National Allied Health Professional Leadership Challenge

Toolkit

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Policy	Estates
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Document Purpose	For Information
Gateway Reference	15933
Title	National Allied Health Professional Leadership Challenge Toolkit
Author	Department of Health
Publication Date	05 Apr 2011
Target Audience	Medical Directors, Directors of PH, Directors of Nursing, Directors of Adult SSs, Directors of HR, Allied Health Professionals, Emergency Care Leads, Directors of Children's SSs
Circulation List	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs , PCT PEC Chairs, PCT Chairs, NHS Trust Board Chairs, GPs, Higher Education Institutions, Professional Bodies
Description	The National Allied Health Professional (AHP) Leadership Challenge programme provided clinical leadership development for nearly 1000 AHPs from bands 5–9. This toolkit takes the learning from this programme to provide the information and tools necessary to develop leadership challenges to suit any organisation's needs.
Cross Ref	AHP Bulletin July/August 2009
Superseded Docs	N/A
Action Required	N/A
Timing	**N/A**
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National Allied Health Professional Leadership Challenge

Toolkit

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First published April 2011
Published to DH website, in electronic PDF format only.
http://www.dh.gov.uk/publications

Why develop clinical leadership?

> "The efforts that we make or the kind of leadership that we show is going to be incredibly important both for improving the quality of services for our patients but also providing leadership to people that we work with"
>
> *Sir David Nicholson, CBE, NHS Chief Executive*
> *National Allied Health Professional Leadership Challenge Final, 2009*

> "Clinicians with leadership skills have the greatest ability to deliver better services for patients and foster innovation, quality and safety"
>
> *Karen Middleton, Chief Health Professions Officer*
> *Clinical Leadership Interim Report, 2009*
> *National Leadership Council*

The health and social care system requires high quality leadership to deliver better outcomes for patients in terms of safety, effectiveness and patient experience and to deliver the necessary productivity savings. The NHS is complex and part of a wider system. Maximum creativity is needed to drive up quality and, in the current economic situation; all the diverse leadership talent available needs to be liberated.

Putting leadership in the hands of clinicians will bring different perspectives and challenges to the decision making process. Clinicians can help to find creative solutions to the challenging times ahead, with a focus on areas such as rehabilitation and reablement in order to increase safe discharge, reduce readmission and support people to get back to work and off benefits, keeping people at home and independent for longer.

Clinicians have the competence to become leaders, but frequently need the confidence to step out of their comfort zone and take up new challenges.

The National Allied Health Professional Leadership Challenges raised the visibility of what AHPs can and do contribute to leading service improvement and innovation. Moreover, they raised the confidence of AHPs to go back to their organisations and lead change to improve outcomes for patients and increase productivity.

Leadership Challenges:

- enable employers to recognise and develop the potential in individuals to lead service transformation
- strengthen succession planning by establishing a talent pool of future clinical leaders
- establish a transformation approach to the development of clinical leaders at all levels and across all boundaries
- influence key decision makers and commissioners about how AHPs could and should lead service transformation
- provide a highly positive learning experience
- increase clinicians confidence in ability to take on new projects within their organisations

- motivate participants with many reporting instantaneous impact translated into real improvements in patient care when allied health professionals went back to work.

What is a leadership challenge?

The National Allied Health Professional (AHP) Leadership Challenge programme has provided leadership development for nearly 1000 allied health professionals from bands 5 – 9. These experiential learning events are a useful vehicle to enabling AHPs to appreciate the transferable skills they have and where certain gaps might need addressing in their leadership development.

This toolkit takes the learning from this programme to provide the information and tools necessary to develop leadership challenges to suit any organisation's needs.

Leadership Challenges are intensive experiential learning events based on fictional, but realistic scenarios, exposing participants to the high-level challenges of delivering health and social services in order to identify both the existing qualities, and those to be developed for the leaders of the future.

The safe, yet demanding, environment stimulates participants to take part in challenges they would not otherwise have thought they could tackle and highlights the areas they need to develop to move on in their careers.

In the National AHP Leadership Challenges, participants applied as individuals and were placed into teams who compete against each other using their creativity to solve the challenges posed. Before attending the event the individuals were not aware of who they would be teamed with. In setting up the teams, care was taken to mix individuals from different professions and grades and to ensure that people were not placed in a team with people from their organisation. This enabled participants to break out of their conventional role and behaviours. The first round took place in 10 regions with the winning team from each of the regional events going forward to a national final and competing to be the overall winner. Some regions have since gone on to deliver one off challenge events focused on local priority areas.

Jo Brady from Heart of England Foundation Trust took part in the 2009 challenge in the West Midlands. Following the event, she went back to work and put into practice her plan to realise "her dream" to have occupational therapists and physiotherapists on the emergency floor to prevent social admissions to acute beds. She says that taking part in the challenges gave her the confidence to make this happen. In the three months since setting up The Rapid Emergency Assessment Communication Team (REACT), 958 bed days and £105,380 have been saved.

By taking part in a Leadership Challenge event, participants will be able to:

- use, understand and acknowledge the transferable leadership skills they possess already, by working in the simulated exercises in a safe and collaborative and contestable way
- understand how to work in a changing environment

- identify how they can support their services and organisations to meet the quality and productivity challenge
- identify further leadership training and development opportunities that will positively influence their own teams, services, department and organisations and support the development of more productive services
- recognise the benefits of cross organisational networking

"Before the event I was unaware of what happens at a strategic level, and the impact that this has on my work. I have gained a wider understanding of the current climate of the NHS and the need for change to come from the frontline. I feel that now I have the skills to attempt to initiate this change, and I now have the skills to attempt to initiate this change, and I now take on challenges that I would not have done previously"
Hannah Mills, physiotherapist

