Royal College of Psychiatrists in Scotland.
Management and Leadership Handout

This document is intended to be published on the management website of the RCPsych in Scotland and to be used alongside the Management and Leadership Skills Course for higher trainees in psychiatry. It was created and is updated by the Chairs and Members of the Medical Managers Group of the RCPsych in Scotland.

In terms of the Medical Leadership and Competency Framework (see below) this document looks mainly at (1) Managing the Service, (2) Setting Direction and (3) Improving Services.

Medical Leadership
Competency Framework

CONTENT

1. Managing the Service

The structure (i.e. the building blocks) and the organisation (i.e. the way in which the building blocks interact) of the health service are ever changing. This is, in part, to reflect broader changes in society but can also reflect politicians, managers and clinician desire to improve service or to be doing something.

1.1Structure of NHS Scotland

1.1.1 Scottish Government

Since devolution in 1999 the Health Service in Scotland has been a devolved issue. This means that it is the responsibility of the Scottish Parliament to determine health policy, to allocate resources, to implement the policies and oversee the use of these resources. Within the Scottish Parliament there is a Cabinet Secretary for Health and Sport. Since 2016 there has also been a specific junior Minister for Mental Health.

Other Members of the Parliament can express a view during debates on health issues and are able to ask questions of the Minister at appropriate times. Ultimately MSPs decide on broad health policy or legislation by casting their votes for or against proposals.

Once the democratic process has determined the overall aims and structure of the health service it is the business of the Scottish Government Health Department (SGHD) to make this happen. The Chief Executive of NHS Scotland is also the Director General of Health and Social Care and is a civil servants who is accountable to their Minister.

Mental Health (but not addictions or intellectual disability) is part of the Mental Health and Protection of Rights Division of the Scottish Government Health Department. It develops the National Mental Health Strategy and work to reduce suicide and self harm and has responsibility for the development of Mental Health Legislation and supporting Scottish Ministers statutory role in respect of Restricted patients.

1.1.2 Health Boards

NHS Trusts previously planned and delivered their own services and related to Health Boards through purchasing and providing agreements. This arrangement was dissolved after devolution with the intention of replacing competition with collaboration. This is radically different to the model south of the border where Trusts were encouraged to become Foundation Trusts and the purchaser provider split was maintained with the introduction of GP commissioning groups.

Each geographical Health Board in Scotland is a single operating unit that is responsible for managing all the acute hospital services, mental health services, public health and primary care services. There are 14 of these ‘territorial’ Health Boards in Scotland. Regional planning structures have been strengthened in recent years and there have been discussions about reducing the number of territorial

Health Boards to four at some point in the future. There have also been separate discussions about developing regional or national Public Health services.

In addition to the territorial Health Boards, there are also seven special Health Boards and one Public Health Body. These are:

- Scottish Ambulance Service (SAS)
- NHS 24
- The State Hospital's Board for Scotland
- NHS Health Scotland
- NHS Health Improvement Scotland (HIS)
- NHS Education Scotland (NES)`
- NHS National Services Scotland (NSS).
- Golden Jubilee Foundation

Some of the special health boards such as NHS Education Scotland (NES) and the State Hospital will be familiar to you but others will be less familiar. The Golden Jubilee focus is on national waiting times and providing surgical operations. NHS 24 provides health advice and information and out of hours telephone triage. Health Scotland is a public health body that promotes ways of improving the health of the population and reducing health inequalities. National Service Scotland provides services such as health protection, blood transfusion and information (ISD) as well as commissioning national services (including some psychiatric services). A description of HIS is provided in the section on improving services.

Memberships of Health Boards vary across the country reflecting local differences but there are commonalities. They will all be chaired by a Ministerial appointee and have a number of other non-executive lay members. These people all contribute to the work of the Board in planning and overseeing service delivery but do not carry out (execute) any of the other Board functions. The Executive Board Members usually include:

- Chief Executive
- Director of Finance
- Employee Director – representing all staff
- Medical Director
- Nurse Director
- Director of Public Health
- Director of Human Resources

The Board has a responsibility to consult its staff about changes and has a formal structure of professional advisory committees. The Hospital Sub-Committee represents hospital medical staff and the GP Sub-Committee represents General Practitioners. Both are Sub-Committes of the Area Clinical Forum which represents all professional groups. The LNC is the Local Negotiating Committee and is where the Health Board managers would meet with the BMA to discuss terms and conditions of service. The BMA is the main trade union organisation that represents doctors in the United Kingdom.

