GP Clinical Leadership Fellows.
Context, Impact and Recommendations.
2009/10

Our Future Clinical Leaders in Our NHS
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Clinical Leadership Fellows 2009/10

- Create clinical leaders, reflective practitioners, change agents, and lifelong learners.
- Put the GP voice into DoH strategic planning process.
- Put patient voice into medical education.
- Deliver significantly improved quality, significantly improved productivity, significantly improved health by:
  - Improving the quality and safety of services.
  - Improving access to these services.
  - Improving health and well-being.
  - Improving education
Leadership – *enabling culture change*
Clinical Leadership Fellows (Senior Registrars). Changing thinking and focusing on patients in need. Similar model to NESC Practice Leaders Programme.

**Education** – *supporting patient centred leadership education*
Leadership education for GP Trainees, Lead or be led.

**Investment and Recognition** – *rewarding improvement*
e.g. Valuing the GP voice, publications, leadership posts

**Partnerships** – *enabling breakthrough*
e.g. Social Care, DoH, create innovation opportunities
Ten years of innovation, engagement, improvement.

More than 100 Clinical GP leaders.

Tangible Improvements with national and local recognition.
Framework: Patient Centred Education in Complex Systems

**Whole System**

- Service Improvement Models (PDSA)
- NHS Systems and Strategy
- Darzi Pathways /Analysis of Systems

**Whole Self**

- Medical Leadership Competency Framework
- Neuro linguistic Programming (insight)
- Personal Success Criteria

**Whole Patient**

- Patient Centred Education
- Patient Centred Projects
- Narrative Based Research

**Health Quality Productivity**

- Understanding duality. Patient & doctor views of health & wellbeing

Project design includes system impact and personal effectiveness

Case Study using Carers Strategy. DoH, Carer, GP.
Working together

Oxford Deanery Leadership Fellows Programme and Department of Health in the South East (DHSE)
Working together-outcomes for DHSE

- Clinical engagement
- Promoting whole system working
- Primary care clinical voice in DHSE work programmes and projects
- Programmes and projects delivered with GP contribution evident
- “Tested” with primary care
- Project on differential diagnosis rates in dementia
Working together - outcomes for delivery

• Create informed clinical leaders of the future

• Knowledge of recent policy developments, e.g. Carers and personalisation session

• Making links across primary care and social care to benefit patient care

• Attendance at policy into practice events, e.g. National Dementia Strategy Implementation Reference group
Clinical Leadership Fellows Presentations
• Improving Access to Psychological Services (IAPTS)
• West Berkshire and South Central SHA
• 280 million GP consultations per year – 30% related to mental health issues

• Evidence that depression and anxiety is common and increases health service demands & costs

• CBT most effective means for treating anxiety and depression (NICE Guidance October 2009)
Personal Impact

- Increasing referral rates:
  - 208 referrals 01-06/2009, 1208 10-12/2009 (x14.5 fold increase)
  - 22/30 practices referring (01-06/2009), 30/30 referring 10-12/2009

- Negotiating clinical space for therapists in general practice

- Evaluating PCT RISC system to identify that LTC and depression co-exist (426/20,232 patients, 2.2%)

- Creation of NICE based template (working with industry)
Recommendations

• Focus on core principles of services depression and anxiety treatments availability & establish reputation.

• Easing the referral process from health professionals & smoothing communication stream.

• Working with dynamic ways to increase community presence and accessibility.
Recommendations (2)

• Design:
  – development of self-referral to ease access.
  – specialist groups (LTC).

• Process:
  – evaluating efficacy of CBT interventions.

• Quality:
  – development patient satisfaction,
  – handling clientele risk appropriately.
• NHS Health Checks
• Buckinghamshire
• National Screening Programme to prevent heart disease, stroke, diabetes and kidney disease.
• Everyone aged 40-75 has 5 yearly check
• NHS Buckinghamshire has set up programme of delivery in deprived GP surgeries and is piloting pharmacy delivery and community delivery.
Personal Impact

- Option appraisal to find cost effective solution
- Working with GP’s to get involvement
- Setting up new lifestyle interventions to offer patients
- Evaluating uptake
- Setting up pharmacy pilot and community pilot
- Working on IT solution to collect data needed
- Training programme for nurses/HCAs
Recommendations

• Real chance to encourage change in patients and prevent chronic conditions.
• Real chance to prioritise prevention in GP surgeries.
  – More emphasis from PCT’s on lifestyle interventions.
  – More emphasis from PCT’s to engage with GP practices and get out there to deliver the messages.
• Reducing Health Inequalities in Diabetes Care
• Buckinghamshire
Context

• World Class Commissioning and PCT priority
• Bucks PCT: Poor outcomes despite high costs
• Marked variations between practices:
  – Prevalence
  – Optimal outcomes
  – Cost-effectiveness
  – Emergency admissions
Personal Impact