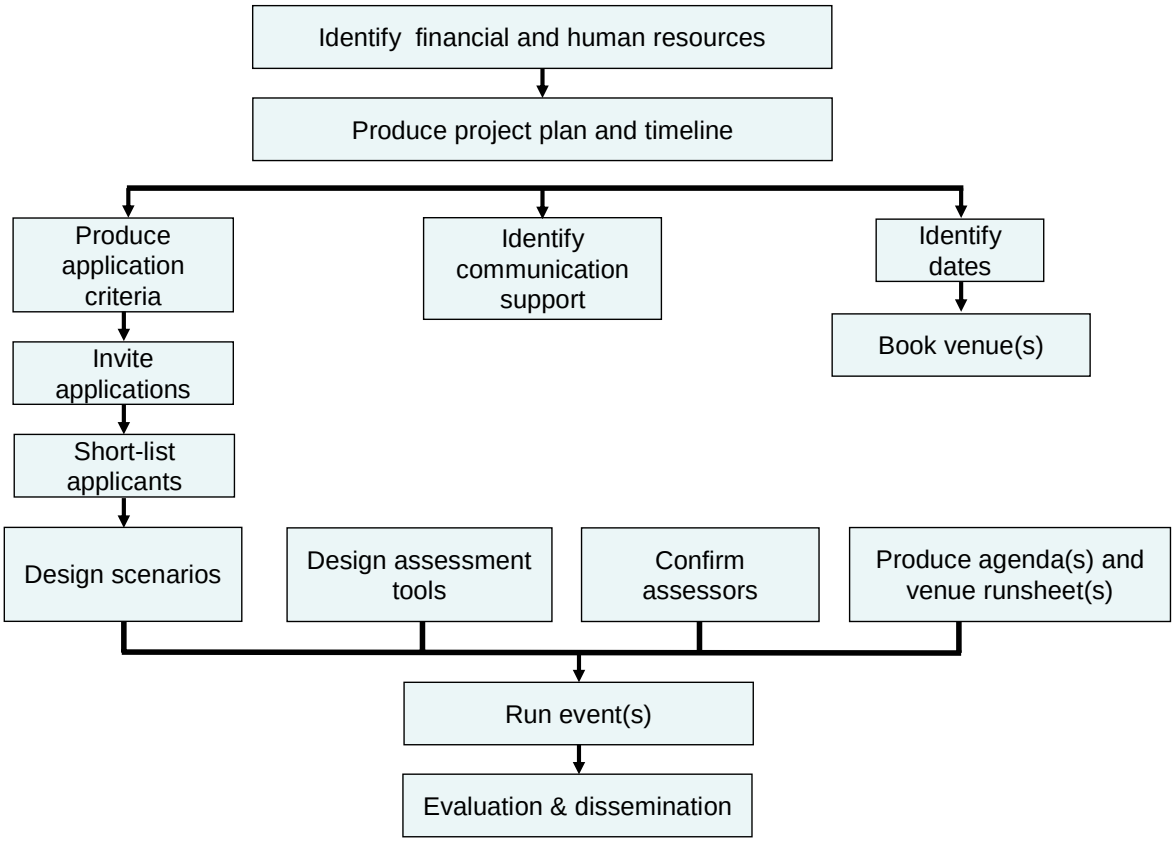
Hannah was a band 5 when she took part in 2009 and went on to implement self-referral in her trust as a Department of Health AHP Service Improvement Project Lead at grade 6.

The challenges can be delivered in a number of ways, but there are some elements that are crucial in delivering a successful outcome such as the programme structure, scenario and the assessment process.

How to run a leadership Challenge event

Designing and delivering the Leadership Challenge model takes a great deal of work. This includes producing scenarios, booking venues and running the application process. The steps required are illustrated in *figure 1* below. Identifying adequate resources in terms of finance and staffing is essential.

Figure 1: The process



The programme

There are a number of ways in which a Leadership Challenge event can be delivered on the day. However, there are certain key elements that are necessary to deliver the accelerated learning and test leadership skills, such as collaboration, political acuity, influencing skills and managing the scenario itself.

The teams are given the scenario to begin working on with a defined end point, such as a presentation at a specified time. At regular intervals during the day, the teams have to attend briefings where they are given crucial pieces of information that are necessary for their decision making process. They are then given

deadlines to complete and hand in different pieces of work that build towards their final deliverable, for example, a business case or a communications plan.

At intervals during the day, the team are unexpectedly interrupted and given other information that influences their way of working or timelines, or asked to undertake other tasks such as a give a media interview.

The scenarios

The event(s) require challenging and innovative scenarios that reflect topical issues pertinent to health and social care today, for example, based on the need to improve quality and productivity. If more than one event is being held, a different scenario should be used in each event.

A fun scenario can be used as a warm up so that teams can work out their roles, strengths and abilities. This allows participants to get into the right frame of mind for a fast moving scenario to come. It is also an opportunity for assessors to practice using a performance tool and for feedback and coaching about what was expected of the teams in the main challenge, allowing participants to build on their approach and absorb the learning

If a final event is planned, the scenario used should be pitched at a higher level, both in terms of complexity of the scenario and the quality of input expected from the competing teams.

The assessment process

Assessment is a key element of the Leadership Challenge model. Two assessors will be required for each team and should be adequately trained to undertake the assessments.

Two types of assessment take place; assessment of written work against ‘model’ answers, and qualitative assessment by observation.

Each team should have an observational assessor assigned. Assessor briefing packs should be sent out in advance to enable the assessors to adequately prepare for their role. These should contain a performance assessment tool and detailed explanations of the events. Assessor training is required before the event begins to ensure consistent assessment takes place.

It is recommended that each team be assigned a lead assessor and a second assessor. The assessor pairs require a detailed timetable that showed when they should be assessing their two teams and when to compare notes. This process ensures that the scores are as comparable as possible.

The programmes, scenarios and assessment tools used in the National Allied Health Professional Leadership Challenge 2010 can be found in the appendices to this toolkit.

The checklist:

The following checklist shows the steps taken in preparing for, delivering and evaluating the National AHP Leadership Challenge 2010. The templates used, including the scenarios and assessment tool, are embedded for your information and will open if double clicked on.

Short films recorded at the 2009 and 2010 challenge event finals illustrate how the events work and their impact. They can be downloaded at http://www.dh.gov.uk/en/Aboutus/Chiefprofessionalofficers/Chiefhealthprofessionsofficer/index.htm .