1.1.3 Health and Social Care Partnerships

The most significant development in recent years has been the development of Health and Social Care Partnerships (HSCP). The aim of this reform was to meet

the challenges of Scotland's ageing population by shifting resources to community-based and preventative care at home, or in a homely setting. To achieve this, the Public Bodies (Joint Working) (Scotland) Act 2014 requires councils and NHS boards to work together to form new partnerships, known as integration authorities (IAs). The aim is to ensure services are well integrated and that people receive the care they need at the right time, and in the right place. A single Director is responsible for integrated budgets for health and social care but HSCPs across Scotland are very different in terms of their size, resources and local context. All IAs are responsible for the governance, planning and resourcing of social care, primary and community healthcare and unscheduled hospital care for adults. Some areas have also integrated additional services including children's services, social work, criminal justice services and all acute hospital services. Most HSCPs include community Mental Health Services. Inpatient mental health services often cover more than one HSCP and inpatient services are usually hosted by one HSCP or managed alongside Acute Hospital Services.

1.2 Operational Management and Clinical Leadership

Operational management is the day-to-day management of services to make things happen. It involves ensuring that the right people and other resources are in the right place at the right time. Perhaps the best example in healthcare is the management of a hospital ward where it is necessary that an adequate number of staff of the right grade and with the right training are on duty to care for the patients on the ward and they have the right equipment to do their job. There may be a Strategic Plan to reduce waiting times but implementation of this Strategy will require operational management to ensure that teams are functioning well to deliver the standards.

The difference between management and clinical leadership has been described as managers do things right (climb the ladder) and clinical leaders decide what the right thing is (that the ladder is against the right wall). In reality many clinical leaders are managers and many managers, clinical leaders. It is no use either climbing the ladder against the wrong wall or having the ladder against the right wall but being unable to climb it.

Typically with management you have delegated responsibility and accountability while leaders often have to work across organisations or professional groups and rely on influencing rather than telling. In reality good managers are also leaders and many leaders are also good managers.

Doctors often come into formal management positions late and only gain experience of managing other people or services after taking up Consultant posts. Even when doctors are involved in management roles, e.g educational roles, they may not define themselves as managers. Across the UK only around 5% of Chief Executives of Health Boards are Doctors. This is low compared to some other healthcare systems where active involvement of clinicians in management is pushed from an early stage. The Francis report identified that the disengagement of doctors was one of the factors behind patients being harmed at Stafford Hospital. Several studies have shown a positive relationship between medical engagement and organisational performance.

2. Setting Direction

2.1 Strategy

A strategy is essentially a means of getting from point A to point B. In a health context strategic planning involves:

1. A review of the current situation (where are we now).
2. An identification of the end point of change (where we are going).
3. A mapping out of the possible ways of getting there and the likely things that are going to change (how are we going to get there)

Strategies can vary in scope and timescale. At its broadest we have a national strategy for all health services and at the narrower end there are local strategies to cover a Health and Social Care Partnership or one part of a mental health service e.g. child and adolescent services. It is important to be aware of the strategic plans relevant to your area because any development you may wish to introduce must "fit" with the strategic aims for your service.

2.2 Influencing the system and the RCPsych in Scotland

One way to influence policy is through the Royal College of Psychiatrists in Scotland (previously the Scottish Division of the RCPsych in Scotland). The College is in a position to suggest changes to existing policy and will always be asked to comment on changes being proposed from elsewhere. The RCPsych in Scotland Executive meets bi-monthly in Edinburgh. It consists of elected members and the Chairs of the various faculties of the RCPsych in Scotland. Like all other RCPsych groups, it also includes user & carer representation.

2.3 Strategic Planning in Scotland

The current political thinking on the NHS in Scotland is set out a number of different strategy documents including:

- Choose Life (2002) and the Suicide Strategy for 2013-16 (2013).
- Towards A Mentally Flourishing Scotland' (2009) *(health promotion).*
- Quality Strategy (2010)
- 20/20 Vision (2011)
- Realistic Medicine (2015)
- National Clinical Strategy (2016)
- Mental Health Strategy (2016)

All these documents are available on www.scotland.gov.uk

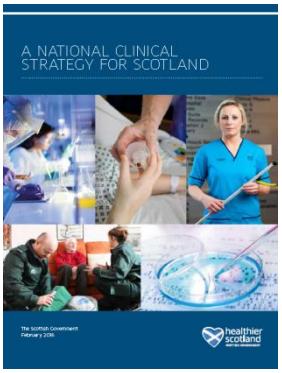
2.3.1 Mental Health Strategy 2016

This is the successor to the Mental Health Strategy for Scotland 2012 – 2015 (2012) and Delivering for Mental Health (2006). Older people and dementia strategies such as Reshaping Care for Older People (2010) and the Dementia Strategy (2010) are part of a separate but related workstream. Addictions and learning disability services also have their own strategy papers such as Mind the Gap, Same as You and their successors.

