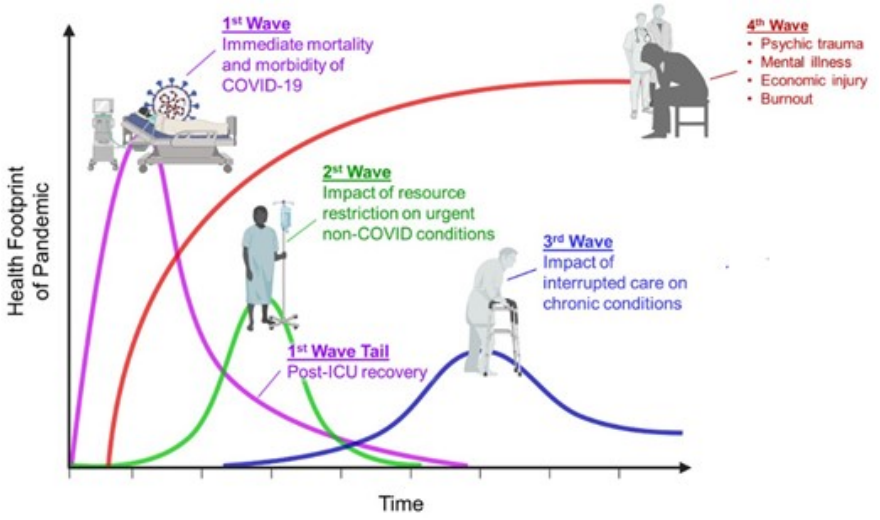
function to ascertain priority/urgency and the individuals 'need' and are then allocated to the appropriate team member.

Our health and social care systems have been forced to pause more routine activities and procedures, which will need to be addressed as the current pandemic begins to subside. However, we must also be mindful of the future implications from this pandemic; a potential 4th wave, which may result in a long-lasting legacy of patients suffering from mental health problems, anxiety, depression and loneliness. This is illustrated in the diagram - Potential Impact from the Covid 19 Pandemic:



In light of the Covid 19 pandemic, the importance of communities being, and remaining, well connected and looking at the roles such as link workers and community volunteers can play is vital. This includes roles to support individuals who are 'shielding' and individuals who are isolated or have difficulties with mobility. Social Prescribing can play an important part in enabling individuals and community health and wellbeing.

For more information or if your PCN, CCG or ICS would like support contact enquiries@pcc-cic.org.uk

Health Equity in England: The Marmot Review 10 Years On; Professor Sir Michael Marmot etal.

Victor Tseng, Pulmonary & Critical Care Physician, USA.

PCC Events

We are converting some of our workshops to be managed via webinars, MS Teams and Zoom, to name a few of the platforms we have been using. This is just a flavour of what is available. See www.pcc-cic.org.uk for the full range of support we can provide.

Virtual Confidence – a six module mini confident leader programme

This programme replicates some elements of our flagship face-to-face Confident programmes in particular focussing on group coaching and peer support. We will provide leadership development content that aligns to your current issues, for instance COVID related change at pace, personal and organisational resilience and stress management. The programme offers knowledge, information and resources as well as headspace to work things through and an important feature is the building of a sustainable network that forms ongoing support.

Taking control of stress – building your resilience

Most of us will suffer work-related stress, especially at the current time – and the problem is most acute for public sector staff, particularly those in the NHS. This live online training session on 16 and 23 July will show you how to understand the things that cause you stress ("stressors") and how to become more stress-resistant. You may not be able to avoid all the causes of stress, but you can become better at recognising them and at building up your reserves of resilience to mitigate the effects of stress. The training will be delivered via four 60 minute webinars and delegates will need to take part in all four sessions.

Time to reflect

The Covid-19 crisis has accelerated the transformation of care, with pressures on workforce driving practices to work together, with other partners and in different ways. The need to manage who comes through the front door has meant forcing the digital revolution earlier than many practices may have anticipated. Practices are now using video consultations, on-line consultations and effective triage, and it is likely many practices will retain some of the new ways of working when the peak has passed.

Leaders have emerged – there is a clear shared purpose, with the leaders able to direct activities and efforts towards some shared goals and the vision of operating in the best way that is possible for patients in the midst of the crisis. Some of the old power of hierarchies have left – and new power focused on networking with other professionals and working with the community has emerged.

When you consider change, one of the essential elements is a call to action – and there could not have been a stronger call to action than Covid-19.

So what will stay and what will go? In the months that follow, there will be increased pressures on primary care, as they play catch up with those patients who should have accessed services and couldn't, those who needed secondary care and couldn't access the support needed, who now need primary care to pick up the pieces.

For PCNs there needs to be time to reflect and consider:

- Where are we now
- What has worked well
- What do we want to keep doing that we have now started
- What have we learnt

We should be thinking now about which changes we have implemented will help and support us best in the future. Things to consider include:

Can we deploy some of the digital solutions to help us best manage support to care homes longer term?

How can we continue to support secondary care going forward?

