



## ***‘Reading the Compass’***

a report of a workshop event held on the 14<sup>th</sup> March in Leeds  
on the leadership needs of the allied health professions

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# ***‘Reading the Compass’***

satisfying the leadership needs of the allied health professionals

## **Introduction**

The idea behind this exploratory event was to allow a small group of key players from the world of AHPs to step back from their day to day concerns and spend some focussed time and energy on the future. We drew on the wide range of experience and judgement in the room to map out the environment in which AHPs will be operating in the future, to consider what direction the professions should be taking and to think about how we get the right leadership for the journey. The programme was highly participative, was certainly good fun and hopefully will be influential in the way we both find and develop AHP leaders in the future.

## **Section 1: The Future Operating Context for AHPs**

We asked sub- groups to consider the forces and drivers at work in ## key areas and then to consider their likely impact on health and social care services taking a five year horizon. This gave us the starting point for our subsequent analysis.

### The Provider Side

- NHS is going to look very different in five years. We would see a mix of Foundation Trusts (which would have greater autonomy from the Centre), private sector, social enterprise and third sector organizations. PCTs would manage no provider services. There would be continued out-sourcing of local authority services.
- Primary care ‘companies’ will emerge as providers of a wide range of community based services – these may be run by GP practice collaboratives.
- There will have been a consolidation of acute providers as Monitor’s FT assessment process identifies unsustainable Trusts that are then merged into larger and better managed FTs.
- Lord Darzi’s drive to move services out of hospitals will have succeeded so that many more services will be provided in community settings or at home. This will mean that providers will be less ‘building’ and more ‘service’ focussed.
- There will be new providers that have exploited informatics and telemedicine technology to supervise patients and staff remotely – thus enabling the level of home based care to grow.

- In order to support better service integration services would increasingly be provided not by single organizations but by extended multi-organizational supply chains often involving providers from different sectors. This will cause difficulties about legal responsibilities and clinical governance as well as requiring complicated legal and financial arrangements along the chain. The role of lead contractor will be critical. Which organization takes this lead role will depend on local provider strengths and commissioner preferences.
- Providers will work in a competitive climate and this will promote a much stronger focus on cost reduction – particularly in relation to staff and buildings. This in turn will make all providers much more innovative and eager to change if there are *demonstrable* business benefits.
- Providers will all be much more ‘business minded’ in the way they plan for and provide services. This will apply particularly to the way they staff services and utilise their (expensive) trained workforce and in the measurement of outcomes.

### Commissioning

- The World Class Commissioning movement will drive up the quality and strength of PCT commissioning – PCTs will develop much greater analytical power and be more business ‘savvy’ when it comes to dealing with the market.
- PCTs will become much more ‘impartial’ with regard to commissioning for the needs of their community being their overriding concern and will therefore become much less protective of ‘home’ providers.
- They will have available much better information about demographic change and health needs on a much more local geographical scale and be better informed about deprivation and inequalities.
- There will be a much better use of evidence in the commissioning of services – gaps in evidence will create the need for research to identify best practice
- Commissioners will learn from better evidence about how the high costs of pharmaceuticals and periods of intensive acute care can be avoided by good AHP interventions and better care management.
- There will be much greater contestability in the system with PCTs having to consider ‘any willing provider’ as long as they satisfy the CQC registration requirements.
- The further development of PBC remains in the balance especially if GP collaborative develop as providers of a wider range of community services.
- There are a number of factors which will make service users much more influential – personalised budgets, micro commissioning, direct payments, self referral and the extension of patient choice – among them as well as PCT being much more sensitive to public satisfaction with services.