The Mental Health Strategy 2016 has several overarching themes.

1. Focus on prevention and early intervention for pregnant women and new mothers.
2. Focus on prevention and early intervention for infants, children and young people.
3. Introduce new models of supporting mental health in primary care.
4. Support people to manage their own mental health.
5. Improve access to mental health services and make them efficient, effective and safe.
6. Improve the physical health of people with severe and enduring mental health problems to address premature mortality.
7. Focus on 'All of Me': Ensure parity between mental health and physical health.
8. Realise the human rights of people with mental health problems.

Like it's predecessor, it is a mix of new and existing commitments rather than a comprehensive blueprint for how mental health services should look in the 21st Century. There are a number of other strategic documents that cover all areas of healthcare including mental health.



2.3.2 Quality Strategy (2010)

Despite being six years old, this paper is still quoted in most of the major Strategic papers. The ambitions are **person centred** - mutually beneficial partnerships, **effectiveness** - right treatment at the right time, no wasteful variation and **safety -** no avoidable harm. In addition to person-centred, safe and effective, services are also expected to be **efficient, equitable** and **timely**.

2.3.3 20/20 Vision (2011)

The Scottish Government's 2020 Vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting and, that we will have a healthcare system where:

- We have integrated health and social care
- There is a focus on prevention, anticipation and supported self-management
- Hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm.

- Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions
- There will be a focus on ensuring that people get back into their home or community as soon as appropriate, with minimal risk of re-admission

2.3.4 Realistic Medicine (2015)

Another influential report was the CMOs report 2014-15 on Realistic Medicine and many of the ideas were adopted as part of the national clinical strategy.

2.3.5 National Clinical Strategy (2016)

There is broad agreement on the main challenges facing the health services in Scotland over the next few decades. These include an ageing population, increased long term conditions and complex needs; obesity, physical inactivity, harmful use of alcohol & smoking; workforce pressures including more females and less working age population; new technology and developing public expectations.

The national clinical strategy suggests that services should be based around Primary Care/HSCP and should build capacity and have a broad mix of professionals based around practices. The intention would be to shift work from acute hospitals, provide anticipatory care, alternatives to hospital admission and prompt discharge. It suggests that secondary care should develop fewer inpatient sites for highly specialised services with local hospitals providing outpatients, diagnostics, day surgery and emergency care. It describes a new Clinical Paradigm (similar to realistic medicine) that: has the least invasive or disruptive processes as a first step; avoids unwarranted variation; avoids wasteful investigations that don't add value; develops a partnership with patients based on comprehensive information and adapts treatment to patient preference

2.4 Performance Targets and Outcomes

2.4.1 National Quality and Outcome Measures

At Scottish Government level there are national outcomes. The 12 National Quality Outcome Measures are healthcare experience, staff experience, staff attendance, hospital acquired infections, emergency admissions, adverse events, (HSMR), living longer (>75), patient reported outcomes, patient experience of access, (self assessed general health) and dying well.

2.4.2 National Performance Framework indicators

They include childrens dental health, babies birth weight, children's weight, physical activity, smoking, drug use, general health, mental wellbeing and a range of indicators relating to improved management of chronic conditions and the frail elderly. These include premature mortality, proportion receiving care at home rather than in a care home or hospital, reducing emergency admissions to hospital, improving end of life care, reducing alcohol related hospital admissions

2.4.3. Health and Social Care Integration Indicators

There are also performance targets for Health and Social Care Partnerships. These were intended to measure how successful HSCPs were at promoting good health and keeping patients in the community. They include a number of survey questions looking at adults supported at home as well as rates of emergency admissions and bed days, readmissions within 28 days, proportion of the last six months spent at home before death, delayed discharges etc.

2.4.4 Local Delivery Plan

The Local Delivery Plan (LDP) is published annually and is the single outcome agreement with public bodies. It includes finance and workforce plans as well as delivery trajectories against targets. The Minister for Health will visit Health Boards bi-annually for accountability reviews. The visiting team will meet with staff and patient groups before reviewing the Local Delivery Plan with the Board and then taking questions at a Public meeting. The Minister then writes an outcome letter to the Chair of the Board

The performance targets set by the Scottish Government used to be called HEAT targets (**H**ealth improvement, **E**fficiency, **A**ccess and **T**reatment) but since 2015/16 the Local Delivery Plan (LDP) Standards have replaced the system of HEAT targets and standards (with the vast majority of LDP Standards being former HEAT targets). These performance targets were designed to improve services and focus prioritisation but sometimes the focus can seem to become achievement of the target rather than the desired outcome.