What have we learnt about digital solutions that in the longer term will enable redesign of out-patients processes?

Not to mention considering the bigger questions about how do we now work with the integrated care system (ICS) to ensure that the funding will flow to enable primary care driven innovation to continue. With the investment and impact fund there is an opportunity – if primary care can continue to lead the transformation of services. It's time to share learning with other ICS partners and ensure the primary care contribution is properly recognised.

So after spending some time reflecting, PCNs should now consider:

- What is our vision going forward
- What are our priorities
- How can we break this down into population groups to be served
- For each group, who are the right partners to work with
- How do we build on our successes and now take forward the delivery services for these patients
- What services can be better delivered on a network (or cross network) basis,
- What have we learnt and how do we use this learning to improve these services,
- How do we involve patients in these discussions
- How can we ensure sustainable financing models and appropriate governance for these services

PCNs and practices have adapted well to rapid change, embracing new models of care and they can now build on this to enable the greater provision of proactive, personalised, co-ordinated and more integrated health and social care for their patients. But the first step should be to reflect on the response to Covid-19 and build on what has been achieved, making sure contributions and successes have been recognised.

For facilitation support for your PCN or practice to reflect, learn and start to map the way forward contact enquiries@pcc-cic.org.uk

Helen Northall
Chief Executive, PCC

Covid-19 impact assessment and action planning support

During the Covid-19 crisis, all practices and PCNs will have implemented or experienced a number of changes PCC has developed a three step process which includes an impact assessment to help PCNs understand the effect that Covid-19 has had on work. For details contact enquiries@pcc-cic.org.uk

Communities come together in Rugby to support key workers

COVID-19 has proved to be a challenge across the country since March, but as we begin to emerge from the often desperate times of the past months, stories of how communities have pulled together have emerged to point to a potentially brighter future. One such story is that of Rugby Primary Care Network PPE Project - a collective of local people with 3D printers who started using their printers to manufacture face visors for use by those working in health and social care settings.

The initiative was started by Jo Thomas, a Higher Level Teaching Assistant at Bilton Church of England Junior School who received a link to the PRUSA website. PRUSA is a company who have developed a design for 3D printed face shields for medics and professionals and made it open-source – i.e. free to all. Through Kellie Preece, Practice Manager at Westside Medical Centre, Rugby, Jo was put in contact with Dr Keith Edgar a recently retired GP who had answered the call to return to the front line and is working as a locum GP at the practice. Keith immediately saw the benefit of Jo's idea and, supported by Willy Goldschmidt, Chairman of the Friends of St Cross Hospital, and Peter Maddock, a former Rugby PCT Chief Executive all of whom are members of the Rugby Health and Care Improvement Forum (RHCIF), set about ensuring the face visors could be made available across the local health and care community.

The Trustees of the Friends of St Cross agreed to support this initiative by buying the raw materials for the production of the face visors and also enlisting volunteer drivers to collect and distribute the visors. Other individuals and community groups also got involved as the need to increase production became apparent using their own 3-D printers to print visors. They include Coventry University School of Engineering, the Monks Kirkby and Dunchurch Collectives, DDS Concept and Prototype Ltd and Aston Martin.

By the beginning of May, Rugby Primary Care Network PPE Project had made and distributed 6,103 face visors to over 70 organisations both inside their local area but also outside, including nursing homes, Myton Hospice, the phlebotomy department at St Cross, the orthopaedic theatres at Leicester General Hospital, Kettering Paediatric Wards, a number of foodbanks and nursing homes supported by St Andrews Church Coventry. A substantial number of care providers are also supported through the supply of visors to Warwickshire Country Council.

With demand for the visors continuing to rise, the network will continue to provide to those who need them but has now identified the need for scrubs and scrub bags which they plan to begin distributing by mid-May.

This initiative has genuinely been about a community supporting each other, and the team hope that it may be a catalyst for change. As Peter Maddock says "We want it to be recognised that our key workers are so important to us, and that we can all do more to support them in the way we relate to them and value them. We hope that what we have done in Rugby will be something that continues in the future and not just a moment in time."