- Service users – through individual research and through the work of patient interest groups - will become much more knowledgeable about their conditions and best practice and therefore much more demanding in explicit ways. This will be especially true of those with long term conditions.
- There will need to be new relationships formed between health and social care with regard to stronger integration of commissioning and in the way services are funded.
- PCTs will try to commission integrated 'pathways' rather than services from individual providers – which in turn will force providers into formal supply chains and make the care management and pathway design functions much more significant than they are now.
- Commissioners may move to capitation budgets either for care groups (particularly those with long term conditions) or for whole sub-populations through extending the responsibilities of PCB collaboratives. The effect of either will be to increase the importance of active care management.

## Service Design

- We will experience a rapid shift of services out of acute hospitals and into a much more diverse range of settings in community settings – smaller hospitals and something akin to the polyclinic idea will become more common settings for patients to receive quite complex diagnosis and treatment. This trend will accelerate with the increased use and acceptance of mobile 'visiting hospitals'.
- This may stimulate a reversal of fortunes for Community Hospitals which are often in the right place but need a more appropriate care model that can provide people in small towns access to acute diagnostic and treatment services.
- The acute care that remains in big hospitals will become increasingly specialised.
- At the same time there will be much more emphasis on caring for people at home – partly because of better care management and partly because of the adoption of reliable remote technology to supervise both patients and staff.
- Being cared for at or near home will become the 'default position' rather than hospital.
- In addition we will see care provided outside of conventional health settings like sports centres, libraries, schools, shopping malls and workplaces – indeed at any place where it is more convenient for patients to access their care.
- We will see the end of outpatients as we know it –with a shift to diagnostic-backed – patient assessments made in more local settings.
- We may also see the adoption of 'consultation from home' as smart telemedicine and better phone and internet links change the quality of information that can be exchanged remotely between clinician and patient/client.

- This shift to mobile services and remote technology will be championed in sparsely populated rural areas.
- Services will increasingly be commissioned to include elements of prevention and health maintenance and promotion.
- The 'services' that will be commissioned – particularly for long term conditions – will have the active management of patients at the core rather than just the delivery of discrete therapies and treatments.

## The Policy Environment

- The short term policy horizon will be dominated by Lord Ara Darzi's work on 'out of hospital' care – encapsulated in the idea of 'polyclinics' with high levels of anticipation about his forthcoming report.
- The existence of a regulated market for healthcare will be retained and strengthened both in terms of competition *IN* a market (patient choice) and competition *FOR* a market (contestability). PCTs will have to respond fairly to 'any willing provider' and there will be much greater SHA performance management of PCTs to prevent uncompetitive behaviour.
- There will be a constant drive to make the health system progressively more consumer driven. This will involve an increasing availability of information about service availability and quality to support the move to 'free choice' of provider.
- Users with long term conditions will be encouraged to have greater control over their care.
- There will be policy initiatives that are designed to overcome a perceived 'democratic deficit' – perhaps by changing the governance of commissioners but certainly making sure they are more formally aware of public preferences and levels of satisfaction.
- The Wanless argument about health improvement will return onto the agenda as the impact of public health trends such as obesity become clearer and become part of the public's consciousness.
- This will prompt initiatives that are designed to integrate the policies of DWP, Social Care, the NHS and education in the pursuit of population health and welfare
- There will be a liberalisation of education and training for health workers – with the old relationships between the Government and education providers becoming obsolete.
- European policy on free movement of labour, capital and services may become more apparent in the UK's health system – especially in relation to competition and the registration of professionals. There may also be an explicit declaration on the rights of European citizens in relation to health care.

## Regulation

- In general there will be a strengthening of regulation across the system.