2.4.5 Mental Health Targets

Until 2011 the only mental health target was suicide reduction. The HEAT target was 20% Suicide Reduction between 2002 – 2013. This was seen as a health improvement target rather than a mental health service target. There was an 18% reduction from 2002 - 2012 and the target was just missed.

Several mental health access targets have been developed in recent years including faster access CAMHS; Psychological Therapies and drug & alcohol treatment as

well as targets for provision of alcohol brief interventions, establishing a dementia register and post diagnostic support for dementia.

In 2016 the LDP performance targets for Mental Health Services were:

1. People newly diagnosed with dementia will have a minimum of 1 years post-diagnostic support.
2. 90 per cent of young people to commence treatment for specialist Child and Adolescent Mental Health services within 18 weeks of referral.
3. 90 per cent of patients to commence Psychological Therapy based treatment within 18 weeks of referral.
4. 90 per cent of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.
5. NHS Boards to sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings.

There are also several other LDP targets that are relevant to all services including mental health services:

1. 95 per cent of patients to wait no longer than 4 hours from arrival to admission, discharge or transfer for A&E treatment. Boards to work towards 98 per cent
2. 100 per cent of patients to wait no longer than 12 weeks from the patient agreeing treatment with the hospital to treatment for inpatient or day case treatment (the Treatment Time Guarantee which is underpinned by legislation).
3. 90 per cent of planned / elective patients to commence treatment within 18 weeks of referral.
4. 95 per cent of patients to wait no longer than 12 weeks from referral (all sources) to a first outpatient appointment (measured on month end Census). Boards to work towards 100 per cent.

From 2018/19 the performance targets for Health Boards may change to become annual performance plans. Over recent years work has also been done to develop 30 Mental Health Quality Indicators across six domains linked to the quality framework e.g CAMHS quality indicators.

2.5 Job Planning – setting direction for individual doctors

The main tool used to set objectives for doctors is job planning. This also sets out the agreed timetable for doctors and ensures they have an appropriate timetable of clinical (Direct Clinical Care) and non-clinical (Supporting Professional) activities.

3 Improving Services

3.1 Structures to improve services

3.1.1 Health Improvement Scotland.

This Health Board replaced QIS (NHS Quality Improvement Scotland) but also incorporated various other bodies. Its three main areas are Evidence, Scrutiny & Improvement.

Evidence incorporates SIGN (clinical guidelines), SMC (Scottish Medicines Consortium) and the SHTG (Scottish Health Technologies Group). The SMC decides if new drugs are cost effective for use in the NHS and their website provides useful summaries of evidence. There is an expectation that drugs approved by the SMC are made available by health boards and included on formularies but some Boards may choose not to include a 'me too' drug if other alternatives are already on the formulary. An IPTR (Individual Patient Treatment Request) needs to be made to the Health Board for non SMC approved drugs such as Agomelatine.

Scrutiny includes Healthcare Environment Inspections, Older Peoples Services Inspections and Independent Care Inspections as well as one off reports. Inspections include positive comments such as 'Patients who we spoke with were happy with the care they received during their stay in Glasgow Royal Infirmary and we observed some good interactions between staff and patients' but it tends to be the negative comments that get picked up by the media such as 'The environment within Glasgow Royal Infirmary does not consistently allow for the dignity of patients to be respected. For example, patients in some wards cannot access a toilet…..'

Improvement includes the Scottish Patient Safety Programme (SPSP) and the Scottish Health Council. SPSP work includes Healthcare Acquired Infections, Medicines Management, Hospital Mortality and more recently Venous-thrombo-embolim and Sepsis. The Mental Health Safety Programme started in 2012 and covers risk assessment, transitions, medicines reconciliation and seclusion/restraint.

The SPSP approach is to start small and do small scale PDSA (plan, do, study, act) changes at individual patient or ward level and then extend changes that work. It is intended as a bottom up approach but combines this with collection of hard outcome (rather than process data) and a variety of health improvement techniques. Quality Improvement methodology rather than audit is now the preferred national approach to improving services.

3.1.2 Care Inspectorate

National Care Standards have been created by the Scottish Government to make sure that a wide range of care services provide good quality care. The Care Commission (now replaced by SCSWIS - known as Care Inspectorate) regularly inspects care services to make sure these standards are met.

3.1.3 The Mental Welfare Commission

The Mental Welfare Commission is an independent organisation working to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. Their role is to ensure that individual treatment is in line

with the law and practices that work well and to challenge those who provide services for people with a mental illness or learning disability to make sure they provide the highest standards of care. They provide advice, information and guidance to people who use or provide services. The MWC also influences how services and policies are developed. It also gathers information about how mental health and adults with incapacity law are being applied. They use that information to promote good use of these laws across Scotland.