• Established and shared good practice
• Empowered GPs to reduce variations between practices:
  – Piloted new patient pathway
  – Targeted screening to find the missing thousands
  – Efficient use of resources and referrals
  – Tailored support
Recommendations

• Implementation across Bucks:
  – Targeted screening
  – Patient pathway for prediabetics and new diabetics
  – Patient Structured Education for BME groups
• Atrial Fibrillation (AF)
• Buckinghamshire
• AF major cause of stroke but significant improvements can be made in diagnosis and management
• Prevalence 0.3-2.4% Bucks (1-1.3% Nat’l)
• National Stroke Strategy – quality marker 2 - managing risk
Impact

• Increase detection AF – opportunistic screening

• Eliminate barriers to warfarin prescribing
  – identify pt in need (GRASP) and treat
  – ensure future patients get appropriate management
• Currently in planning stage
• Recommendations likely to include
  – Establish joint working with cardiology, haematology and general practice
  – Enthuse and educate GPs to bring about system change
• Dementia Training Needs and Provision
• Oxfordshire and DoH
National Dementia Strategy 2009

• Objective 13: Scoping of training in dementia
• Objective 2: Development of early diagnosis
Personal Impact

- Documenting training available
- Survey of training using competencies
- Increase awareness of importance of early diagnosis in primary care
Recommendations

- Wide variety of training
- Gaps in training currently
- Primary care vital if we are to improve rates of diagnosis so no-one is left alone to manage their care.
• Needs assessment of how people with Learning Disabilities currently access End of Life Care

• East Berkshire
Context 1

• 10,000 population with LD in whole of South Central - 10% of these within East Berkshire
  (1.4 million national population with learning disabilities, estimated to increase)

 • Healthcare services for people with LD key priority for 2009-2012:
   a) 'Healthcare for all' an independent inquiry by Sir Jonathan Michael following ‘Six Lives’ & ‘Death by indifference’ report
   b) Recommendations by Sir David Nicholson June 2008 to all NHS & SHA to ensure services make reasonable adjustments for people with LD
   c) Valuing People Now- Jan 2009, reduce inequalities & commissioning of services
   d) Health action planning & health facilitation for people with LD- good practice guide
• EOLC provision key local priority (Berkshire PCT) for 2009
  
a) *Lord Darzi NHS Next stage review - 2008*
  
b) *National Strategy for end of life care - 2008*
  
c) *National Sir Roger Bannister Summit* (King’s Fund Nov 2009) to discuss 10 key steps to implement EOLC strategy

- Profile & incidence of cancers different in people with LD
- Overcome barriers to access appropriate preventative/EOLC- e.g. communication, challenging behaviours, diagnostic overshadowing using tools e.g. DISDAT
- Patients having greater choice & control over their lives (*Ambition 6 & 8-10*)
Impact

• How to identify patients with Learning Disability/difficulty- (White Paper 2001 definition, British Psychological Society 2001 recommends using WAIS-III UK to determine IQ and need to assess social function)

• What is the current network of services in East Berkshire, for people with LD - LD Team including CTPLD, Psychologists, Dieticians, Nurses, etc. Not present in all areas, and expertise of team members varies (please see project for further details).

• Process of how people with LD currently access end of life care in East Berkshire- Difficult to assess, lack of data. Bracknell the exception as have good database & GPs work closely with CTPLD to ensure appropriate access of people with LD to all areas of NHS.
Recommendations

• Need for a comprehensive central database/register of people with LD, including diagnosis of chronic disease and cancer (Ambition 12)
• Future audit/survey to evaluate how effective the current system is
• Data from annual health checks (in place since 2007) useful to predict future commissioning of services re: EOLC for population with LD
• Ensure high standard of care across South Central (Commitment 5 & 6)
The Next Steps……

• Project the vision of my project-liaise with Dr Mark Roland, EOLC Clinical Director South Central SHA
• Create future leadership fellow project to take this work forward, working with Dr Matthew Stephenson, LD Consultant Ridgeway Partnership
• The key to future change is having data—who are the people with learning disabilities? Who can create & maintain a central database for south central SHA?...

THANK YOU FOR LISTENING!
• Black and Minority Ethnic (BME) health: local partnership building and the GP voice.
• Oxfordshire and beyond
• Importance of topic: legislative and policy framework.
• Scoping and defining the problem:-
  – The essence of ethnicity.
  – Language and communication.
  – Partnership building and trust.

“‘Normal’ people find it difficult to talk to GPs”
[professional from Social Care].
Partnership building at many different levels:

1. **Strategic**
   - County Council: Joint Adult Social Care Equality Assessment.
   - Strategic Equality Leads Group.
   - Consultation with SDM (joint commissioning) at OBMH.