Before the Event	✓
Planning • Produce a project brief • Develop a project plan including timelines and outcome measures • Identify resources	
Event Preparation • Produce a draft programme • Book suitable venue/s • Ensure venue/s meets audio visual requirements • Invite assessors • Invite guest speakers • Invite 'press officers' • Arrange photographer and cameraman (if required) • Arrange prizes	
Communications • Publicise event internally through emails, newsletters, word of mouth etc • Publicise externally through media releases and advertisements in trade	

publications	
Application Process • Design an application form that captures the data required for the event. Ensure form allows personal data capture for future reference • Produce selection criteria • Evaluate application forms and select successful applicants • Allocate applicants into teams • Notify applicants of the success/failure to secure a place • Confirm successful applicants attendance	
Scenarios and assessment • Develop scenarios • Develop model answers for scenarios • Develop tool to assess performance in the scenario	
Prior to the event • Finalise agenda/s • Send out information sheets to participants, assessors, speakers, press officers and other VIPs • Organise packs for participants, assessors, press officers and VIPs • Write briefings for VIPs and media attending • Visit the venue and develop a 'run sheet' of all actions and timings for the event • Produce evaluation forms	
During the Event	✓
Set up • Signage • Set up a central 'Hub' where participants can come to collect supplies, ask	

questions, hand in written work and receive hourly briefings • Run sheet and intervention timings	
Paperwork for participants • Scenarios • Briefings • Intervention response forms • Reflective learning tool • Feedback • Evaluation form	
Deliver to participants • Deliver interventions • Hourly briefings • Press intervention • Man ‘The Hub’ • Receive intervention response forms • Film and photos • Distribute certificates of attendance	
Assessors • Assessors briefing • Assessor debrief • Agree final scores • Agree feedback process	
Organiser	

• Opening address • Closing address • Announce winners • Give prizes and winners certificates • Photos	
After the Event	✓
Deliver to winners • Ensure that all prize commitments are delivered	
Evaluation • Analyse data from evaluation forms • Survey of impact 6 months after the event • Evaluation report capturing learning	
Write thank you letters to: • Assessors • Speakers • 'Press Officers' • VIPs	
Communications • Send out press release • Keep participants details for future communications	

Appendix 1 Programmes

Sample programme – regional events

Day One

	Participants	Assessors
1400		Assessors arrive Briefing/training commences 14.30 sharp
15.00	Participants registration and coffee	
16.00	Introductions and overview of the 2 days timetable	
16.15	Key note speaker	
17.00 - 18.00	'Warm up' scenario exercise	
18.00 - 1830	Participants debrief with Frontline facilitators	Assessors debrief
19.30	Dinner and networking – assessors feedback to teams on 'warm up' scenario	

Day Two

08.30	Scenario introduction and setup stage one	
10.00	Set up scenario stage two	
11.00	Set up scenario stage three	
12.00	Set up scenario stage four	
13.00	Brief for presentation	
13.30	Five minute presentation on lessons learned (two groups present simultaneously)	
14.00	Participants 'debrief on expected answers and work on PDPs	Collation of assessors scoring
15.00	Announcement of winning team, presentations and final remarks	
15.30	Assessors feedback to participants	
16.00	Close	

Sample Programme – final event

Day One – participants and assessors

<table>
<tr><th></th><th>Participants</th><th>Assessors</th></tr>
<tr><td>14.00</td><td></td><td>Assessors registration
and check in</td></tr>
<tr><td>14.30</td><td></td><td rowspan="2">Assessors briefing/training
commences at
14.30 sharp</td></tr>
<tr><td>15.00</td><td>Participants registration
and check in</td></tr>
<tr><td>16.00</td><td colspan="2">Karen Tanner – Allied Health Professions
Leadership Programme Manager
Department of Health

Introductions and welcome</td></tr>
<tr><td>16.15 – 18.00</td><td colspan="2">Ross Baglin- Director of Talent and Leadership,
Department of Health

Development session and group exercise</td></tr>
<tr><td>18.00 - 1830</td><td>Participants debrief with
Ross Baglin</td><td>Assessors debrief</td></tr>
<tr><td>19.30</td><td colspan="2">Dinner and networking

Karen Middleton – Chief Health Professions Officer
Opening remarks

Assessors feedback to teams on group exercise</td></tr>
</table>

Day Two – participants and assessors

08.30	**Karen Tanner** – Allied Health Professions Leadership Programme Manager Department of Health Welcome and good luck! **David Behan** – Director General, Social Care, Local Government and Care Partnerships Department of Health	
08.45	Scenario introduction and setup stage one	
10.00	Set up scenario stage two	
11.00	Set up scenario stage three	
12.00	Set up scenario stage four	
13.00	Brief for presentation	
13.30	Five minute presentations and Q & As (two groups present simultaneously)	
14.15	Participants 'debrief on expected answers	Collation of assessors scoring
15.15	Assessors feedback to participants	
15.45	**David Nicholson –** NHS Chief Executive Announcement of winning team and presentations **Karen Middleton** – Chief Health Professions Officer Close and final remarks	
16.15	Drinks reception and meet the teams	

Appendix 2 Scenarios

Designed by Frontline for the Department of Health

Sample regional scenario

A key element of the Primary Care Trust's (PCT) strategy is to improve the equity and access to stroke services, with a particular emphasis on:

- shifting care from acute to community rehabilitation
- reducing total length of stay within the hospital setting
- choice and dignity for patients and carers
- pro-active support networks
- reducing incidence rates, focussing on prevention

Recent analysis of data relating to stroke services indicated:

- increasing length of stay
- under-utilisation of community therapy services
- variation in incidence rates across the PCT boundaries

You are a group of clinical leaders drawn from organisations across the health economy, including social care, PCT commissioners, PCT provider organisation and acute care. Reporting to a steering group, you have been tasked with redesigning the approach to managing the stroke services.

You should be prepared to make a presentation to the PCT at the end of the project, setting out what you intend to do to solve the issue.

You will receive an update every hour, representing perhaps 6-8 weeks elapsed time. You may send no more than 2 people to this update, which will be at the Hub. At each update you will be given information and set tasks to deliver. You may need to suspend disbelief in some instances! You will be able to ask questions, but there will be a time limit on these, and the information you want may be unavailable. The next update will be at 10:00, and thereafter every hour.

In addition to this, every so often you will be asked to report to a particular location – usually the Hub - to give the response to a task, or address a question, following a request that will be delivered to your group working area in writing. In most instances this will require a bullet point answer, which you should give on the sheets of paper provided – we do not expect polished prose.