- Monitor will extend its regulatory reach to look at non-financial (clinical) risks and also to how closely FTs' plans are sensitive and aligned to commissioning intentions and public need.
- The CQC's role in the registration of providers will challenge the system – especially new entrants and the smaller providers.
- Commissioners will become more explicit about what they expect from providers in terms of competencies and in terms of general governance arrangements.
- Provider organizations will have to develop stronger internal governance arrangements in relation to HR practice (e.g. appraisal and CPD) and the competence of professionals and other staff providing direct services to patients. This will become more important as providers innovate in the design of the workforce and as skill-mix changes produce jobs that fall outside conventional professional boundaries.
- Providers will also have to develop clearer definitions of standards and measures of quality as part of their routine performance monitoring.
- These increasing regulatory demands may prove difficult for smaller providers (such as collaborative of professionals) and individual practitioners to satisfy.
- The higher level of regulation of professionals (e.g. HPC) will have to meet several new challenges – there may well be new professions emerging and older professional competencies will be reshaped. Especially important here will be the need for care management competencies for professional staff (especially those able to refer independently of doctors) and the appropriate regulation of 'assistant' practitioners and semi-professionals.
- They will also have to cope with the migration of professionals across Europe and be able to assure the public that professionals from other countries and other systems of care delivery are safe to work in the UK system
- The increased likelihood of 'pathway commissioning' and the increase in multi-provider supply chains (see above under the *Provider Side* section) will cause difficulties for regulators. Both Monitor and the CQC 'look' down the system at organizational units and do not have a view that runs horizontally across provider chains. The role of the lead contractor and the kind of competencies they will require will have to be thought through.

## Clinical Practice

- There will be changes to both 'how' we treat and 'who' we treat.
- We can expect a sharper division between the informed consumer - able to understand and actively exploit the system - and the uninformed and vulnerable consumer.
- The system will cope well with diagnostic and acute clinical services and the challenge for the health and social care system will be looking after the increasing numbers of those with long term conditions.

- AHPs can expect there to be much more emphasis on looking after these latter types of people. Not only are there more of them but AHPs have a unique position in the system – an ability to work across organizational and sector boundaries and to integrate care and services for the benefit of patients. The shift of services to home and community settings will also strengthen this trend.
- AHP professionals will probably see the emphasis within their clinical lives shift towards:
  - the management of patients and their care,
  - the safe integration of providers involved in complex clinical pathways
  - the management or supervision of a widening range of sub-professionals and assistants
- AHP professionals will also see others' expectations of them move increasingly towards:
  - systematic communication with patients, users and carers
  - the design and maintenance of care pathways
  - the creation and analysis of evidence of 'what works'
  - the assessment and management of risk,
  - the assessment of service performance in relation to quality, user satisfaction and efficiency
  - the use of new technology to support users.
- For those retaining a purely clinical role AHP professionals can expect to see a move to greater specialization and a greater emphasis on them acting as consultants to others.
- Generally there will be a shift in the balance of practice from 'adding years to life' to more emphasis on adding 'adding life to years'.

## Section 2: The Future Demands of AHP Leaders

It was recognised that AHP leaders now held a wide portfolio of skills and competences that enabled them to work well in multi-agency settings and that they were more capable than most of designing and managing complex pathways especially in community settings for those with complex needs. They were natural 'integrators' of services outside hospitals. However there was a feeling that these skills and competencies needed to be extended and rebalanced if AHP leaders were going to respond to all the changes envisaged earlier in the day. The ideas about this rebalancing divide into two clusters. Some were more about skills and competence and some were more about qualities and confidence.

- On the skills and competence side the increased use of business models in the commissioning and design of services meant that leaders

are going to have to acquire more advanced business skills especially those associated with the economic analysis of markets, the identification and management of risk and the financial and contractual integration of supply chains and skills in marketing – both to understand the market (demographics, morbidity and patient needs and expectations) and to ensure that the maximum number of people used them .