Teaming – a more dynamic way to work

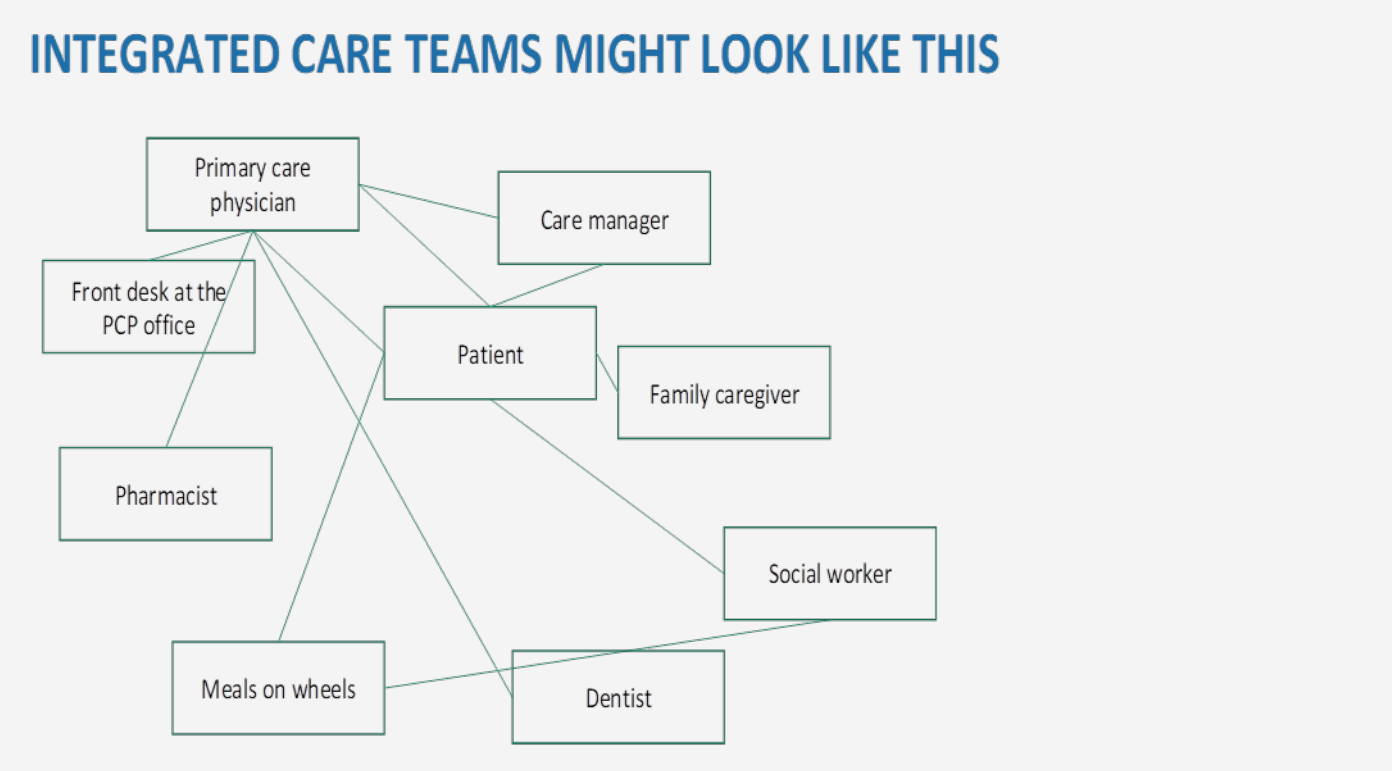
by Barbara Dingley

When you think about a team you probably think about a carefully designed, static group of individuals who are often based in the same building and have time to interact successfully and efficiently. They know each other, their individuals' skills, strengths and weaknesses and are interdependent in achieving a shared goal.

Amy Edmondson, a lecturer at Harvard Business School, has developed the concept of teaming, as a verb, to describe teamwork on the fly. Amy describes teaming as the coordination and communication of people, often across disciplinary boundaries, to get interdependent work done.

This is the way more and more of us have to work today, for example general practice is now having to work across systems within their ICS/STP to provide patient care with new people and do not have the luxury of a stable team environment.

A typical example of teaming is a patient who goes to the A&E department at their local hospital. The hospital is a 24/7 operation, with people working across multiple different shifts, in different specialities who come together to take care of the patient. Often these people won't know each other or have worked together before. They have to work together quickly to support the patient to recover and go home. Once the patient goes home there may be a requirement for community teams to work together and provide care. Again these individuals in the community may not know each other or usually work together.



There are challenges to teaming, including:

- diversity of the groups working together with different values, jargon and expertise so they don't always see eye to eye
- where are people geographically placed, can they meet up to discuss care packages or are they reliant on other forms of communication
- not knowing each other
- each case being unique
- the uncertainty of duration of working arrangements and timescales.

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Teaming will be when work is, or patients needs are complex and unpredictable and there are many advantages, allowing people to:

- learn from each other and gain a broader perspective of each other businesses
- gain an insight into other teams cultures which they may want to adopt
- have the ability to network across a geographical area which may introduce opportunities for new ways of working to be adopted in other projects
- further increase their interpersonal skills.

We discuss this new way of working as part of our leadership programmes. We give delegates the tools to determine how they can turn a group of strangers into a team and develop their leadership skills and capabilities.

At this time of uncertainty during the Covid 19 outbreak teams brought together may choose to adopt teaming. Edmondson explains that teaming is not a design choice it is simply a necessity for certain kinds of work and it takes leadership to:

- surface and understand different views
- analyse and generate new and nuanced options
- examine implications systematically
- make decisions and move forward

To find out more contact enquiries@pcc-cic.org.uk

Barbara Dingley

Director of operations , PCC

PCC welcomes your news for future editions of PCC Insight—if you have something to share or would like to contribute an article please let us know enquiries@pcc-cic.org.uk