Although this scenario is about a specific service, you do not need specialist knowledge to take part. Indeed, we would encourage you to think generically about your approach. All the specific information you need will be available to you during the course of the day. Handout 1 "Information about strokes" - gives you some key information. If your group contains service specific knowledge do certainly use this, but if you find yourselves drawing heavily on it, you are probably getting into too much detail! Remember that the assessment is as much about *how* you address the challenges as about the answers you come up with!

Here is your first challenge:

At 10:00, bring the following items to the Hub:

- your project structure which ensures all interested parties are represented
- your stakeholder analysis which supports the project structure

09:10

The reducing healthcare inequalities sub-group of the Local Strategic Partnership* is interested in your project, particularly how choice and dignity for patients and carers will be addressed and improved, whilst reducing service inequalities. The PCT chief executive is attending the next sub group meeting. Prepare a briefing for her and bring it to the Hub at 09:35.

*A **Local Strategic Partnership** is a single body that:

- brings together at a local level the different parts of the public sector as well as the private, business, community and voluntary sectors so that different initiatives and services support each other and work together
- is a non-statutory partnership

- provides a single overarching local co-ordination framework within which other partnerships can operate
- is responsible for developing and driving the implementation of Community Strategies and Local Area Agreements
- in areas receiving Neighbourhood renewal funding, is responsible for agreeing the allocation of this funding and helping to 'narrow the gap'

09:30

You note that there is an interesting pilot in home support (providing coordinated rehabilitation care to patients within their own homes) underway for people who have had a stroke. This is led by social care in collaboration with the PCT provider organisation. You have on opportunity to meet with the social care dept: what will your agenda look like? Bring this to the Hub at 09:55.

09:50

There has been some media interest in your project, concerned that this review will cut access to stroke services. You have agreed to be interviewed. At least 1 member of the press will arrive for a briefing from your team - you should brief them and then answer questions in accordance with the following timetable:

10:10	Group 1	Group 6
10:25	Group 2	Group 7
10:40	Group 3	Group 8
10:55	Group 4	Group 9
11:10	Group 5	Group 10

N.B. You should remember that the press are notoriously bad at precise timekeeping!

Having received your project structure and stakeholder analysis, the steering group is broadly content but has emphasised:

- the need to engage with a wide range of stakeholders
- a project plan for the lifetime of this project needs to be developed
- the project will run for 12 months and needs to deliver cost benefits of implementing a new pathway/model of care

Some information about the current service is available in handout 2 (location of services, current performance and quality indicators). By 11:00, provide:

- a detailed plan for your approach to service redesign in the next phase of the project
- your main findings about the current services

10:15

One of the lead consultants at the acute trust with a special interest in stroke has emailed the group complaining about the slur on the quality of her service. Draft a response outlining your project deliverables and outcome measures and bring it to the Hub at 11:15.

10:40

The local mayor for town 3 has sent a letter to the PCT. He sees this as an opportunity to save his cottage hospital and wants to know if he can help in any way.

The hospital is in good repair, but only marginally viable due to low volume of admissions and has been the subject of much concern about its future.

Draft a letter to the mayor, responding to his request and explaining your programme of work. Bring it to the Hub at 11:25.

11:00 – Brief Three

Having received your project plan, the steering group is generally pleased with the direction of travel. It is clear to your group that if national best practice guidelines are to be adhered to, some acute service standards need to improve. There is also potential to move a significant amount of rehabilitation into community settings.

The finance director from the PCT has accessed some benchmarking information comparing length of stay and other indicators across a peer group of PCTs, adjusting for demographics and level of deprivation (see handout 3). Based on this data, he believes a significant reduction in length of stay is achievable by shifting care.

The steering group would like you to prepare a paper detailing the level of reduction in length of stay you aim to achieve, the kind of financial savings you think are achievable, and the specific initiatives that will deliver this.

Bring your response to the Hub at 12:00.

11:30

A social marketing company claims that they can target at risk patients, and through a preventative programme reduce admission rates over time. Having reviewed their sales brochure (see handout 4), you have agreed to meet with them. There may well be 'knock-on' effects on other services. Prepare notes for the meeting and bring it to the Hub at 11:45.

The SHA's patient and public engagement lead writes to your chief executive reminding her about the importance of including patients in all service redesign. You agree to meet her. Draft key points to discuss, ensuring you cover how frail and elderly patients will be involved in the redesign process.

Bring your draft reply to the Hub at 12:15.

Your recommendations for service redesign have been discussed by the steering group, but the members want more clarity on the workforce implications of your project. They have asked you to provide a paper detailing the changes in workforce capacity and skills that your project will require across the health community. A current workforce breakdown is provided in handout 5.

Bring your paper to the Hub at 13:00.

12:10

A national stroke charity has written to one of the participating NHS organisations asking for information about current quality standards and a statement about your approach to delivering best practice. Draft a reply and bring this to the Hub at 12:40.

13:00 – Brief Five

The steering group is impressed with your work so far and, as you are a beacon of innovation, puts you forward to present at an innovation conference being run by the SHA. Prepare a presentation setting out your key generic lessons about your successful approach to service redesign so that they can be circulated to other parts of the patch and applied to other services. Your submission is expected by 13:30, and presentations will take place between 13:30 and 14:00.

13:30 – 14:00 – 5 minute presentations from each Team – Teams 1 to 5 go to Room A and Teams 6 to 10 go to Room B

14:00 – 15:00 – Participants debrief including "model" answer and work on PDPs

15:00 – 15:30 – Presentation of scores and final remarks

15:30 – 16:00 – Assessors feedback to participants

Handout 1 – Key information about stroke services[1]

A stroke is a 'brain attack' caused by a disturbance to the blood supply to the brain. There are two main types of stroke:

Ischaemic: the most common form of stroke, caused by a clot narrowing or blocking blood vessels so that blood cannot reach the brain, which leads to the death of brain cells due to lack of oxygen.

Haemorrhagic: caused by a bursting of blood vessels producing bleeding into the brain, which causes damage.

Transient ischaemic attacks (TIA), also known as mini strokes, occur when stroke symptoms resolve themselves within 24 hours. A large proportion of an identifiable group of high risk TIAs (those lasting more than 10-15 minutes, raised bp, with diabetes) go on to have full blown stroke – these patients are at greatest risk in first few days therefore starting treatment early is key to preventing a full stroke.