2. **Grass roots**

3. **Education**
   - Disseminating knowledge: web-based translation tool.
Recommendations

1. Maximise human resources.
   - Support development of GP leaders with expertise in BME communities.
   - BME expert patients.

2. A robust information databank.

3. A cross-agency forum for communication.

Thank you.
• Obesity
• Oxfordshire 2008/9
In 2002 the proportion of men and women classified as either overweight or obese was 65.4% and 56.5% respectively.

The number of obese individuals in England has tripled since the 1980s.

Nearly one in four people in the UK are obese.

Reduces life expectancy by an average of 9 years.

NICE advise specialist obesity assessment pre surgery – This could be implemented locally.

In Oct/Nov 2008 the SHA produced a market roadmap for the PCT and Obesity treatment was identified as a priority area.
Personal Impact

• To establish a care pathway for morbidly obese patients – BMI>40

• Pilot intervention in the form of a multidisciplinary team clinic, audit the outcomes

• Appraisal of options to find cost effective solution

• Developed service outline and specification with PCT

• Working with local GPs to develop local service as currently not available
• Commissioning of MDT service

• Currently service has been through procurement and at contract stage.

• Joint working with PCTs & GPs to improve local services and involvement in projects to improve patient outcomes
Medical Education Initiatives

- Foundation Training
- GP Training
- Secondary Care Perceptions of Hospital Training
• Foundation Training in General Practice
• GP Training
• East Berkshire
• Modernising Medical Careers – introduction of Foundation Training programme

• Aspiring to Excellence – Tooke Report 2008

• Changing population, changing training
Development and Impact

• Project:
  – “Education and training will focus on the future needs of the service to ensure a suitably flexible and skilled workforce is available to support the new ways of working. We will link the training and development investment of the NHS in South Central to this vision.”
  “Towards a Healthier Future” SHA South Central Commitment 6

• Self

• Patient care
Recommendations

• Patient centred consulting
  – SHA south central “Towards a Healthier Future” ambitions 3,6,8

• Chronic and common disease prevention and management
  – SHA south central “Towards a Healthier Future” – long term conditions, caring for people in their own homes, ambitions 1,2

• Governance and audit

• Link with national review on Foundation training
• Across Oxfordshire
• Department of Primary Care Oxford University
• NHS Next Stage Review – ‘Our NHS, Our Future’

• New GP licensing examination introduced August 2007 (nMRCGP)

• ‘Aspiring to Excellence’, Tooke, 2008
Personal Impact

• System. Why do people fail exams?

• Person. Improve care, teaching, resources, research

• Self. Experience and skills
Progress

• Next 6 months. Transfer knowledge to next training group, publish.

• Future links. Dept Primary Care and Deaneries.

• Future roles. Trainee Representative on Revalidation Board.
• Evaluating the Experience of Junior Doctors in the NHS
• Across Trusts in South Central
• Pilot study to assess junior doctors understanding of:
  – current organisational structures in the NHS
  – Their value to the NHS
  – How we might improve our awareness and involvement in organisational issues
Impact

- Questionnaire findings: trainees feel undervalued but all have ideas for change
- Teaching outcomes: gave a forum to share ideas, suggest improvements
- Applying both outcomes to bring about change
Recommendations

• Expanding the project across South Central SHA by online survey
• Developing a quality improvement intervention in relation to outcomes
• Integrate findings with undergraduate and postgraduate training programmes
Leadership Fellows

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in an improvement?

ACT

PLAN

STUDY

DO
What Impact?

• Aim
  Grow Primary Care Leaders to Create Culture Change to Improve Patient Care.

• Framework
  Evidence Based, Outcome Based, Complex, Person Centred Medical Education.

• Method
  Whole System, Whole Person, Whole Self. Learning Sets and context specific learning.
Measures

• Individual.
  – Strong goals, improved leadership competencies.
  – Service improvement plans, project reports.
  – Professional behaviours, national and local leadership roles.

• Organisational.
  – Improved workplace learning culture and practise.
  – Clinical engagement.
  – Effective partnership working.
  – Prioritised patient perspectives in professional education.
  – Transformed social practice (transformative learning, transformative leadership).
Outcomes

• Created Clinical Leaders (local and national experts)
• Raised the Quality and Performance of Services
• Changed the way that we deliver care to address the rising demand for services in Primary Care.
• Developed new Partnerships with Patients, DoH and communities to improve quality by including
  – The patients’ voice in medical education
  – The clinicians’ voice in national policy
  – The newly qualified GPs voice in PCT priorities
  – Prevention and well being in clinical decision making
  – Leadership in the GP curriculum

• **Recommendations**
• Six more GP Leadership fellows in 2011
• Create partnership with SHA programmes and Darzi Clinical Leads