One of the ways in which the Commission monitors individual care and treatment is through a visits programme .They visit individuals in a range of settings throughout Scotland: at home, in hospital or in any other setting where care and treatment are being delivered. They also carry out we carry out at least three national themed visits each year to assess and compare care and treatment for particular groups of individuals across Scotland.

Another function of the MWC is to investigate where there are concerns regarding the care or treatment of an individual. They have statutory powers to investigate if required. These reports are published on the MWC website.

Anyone can ring the MWC to raise a concern or ask for advice. This includes patients, relatives and professionals. There is a requirement to inform them of homicides committed by patients but they no longer need to be informed routinely of suicides. They also expect to be informed of serious incidents involving patients detained under the Mental Health Act

3.1.4 Complaints and the Scottish Public Services Ombudsman (SPSO)

All NHS Boards have a formal system for handling complaints and will have a complaints policy. There are strict timescales for responses and the managers who are investigating complaints usually need information within a few days. Concerns can be dealt with verbally and resolved informally if the complainer indicates they are happy with the response but more serious complaints or formal complaints should always be logged with the appropriate manager or complaints department.

Complaints are investigated and either upheld, partially upheld or not upheld. If you have been the subject of a complaint it is reasonable to expect to see a copy of the final response. Ideally this should be before it is sent but short timescales can make this difficult especially if several different individuals have contributed to the response. Any complaints should be discussed as part of your appraisal in line with GMC guidance on revalidation.

The response to the complaint always includes information on the SPSO and anybody unhappy with the response to the complaint can raise this with the SPSO. The Ombusman will only consider complaints when they have been through the local complaints process of the organisation concerned. The SPSO can investigate both the process of dealing with complaints and the content of the complaints. The SPSO also has a function to promote good practice in the investigation of complaints and to share learning to improve the delivery of public services. The final reposts are public documents and are laid before the Scottish Parliament. Like HEI inspections they often end up reported in the media if the findings are negative.

3.1.5 Data Protection

The General Data Protection Regulation (GDPR) and the Data Protection Act 2018 replaced the Data Protection Act 1998 with an updated and strengthened data protection framework. Many of the GDPR's concepts and principles are much the same as the Data Protection Act 1998 but there are new elements and significant enhancements to both people's rights and organisational responsibilities.

All public bodies have a responsibility to protect personal data. Computers should be password protected and data should be stored on the H drive (organisations server) and not the C drive (the individual computer) so that if the computer is stolen or sold the data isn't. Computers holding personal information need to be registered as a information asset.

Information governance breeches are reportable incidents. Examples of breeches would be leaving casenotes in corridors or on tables where they can be knocked into bins by cleaners or taken by other patients; leaving prescriptions for patients in unlocked cars; having lists of patient's full names visible when relatives visit a ward or when other patients claim travel expenses at a desk; sending emails with patient details to personal email accounts or putting patient identifiable data on social media.

The Caildicot guardian is the person who has responsibility for data protection in the Health Board but there will also be an identified Data Protection Officer. In practice the information governance department deals with any information governance breeches or data protection issues. If breeches are reported via the local reporting system (e.g. DATIX), they are informed automatically as they have to report these to the information commissioner within 72 hours.

3.1.6 Freedom of information

Anybody can put in a freedom of information request to a Public body. They have to reply by law within a set time period and if they refuse you can complain to the Freedom of information commissioner. It can be unclear where the boundary between Data Protection lies. Normally small numbers are not reported under FOI to avoid identification of individuals. For example the Scottish Government will not release information on restricted patients as the numbers are so small that individuals could be identified.

3.2 Organisation to improve services

3.2.1 Healthcare Governance

Within any healthcare organisation the main governance areas are Financial Governance, Staff Governance and Care Governance (quality).

Until the late 1990s Chief Executives were only responsible for financial governance and did not have any statutory responsibility for the quality of services. The concept of clinical governance was introduced without any firm idea what would be required to provide assurance of quality. Clinical/Healthcare Governance Committees were established to provide assurance about the quality of services.

Any parallel stream of activity risks taking energy away from providing the service and in the early years there were concerns that some of the information gathering was taking away resource without necessarily increasing the quality of services.

The Quality Strategy defined the main elements of clinical governance (see 2.3.2). Timely largely remained the territory of general management due to the focus on waiting list targets.

Information Governance (Freedom of Information, Data Protection and Duty of Candour) may be part of Healthcare Governance or part of a separate information governance structure.

In recent years the main changes have been (1) that the improvement methodology has moved away from audits to driver diagrams and tests of change (2) The development of Health and Care Governance as part of Health & Social Care Partnerships (3) A move to talking about Quality rather than Clinical Governance.