20 quality markers for best practice in stroke care are set out below:

1. **Awareness raising:**
   - members of the public and health and care staff are able to recognise and identify the main symptoms of stroke and know it needs to be treated as an emergency

2. **Managing risk:**
   - those at risk of stroke and those who have had a stroke are assessed for and given information about risk factors and lifestyle management issues (exercise, smoking, diet, weight and alcohol), and are advised and supported in possible strategies to modify their lifestyle and risk factors
   - risk factors, including hypertension, obesity, high cholesterol, atrial fibrillation (irregular heartbeats) and diabetes, are managed according to clinical guidelines, and appropriate action is taken to reduce overall vascular risk

[1] Based on "National Stroke Strategy", Department of Health, December 2007

3. **Information, advice and support:**
   - people who have had a stroke, and their relatives and carers, have access to practical advice, emotional support, advocacy and information throughout the care pathway and lifelong

4. **Involving individuals in developing services:**
   - people who have had a stroke and their carers are meaningfully involved in the planning, development, delivery and monitoring of services
   - people are regularly informed about how their views have influenced services

5. **Assessment – referral to specialist:**
   - immediate referral for appropriately urgent specialist assessment and investigation is considered in all patients presenting with a recent TIA or minor stroke
   - a system which identifies as urgent those with early risk of potentially preventable full stroke – to be assessed within 24 hours in high-risk cases; all other cases are assessed within seven days
   - provision to enable brain imaging within 24 hours and carotid intervention, echocardiography and ECG within 48 hours where clinically indicated

6. **Treatment:**
   - all patients with TIA or minor stroke are followed up one month after the event, either in primary or secondary care

7. **Urgent response:**
   - all patients with suspected acute stroke are immediately transferred by ambulance to a receiving hospital providing hyper-acute stroke services (where a stroke triage system, expert clinical assessment, timely imaging and the ability to deliver intravenous thrombolysis are available throughout the 24-hour period)

8. **Assessment:**
   - patients with suspected acute stroke receive an immediate structured clinical assessment from the right people
   - patients requiring urgent brain imaging are scanned in the next scan slot within usual working hours, and within 60 minutes of request out-of-hours with skilled radiological and clinical interpretation being available 24 hours a day

- patients diagnosed with stroke receive early multidisciplinary assessment – to include swallow screening (within 24 hours) and identification of cognitive and perceptive problems

9. **Treatment:**
   - all stroke patients have prompt access to an acute stroke unit and spend the majority of their time at hospital in a stroke unit with high-quality stroke specialist care
   - hyper-acute stroke services provide, as a minimum, 24-hour access to brain imaging, expert interpretation and the opinion of a consultant stroke specialist, and thrombolysis is given to those who can benefit
   - specialist neuro-intensivist care including interventional neuroradiology/neurosurgery expertise is rapidly available
   - specialist nursing is available for monitoring of patients
   - appropriately qualified clinicians are available to address respiratory, swallowing, dietary and communication issues

10. **High-quality specialist rehabilitation:**
    - people who have had strokes access high-quality rehabilitation and, with their carer, receive support from stroke-skilled services as soon as possible after they have a stroke, available in hospital, immediately after transfer from hospital and for as long as they need it

11. **End-of-life care**
    - people who are not likely to recover from their stroke receive care at the end of their lives which takes account of their needs and choices, and is delivered by a workforce with appropriate skills and experience in all care settings

12. **Seamless transfer of care:**
    - a workable, clear discharge plan that has fully involved the individual (and their family where appropriate) and responded to the individual's particular circumstances and aspirations is developed

13. **Long-term care and support:**
    - a range of services are in place and easily accessible to support the individual long-term needs of individuals and their carers

14. **Assessment and review:**
    - people who have had strokes and their carers, either living at home or in care homes, are offered a review from primary care services of their health and social care status and secondary prevention needs, typically within six weeks of discharge home or to care home and again before six months after leaving hospital
    - this is followed by an annual health and social care check, which facilitates a clear pathway back to further specialist review, advice, information, support and rehabilitation where required

15. **Participation in community life:**
    - people who have had a stroke, and their carers, are enabled to live a full life in the community

16. **Return to work:**
    - people who have had a stroke and their carers are enabled to participate in paid, supported and voluntary employment

17. **Networks:**
    - networks are established covering populations of 0.5 to 2 million to review and organise delivery of stroke services across the care pathway

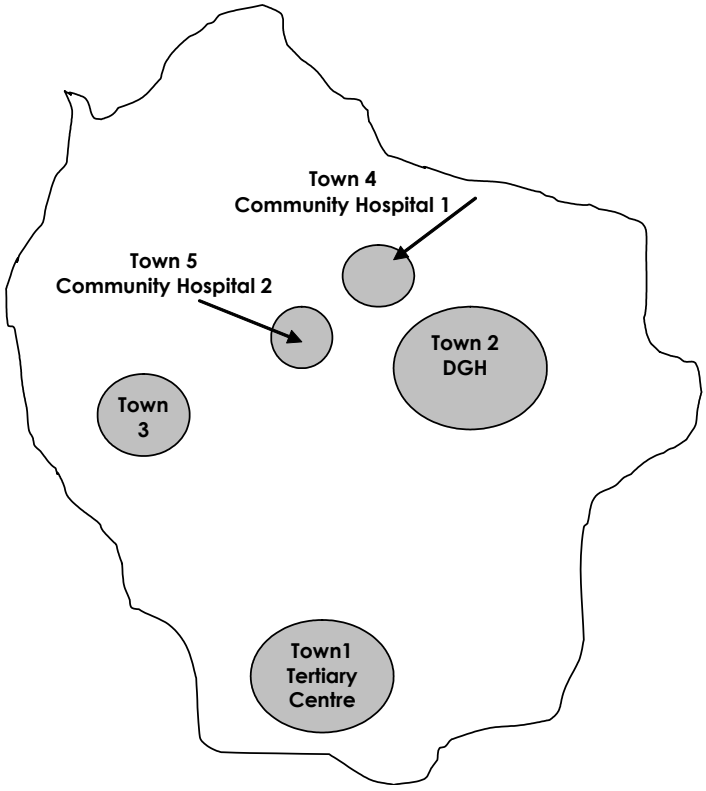
18. **Leadership and skills:**
    - all people with stroke, and at risk of stroke, receive care from staff with the skills, competence and experience appropriate to meet their needs.