- Again with regard to skills there would be an increased need for leaders in the future to have advanced coaching and mentoring skills and excellent communication and negotiation skills derived from a theoretical understanding of power and power bargaining.
- Also skill based was the need for leaders to possess sufficient understanding of research methodology to lead work on evidence-based practice and evidence based models of care.
- However it was in relation to qualities and what was described as the future leaders' *gestalt* that more emphasis was laid. Here the leaders would need to be more business 'savvy' and to be by nature more entrepreneurial both within larger organizations and as leaders of their own businesses. They would have to take a more synoptic, whole systems view and be much more assertive than reactive in relation to the future.
- It was said that the AHP training was a preparation for employment – which may no longer be sufficient. In addition to considering the prospect of running 'businesses', AHPs needed development that recognised that at a senior level they were equipped to handle a wide diversity of roles beyond those defined by the clinical hierarchy and outside of the conventional academic and research roles.
- The new leaders had to develop emotional intelligence and more sensitivity to the small 'p' politics of the operating environment. They needed to have the confidence to influence others and learn to 'punch above their weight' in negotiations. Although capable of following, future leaders should not expect to be lead by others like managers and doctors but should assume the leadership roles themselves.)
- New leaders needed to be better at connecting their professional ethics, their own values and those of the NHS to their own practice and the way that the services they managed were organized.

### Section 3: What is Needed Now

The group reviewed the current education, training and development opportunities by drawing on the work of the recent CHPO Conference before going on to describe the kind of development required to equip the leaders of the AHPs to respond to the challenges of a 'post-Darzi' world. What emerged was a quite radical shift away from conventional development programmes to something that will require creativity and verve to put into place.

- It was felt that those in the existing cadre of AHP leaders that wanted to engage enthusiastically with the new world should be developed as a

matter of urgency. If they were not then these professions would become managed by others. More important than any dent to professional pride was the fact that all the knowledge and understanding about running and integrating services – especially those beyond major hospitals would not be brought to bear on the way that patient services were managed in the future.

- There were a range of ideas about how this and subsequent programmes should be run –but in the main it was recognised that there was a great deal of leadership development opportunity in the system already and there was no need to replicate this.
- With regard to the leaders of the future what emerged very strongly was the need to ‘talent spot’ – to identify those – some of whom might be at the early stages of their career - who had the flair to be an inspiring leader in the future and to work specifically with that group – a bit akin to the graduate management training scheme for HR, finance and general managers.
- There was clear target audience amongst the Band 7s in the existing structure. Here there was a need to review the existing development opportunities for AHPs at this level and ensure that all CPD programmes contained material to stimulate modern leadership.
- The AHPs needed to ‘nurture this talent’ since it was not often part of the management culture of the employing organizations. That required a scheme of coaching and mentoring that was bigger than an individual Trust and perhaps wider than an SHA.
- This raised the issue of AHPs – like young graduate entrants to the police - having to spend years and years ‘on the beat’ learning the craft before they could move into management positions. This wasted real talent and risked those most suited to these leadership roles leaving the profession or the health service.
- The professions also had to get used to the fact that the jobs that AHPs move into may have nothing or little to do with the existing professional hierarchies. As an example - Heather O’Meara is/was a therapist but is now the Chief Executive of large London PCT.
- It was also felt important that the current practice of job adverts being ‘restricted’ to particular professionals should be ceased. It was archaic and did not suit the new relationships between the professions.
- There was a need to establish or re-establish multi-disciplinary regional networks – almost as ‘development clubs’ for AHPs.
- More pragmatically there was a need for a vehicle for communicating with those interested in the wider issues surrounding AHP practice – and a belief that a net based service needed to be provided that allowed the Centre to talk to and listen to the AHPs.
- This led to a plea for a distance learning programme on new leadership so that even those who did not spotted and who were not employed in the most enlightened organizations would not be deprived of appropriate development.

## Section 4: Some Reflections

A small review group was established to look at the output of the *Reading the Compass* event and to think about what needed to happen next. There emerged a series of questions:

- There was a great deal of leadership development available to AHPs through a wide range of suppliers. There were also national and local development programmes for clinicians and real development opportunities for staff through the well run CPD programmes. All these opportunities had to be exploited. *How do AHPs know about the opportunities available to them and about which would be best for developing 'business thinking'?*
- It was no good training clinicians that are incompetent navigators of the operating system in which they deliver care for patients. *How can we ensure that management skills and business thinking are available as part of undergraduate training?*
- We identified that graduate professionals working at level six or seven that showed leadership flair needed to be identified and developed on an individual basis. *How can we ensure that this talent spotting occurs on a systematic basis and on a sufficiently large SHA platform?*
- The professions' current leaders needed a 'fast track' programme to help the new NHS can use their talents for integrating and managing patient care. *How were we going to create opportunities for them to learn experientially through master classes, secondments, external and non-NHS placements, simulations, organizational raids and the like?*
- The dominant and most consistent theme that emerged from the discussions was the need for AHPs to apply 'business thinking' to the way they responded to commissioners and to the way they ran their services. This was not just about skills – it was more a mind-set – a way of approaching the questions associated with delivering patient services. *How can that mind-set be created quickly across the AHP community?*

There were tentative answers to some of the answers. The AHP leads at SHA level might shoulder some of the burden - like reviewing existing leadership development opportunities and ensuring that 'talent spotting and developing' schemes were created across the region. The AHPF might be a suitable agent for handling some of these programmes on a national basis. If the market were suitably stimulated other questions would be answered by providers of leadership development from HE and elsewhere offering distance learning programmes for the level 6/7 professionals and experiential programmes for the smaller cadre of current leaders. .

The question that remained more difficult to answer was the last one – how to achieve a rapid and wholesale shift in thinking across the AHP workforce. How do we demonstrate to a large tranche of AHP staff that the context is

changing and that they already have a great many transferable skills to work successfully in it? How do we develop the confidence of the AHP community so that they think they *can* 'think business' about delivering services to patients?

An idea that emerged was given the working title of the 'leadership challenge' with a 'business' game built around delivering better health care in the new NHS at its heart. This would be used at events where up to 80 professionals working in small teams could rise to the challenge of running the 'business' of delivering high quality care to patients in a realistic but imaginary setting. The 'play' would involve a balance of collaboration and competition but there would need to be winners of each regional round so that we could build up to a high profile national 'leadership challenge' event. There was confidence about the willingness of corporate and other sponsors to support the programme.

Multiple objectives would be met. AHPs would understand the realities of working in a patient led, evidence based, contestable system with powerful commissioners and a multiplicity of providers. AHPs would discover that they had skills that were transferable to the new context but would also appreciate that they needed more. At the regional events we would run an exhibition where providers of leadership programmes and other schemes could promote their offerings thereby bringing customers and providers together. If the simulation/game was designed properly – it could be ensured that in each region a large number of key opinion formers from across the system became more aware of the contribution that AHP's could make to delivering integrated patient care within a regulated market. This process could directly touch a thousand clinicians and with appropriate communications and marketing reach many more.

The scale of the project meant that it could not be mounted by a single SHA nor by the APHF – it would have to be initiated and supported by the centre.

## Appendix 1 - The Contributors to Reading the Compass – 14 March 2008.

Foluke	Ajayi	NHS Employers
Amanda	Allen	South East Coast SHA
Clare	Allen	NHS Institute for Innovation and Improvement
Anita	Fatchett	Council of Deans
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Pauline	Gacal	Council of Deans
Naomi	Hankinson	London SHA
Christine	Hayward	South Central SHA
Sue	Kellie	British Dietetic Association
Carolyn	Kinnaird	East Midlands SHA
Fleur	Kitsell	NHS Education South Central (NESC)
Anne	Lawson-Porter	AHPF Leadership Working Group
Sue	Louth	North West SHA
Laurie	Mc Mahon	Loop2
Karen	Middleton	DH
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Justin	Needle	City University
Jane	Nicklin	East of England SHA
Maria	Quinn	Northumberland, Tyne & Wear NHS Trust
Julie	Parkes	North East SHA
Grahame	Pope	AHPF
Jane	Rook	West Midlands SHA
Karen	Tanner	South West SHA
Jackie	Turnpenny	Greater Manchester and Cheshire Cancer Network
Filao	Wilson	Skills for Health