3.2.2 Managed Clinical Networks (MCN)

These are a means of co-ordinating care for particular conditions or client groups across regions and, in some cases nationally. They bring together service managers and clinicians to plan and oversee pathways of care that may involve patients accessing different components of their care at different places. MCNs also allow the same quality standards to be set for the same services in different parts of the country. The term “Managed Care Network” can be used when health and social care services are both involved.

3.2.3 Integrated Care Pathway (ICP)

An ICP is a specified outline of care, planned to help patients with a similar diagnosis or set of symptoms move progressively through their journey of care to achieve positive outcomes. The process of creating an ICP involves people from different professions working together to agree on what key elements of care should be provided at each stage of the patient’s journey. The advice and experience of local service users and their informal carers is central to the process. An ICP will be based on evidence of effectiveness. Or where that is not available, on what can be agreed to be good practice.

Traditionally doctors have always reserved the right to have clinical freedom in deciding on how best to treat the patients under their care. This freedom is gradually being curtailed by MCNs/ICPs, clinical guidelines, standard operating procedures, access protocols and restricted formularies etc. These limit the resources that can be used and the way resources are used. The aim is to improve the consistency, safety and cost effectiveness of care.

3.2.4 Benchmarking

The aim of benchmarking is to compare performance across Boards and look at differences to identify how to get ‘the biggest bang for your bucks’. Benchmarking provides a framework for asking questions and helps to focus efforts on the right areas. If Health Board A has the lowest number of acute admissions beds in Scotland there will be a limit to how much Health Board A can save from reducing admissions and length of stay. If on the other hand you have twice as many long

stay beds as any other Health Board there may be a scope for reducing beds further. It does not tell you if the Health Boards have too many or too few beds or if they need more or less staff but does give you some idea of the areas you may want to look at for efficiency savings or future investment. One of the problems with this approach is that it is only as good as the data.

3.2.5 Whistleblowing .

The Public Interest Disclosure Act 1998 states that every service should have a whistle-blowing procedure. Whistle-blowing is the disclosure by an employee of information which relates to some danger, fraud or other illegal or unethical conduct connected with the workplace. Whistle-blowing procedures describe the steps you can take to raise a concern if you are worried that your concerns are not being investigated or taken seriously. The first step if you have any concern would be to report it either to your line manager (Consultant/Clinical Director) or via your organisations incident reporting system (e.g.DATIX). The whistle-blowing procedures are intended when the normal reporting systems have failed.

3.3 Health Improvement Methodology

The LEAN approach – increasing patient contact by reducing non value adding activities- is one method of improvement methodology. The most common question about LEAN is what does it stand for ?. The answer is that it is not an acronym. In a world full of SIGNs, it's a word that means what it says. If staff are wasting time going to another room to get things out the drug fridge - is it possible to move the fridge into the same room? If the patient being asked the same questions several times during an admission by different staff – is it possible to ask the patient a question once and make that information available for subsequent staff?

PDSA is Plan, Do, Study and Act. Start small with individual changes at the level of one ward or patient on a particular drug. Try out the change and if successful them extend and redo. It's a bottom up approach. [Compare and contrast with audit where typically all patients on a ward/drug would be audited as a starting point]

DCAQ is looks at demand, capacity, access and queues. This type of approach tries to maximise productivity especially around outpatient clinics and to make the service more effective and to reduce waste. There are a variety of other similar approaches

In Scotland the Scottish Patient Safety Programme has been running successfully for several years and uses a variety of different improvement methodology.

3.4 Project management and Managing Successful Programmes (MSP)

Project management is a skill that can be taught. The best known training in the Public Sector in Scotland is PRINCE. If you are trying to change something and not getting anywhere fast, it's worth checking that you have done the basics using either a project management or healthcare improvement framework. What are you trying to do – do you have a clear objective; who has asked you to do this and do they have the authority to do this – who is the sponsor of the project; who are the key stakeholders – who will be affected and who can influence if the change will be successful. Have you mapped out your stakeholders and checked that you have

targeted the individuals with high influence and who are highly affected. Have you a plan with the project broken down into tasks with a clear timeline for each task. Have you a way of dealing with blocks or unexpected events.

MSP is a standardised way of managing change across public sector organisations where several different projects may be involved. It involves an executive sponsor, vision, mission statement, business plan, programme board, programme manager, business manager and a number of projects. If you hear of a 'programme board' it is likely that a MSP approach is being used to coordinate several linked projects.