19. **Workforce review and development:**
    - commissioners and employers undertake a review of the current workforce and develop a plan supporting development and training to create a stroke-skilled workforce

20. **Research and audit:**
    - all trusts participate in quality research and audit, and make evidence for practice available.

Handout 2 – Current services

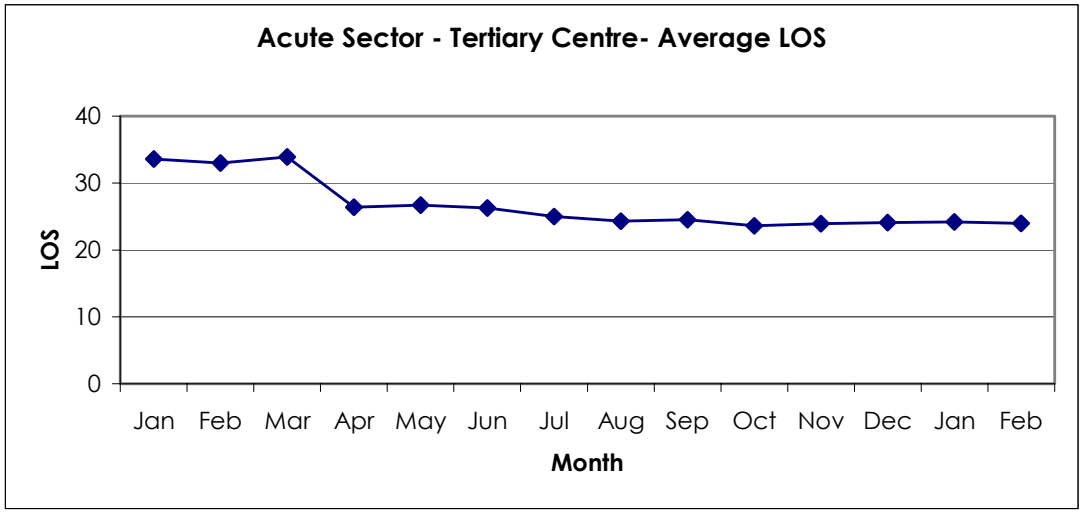
Stroke Services – Geographical representation of services

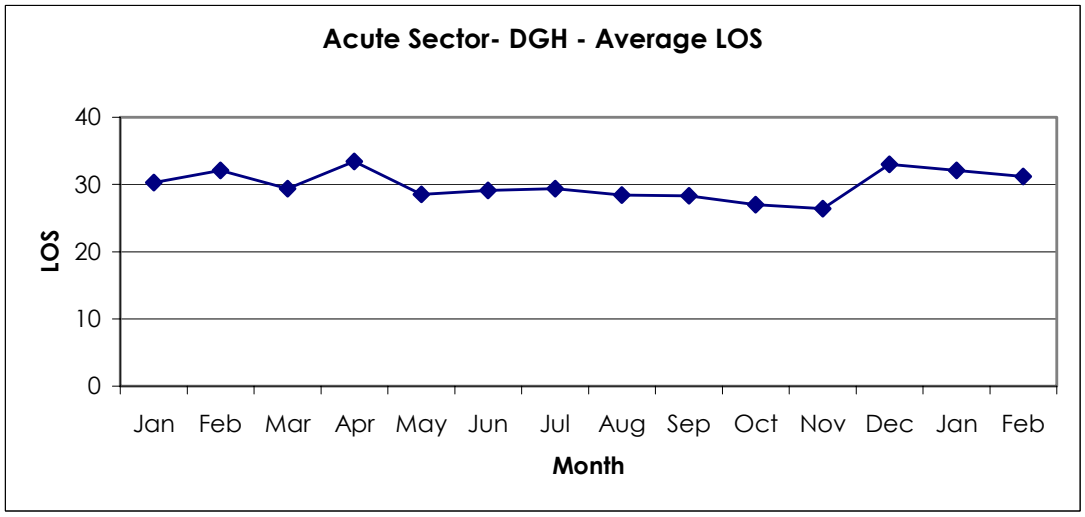


Organisation	Services
Tertiary Centre – NHS Foundation Trust	Acute, specialist, rehabilitation care
District General Hospital	Acute, intermediate care
Community Hospital 1 – Provider Services	Intermediate care, rehabilitation care
Community Hospital 2 – Provider Services	Intermediate care, rehabilitation care

Provider Description	Annual Admissions	Average Length of Stay (days)
Acute sector - Tertiary centre	1,500	26.7
Acute sector - DGH	650	29.9
Provider Organisation (PCT)	99	22.0
Community Hospital 1	343	48.9
Community Hospital 2	275	39.1

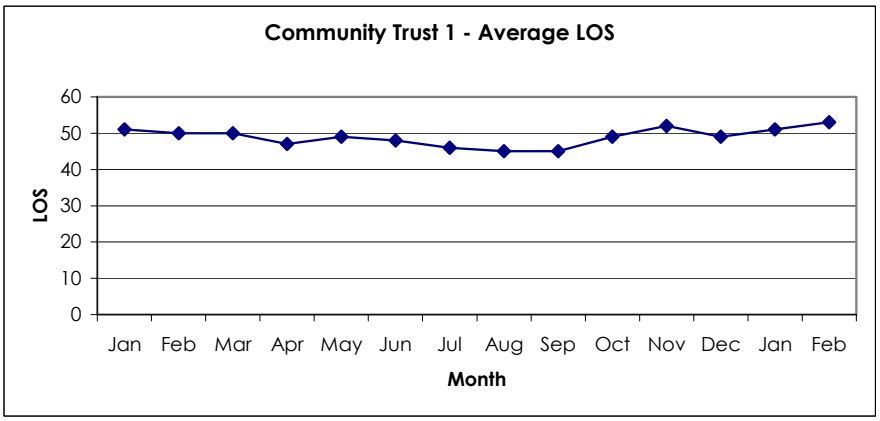
Acute Sector - Tertiary Centre	Tertiary Centre	District General Hospital
Admission Rate per 1000 pop	13	9
Length of stay	26.7	29.9
Multi Disciplinary Assessment (% within 24 hours)	97	77
Relevant access to MRI scan (% within 60 mins)	85	79
% Discharges on predicted date of discharge	90	82
Swallowing service intervention (% within 24 hours)	85	66

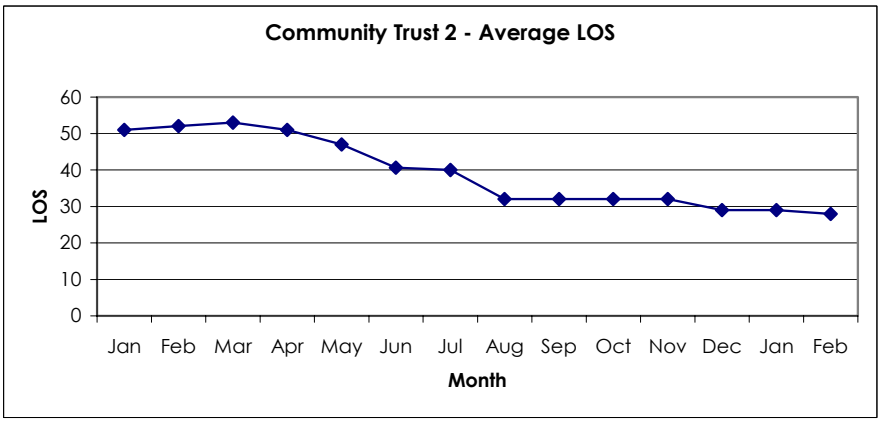




Stroke Services - Community services information report

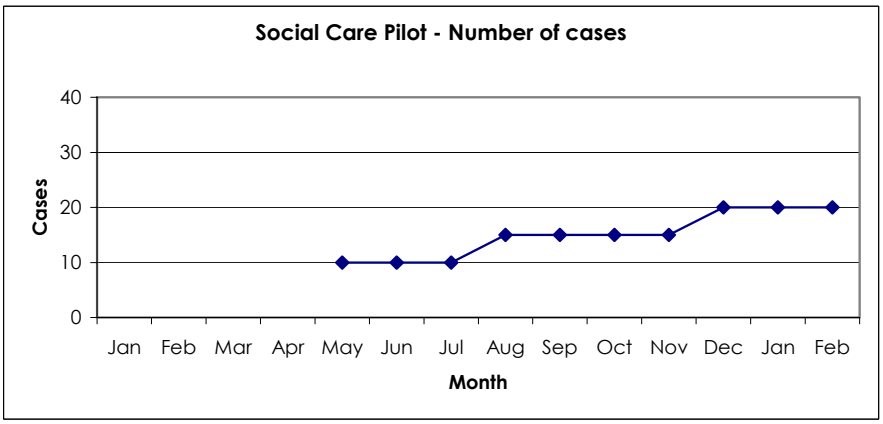
Measure	Community Hospital 1	Community Hospital 2
Rehabilitation LOS	48.9	39.1
Bed Occupancy (%)	75	65





Social Care Pilot

Caseload	150
Bed Days saved	3,000



Stroke Services - Quality of Care Performance Scorecard

Quality Measure	Acute sector -	Acute sector -	Provider Arm (PCT)	Community Hospital 1	Community Hospital 2	Social Care pilot
Admitted to stroke unit within 24 hours						
Access to scanning wthin 60 mins of admission						
Access to MDT team within 24 hoursof admission						
Bed occupancy						
Access to rehabilitation services						
Acute stroke LOS						

Handout 3 – Benchmarking data

Measure	PCT	PCT Peer Group	Cost per patient - PCT	Cost per patient - PCT Peer Group
Average length of stay - total	31.2	29.4	£3,450	£2,950
Average length of stay - acute	27.5	23.8	£4,119	£4,250
Average length of stay - community	44.5	36.1	£3,266	£2,876
Incidence - Rate per 100,000 population				
North locality	5.1			
East locality	4.7			
South locality	4.1			
West locality	3.5			
Total	4.3	3.9		
Annual Health Check				
North locality	76%			
East locality	81%			
South locality	85%			
West locality	91%			
Total	85%	94%	£29	£28
Access to Lifestyle Advice				
North locality	80%			
East locality	78%			
South locality	82%			
West locality	83%			
Total	81%	93%	£45	£40
Community Rehabilitation Services -				
Access rate per 100,000 population	3.1	5.4	£950	£700

Handout 4 – Social marketing information

Lifestyle Group Study

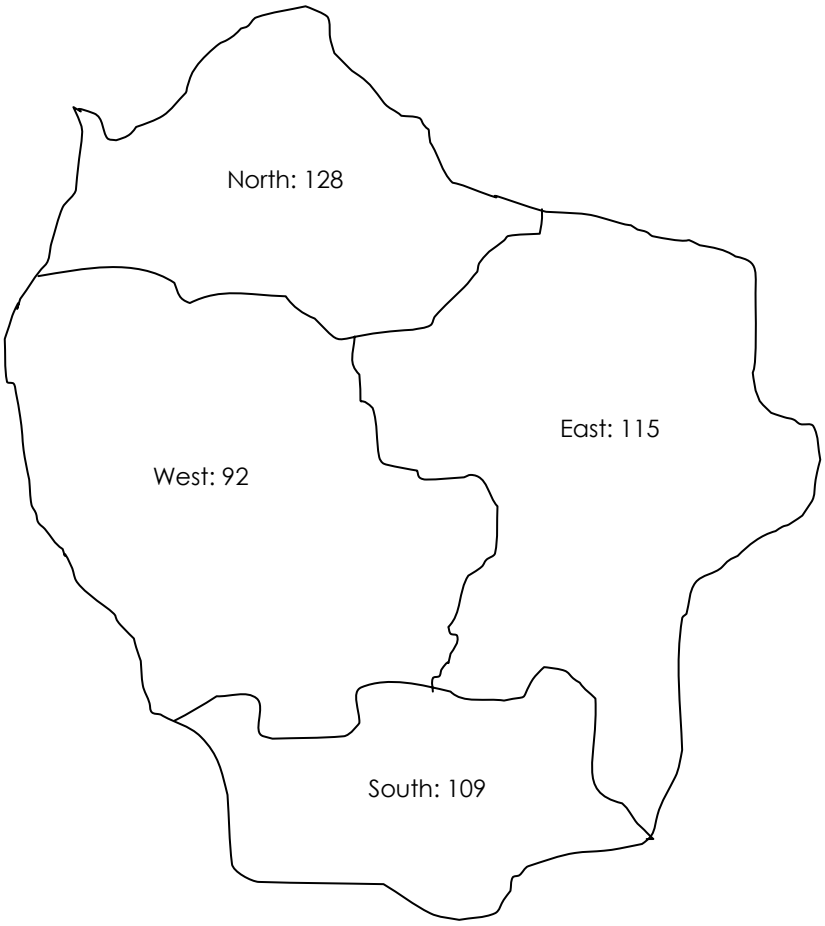
We have been involved in pilot studies across the country, using social marketing and lifestyle type analysis to target patients at risk of heart disease and stroke related conditions.