3.5 Business Plans

Most consultants, have at some point been critical of the way the health care system is being planned and run. It would be disappointing if this were not the case as management of any service should be about continuous improvement and is dependent on the views of practitioners. However trying to exert influence can be a very frustrating experience. This frustration can be felt not only by medical staff but by others who want to improve services including other professionals, managers, elected representatives, patients and carers.

Some changes are progressive and happen gradually over time. At other times there is a requirement for a new service or treatment and there is a need to develop a formal business plan.

The most important first step is to persuade your immediate colleagues of the need for a change or development. If all your colleges think that the idea is 'bonkers' it's unlikely to be successful. Most mental health services or psychiatric hospitals will have Divisions of Psychiatry/speciality meetings where such issues can be discussed. It is important to think of other key stakeholders such as managers, other professionals, primary care, patients and carers. Do not underestimate the importance of talking to people in advance of more formal occasions as it may take time for a new idea to be accepted.

If there is sufficient agreement the next step is to produce a formal proposal, possibly in the form of a business plan. There are many formats for such proposals but they all cover similar areas.

- Justification for change/development.
    - What are the benefits
    - What are the national or local strategic aims that it achieves
    - What are the risks of not making the change

- Who will be affected by the change
    - How will patients benefit & do they need to be consulted
    - How will it affect staff & do they need to be consulted
    - It is always worth thinking this through in detail and working out who are most affected and who are most influential. If somebody or some group is both influential and affected then you need to regard them as important stakeholders and have a plan to consult them, keep them informed and influence them.

- How will your plan be implemented.
    - Are the resources needed to make the change happen available?
    - Are the relevant staff currently in post or could they be recruited?
    - Are there significant training implications

- How much will it cost
    - You cannot be expected to produce a detailed financial plan but you should have some idea of whether your proposal is affordable or, better still, will it save money.

Take account of different personality types when you write a report. Don't assume everyone is the same as you and use what you leant when you did your DISC profiles. Have a short paper or executive summary. If it saves money or will have an impact on targets say so early on rather than on page 33. For those that like change, keep them informed and try to get them to buy into your vision. Include information on the potential impact on patients & staff. Have lots of data and information as an appendix or in the main body of the report for those that like detail.

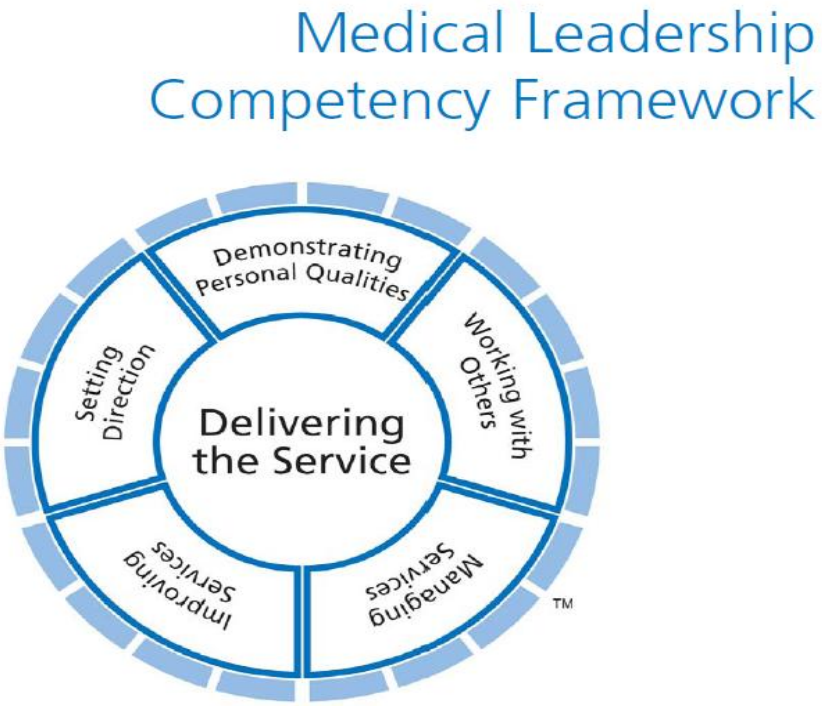
Most importantly, do not be disheartened if others cannot recognise the importance of your suggestion and the genius of your plan. Either seek to amend the proposal or wait until it finds a fit with the next great national initiative. Always remember to push where it moves.

4. Management & Leadership Training

4.1 Training Opportunities

There is a drive at present to look at leadership and management form medical schools to trainees to new consultants/speciality doctors and to established medical mangers. This section is based on the presentation first given by Laura Cameron at the RCPsychiS Leadership and Management Training days when she was a trainee.

One way of thinking about leadership and management competencies is the NHS Institute for Innovation & Improvement and Academy of Royal Colleges Medical Leadership Competency Framework (2009). NHS Leadership Framework is available at www.nhsleadershipqualities.nhs.uk



4.1.1 Local

- Involvement in local service development
- Clinical innovation
- Committee representation
- Local working groups / short life group
- Attendance at management meetings eg. Division
- Critical Incident Reviews
- Shadowing of clinical director or associate medical director
- Shadowing of non-medical managers

4.1.2 National

- National Trainee Representation e.g. RCPsych, BMA etc
- Guideline development groups/peer review e.g. SIGN
- Review /Comment on draft and consultation papers
- National working groups (College/Government etc)
- Defence Unions courses
- NHS Leadership Academy: www.leadershipacademy.nhs.uk

4.1.3 NES Courses

Leadership and management (LaMP)courses:

- LaMP: Dealing with Difficult People & Presentation
- LaMP: NHS & Functions of Management
- LaMP: Persuasion & Negotiation Skills
- LaMP: Leadership and Team Working

NES Medical Leadership Module

4.1.4 National Leadership Unit

- Management Training scheme
- Postgraduate Certificate in Health Leadership and Management
- 360° Feedback Tool
- Managers Development Network

4.1.5 LeAD Leadership for Clinicians

LeAD Online Modules. Created by the Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement in partnership with DH e-Learning for Healthcare. LeAD has over 50 highly interactive e-learning sessions covering the five domains of the Medical Leadership Competency Framework. Access to the educational material is available free for NHS staff by registering at www.e-lfh.org.uk/LeAD.

4.1.6 Health Management Online

- Part of The Knowledge Network
- Aimed at supporting hospital managers
- Index of Leadership and Management taught courses
- Index of policy searchable by subject matter
- Current awareness bulletins
- Catalogue of training DVDs available to all NHS staff for free

4.1.7 Faculty of Medical Leadership and Management (FMLM)

Open to trainees and membership includes a large number of trainees as well as established medical managers. The Faculty of Medical Leadership and Management is a UK-wide organisation that aims to promote the advancement of medical leadership, management and quality improvement at all stages of the medical career for the benefit of patients. Doctors at any stage of training from medical students to Chief Executives can join as members and they organise a national conference and provide access to networks and resources.

It was established in 2011 following on from the rather embarrassing demise of the BAMM (British Association of Medical Managers) which went bankrupt.
www.fmlm.ac.uk enquiries@fmlm.ac.uk

4.1.8 Health Improvement Methodology

NHS Institute for Innovation & Improvement www.institute.nhs.uk provides easy to understand overviews of improvement methodologies such as LEAN and PDSA. The Institute of Health Improvement. www.ihi.org and Health Foundation www.health.org.uk can also provide an introduction to improvement science.

4.1.9 GMC :*Leadership and management for all doctors* (2012)

Leadership and management for all doctors sets out the wider management and leadership responsibilities of doctors in the workplace, including:

- responsibilities relating to employment issues
- teaching and training
- planning, using and managing resources
- raising and acting on concerns
- helping to develop and improve services**.**

4.1.10 Self evaluation

- www.leadershipacademy.nhs.uk/develop-your-leadership-skills
- self assessment tools to identify leadership strengths and development needs
- Consists of a short questionnaire and a personal development plan template.
- Leadership Framework Self Assessment Tool
- Clinical Leadership Self Assessment Tool
- Medical Leadership Self Assessment Tool

4.1.11 Post Graduate Qualifications

- MBA – local or distance learning
- Postgraduate Certificate in Medical Leadership
- MSc Medical Leadership

4.1.12 Kings Fund

www.kingsfund.org.uk includes an up to date leadership & management reading list and produces regular papers on Management and Leadership e.g.The Future of Leadership and management in the NHS – No More Heroes (2011); Medical Engagement: A journey not an event (2014); Medical Leadership is vital for quality medical care (2013) and Quality Improvement in Mental Health (2017).

4.1.13 Websites / Podcasts

- www.nes.scot.nhs.uk
- www.e-lfh.org.uk
- www.knowledge.scot.nhs.uk
- www.leardershipacademy.nhs.uk
- www.fmlm.ac.uk
- www.gmc-uk.org
- www.nhs.leadership.org.uk

Harward Business Review – non healthcare podcast. http://hbr.org
FMLM Concepts of Leadership- healthcare leadership & management. www.fmlm.ac.uk

4.1.14 Project Lift

Project Lift is the name of the NHS Scotland approach to talent management, leadership development, appraisal and recruitment.

www.projectlift.scot - allows you to find out more about Project Lift and complete a Self-Assessment Questionnaire. This provides a tailored feedback report based on the leadership profile, along with suggestions for next steps and information on the development resources available