We have worked with commissioners to focus on specific lifestyle groups and target them with information and access to local community based services.

The early benefits that are being seen are:

- reduced number of admissions to Cardiology services
- increased numbers of patients accessing smoking cessation services
- improved rates of diabetes
- increase in exercise being undertaken

Using our lifestyle database we have been able to predict the impact on the four localities across your PCT and using our index have ranked these in terms of the impact that our programme of work will have. The average England index is 100, therefore the greater the index the bigger the impact.



Therefore we feel there is potential to improve the health and well-being of your population and enable costs savings from undertaking our Lifestyle Programme.

Handout 5 – Workforce data

Provider

Acute sector - Tertiary centre	Staffing	Consumables	Estate	Overheads	Total £
	1,800,000	1,125,000	1,125,000	450,000	4,500,000

Acute sector - DGH	Staffing		Consumables	Overheads	Total £
	Non-Agency	Agency			
	731,250	292,500	316,875	1,096,875	2,437,500

Provider Arm (PCT)	Staffing	Consumables	Estate	Overheads	Total £
	200,000	42,000	33,000	35,000	310,000

Community Hospital 1	Staffing	Consumables	Estate	Overheads	Total £
	771,750	154,350	385,875	231,525	1,543,500

Community Hospital 2	Staffing	Consumables	Estate	Overheads	Total £
	440,000	110,000	330,000	220,000	1,100,000

Workforce

	Whole Time Equivalents				
Organisation	Medics	Nursing	Rehabilitation	A&C	Managerial
Acute sector - Tertiary Centre	7.5	33	9	3.66	2.5
Acute sector -DGH	4.5	26	4	2.66	2
Provider Arm PCT	1	3	6	2	0.66
Community Hospital 1	3	17	9	1	0.5
Community Hospital 2	1.5	9	12	1	0.5

Sample national final scenario

The NHS organisations in your healthcare economy have been working hard on improving their efficiency and effectiveness over the last couple of years, and they have been moderately successful. The NHS chairs and chief executives from the whole healthcare economy recently got together for a "think tank" session at which they concluded that, to achieve further gains, the whole healthcare economy needs to work together. You are a group of clinical directors who have been formed into a steering group tasked with developing a healthcare economy strategy to improve the efficiency and effectiveness of health and social care in the region. It is intended that the new strategy will be published in 6 months' time. You will initially be looking at adult health and social care services.

You will receive an update every hour, representing around 6 week's elapsed time. You may send no more than 2 people to this update, which will be at the Hub. The next update will be at 10:00, and thereafter every hour.

You will also receive written instructions at your work area periodically, and it is possible that you may be visited in your group working area during the course of your work, so be prepared for interruptions!

Handout 1 "description of the healthcare economy" – gives you some key information.

At 10:00, bring the following items to the Hub:

- your key priorities for the project
- an explanation of the rationale for choosing these priorities
- the outcomes you will use to measure success
- how you will manage the change in the context of the national and local ambitions for delivering 'Equity and excellence: Liberating the NHS'

09:15

After discussion you decide that getting GPs to take on a demand management role will be vital to your project. One of the PCTs involved in the project offers to set up a meeting with their PEC* chair, who is particularly influential with GPs across the whole healthcare economy and will be taking a prominent role in GP commissioning.

Handout 2 contains some information on demand management by GPs and handout 3 sets out the role of GP commissioning consortia envisaged in 'Liberating the NHS'.

Prepare an agenda for this meeting alongside a key messages briefing and bring it to the Hub at 9:35.

*A Professional Executive Committee (PEC) is a partnership between a PCT and its partners in commissioning, including practice based commissioners and local authority commissioners. Through the PEC, key local clinical professionals are involved including GPs, community nursing, pharmacy representatives and allied health representatives.

The fundamental role of the PEC is to think of ways of improving health and social care delivery in the local healthcare economies so that patients can access both primary care and secondary care services quickly and without delay. There is only a finite amount of money available and it is one of the PECs functions to think innovatively on ways of delivering services without cutting down on the quality of care.

09:30

The ambulance trust has carried out some research around reasons for call-outs which has shown that a very high proportion of the calls it responds to should not require attendance at accident and emergency, and many are due to falls which could have been prevented (handout 4 contains a summary of this research).

You consider that this could be an important element in your work and decide to produce a paper showing how your project will deal with the issues raised by the research.

Bring your paper to the Hub at 10:10.

09:45

The Professional Executive Committee (PEC) chair has agreed to meet with you. Given they are a busy working GP, they will pop by when they get a chance – so be prepared!

Actors' briefing – participants will not see this

You are the PEC chair, and need to be convinced by the idea of demand management being carried out by GPs. You want to know:

- how patients will benefit
- how GPs will benefit
- what resources they will be given (including payment) to take on this new role

You must drop in unexpectedly to each of your teams on approximately the following timetable – they will have been warned you are coming but will not know exactly when.

	Actor 1 **Jonathan and Liz**	**Actor 2** **Anna and Andrew**
10:00	Waterloo	Cellar 1
10:20	Westminster	Cellar 2
10:40	London	Churchill
11:00	Thames	Meston
11:20	Albert	Chelsea

[Logistical note – we will need to run quick copies of the teams' agendas so the "PEC chairs" will have them in their hand when they come in.]

The meeting will be scored based on the provided scoring schedule, Frontline and the actors.

10:00 Brief Two

You have realised that your key priorities to improve the adult health and social care across your healthcare economy will require consultation with major stakeholders. You need to produce:

- options for change for unscheduled care, major trauma services and emergency stroke services and your rationale for these options
- your consultation strategy for these options

Handout 5 provides information on best practice in unscheduled care, major trauma and stroke services.

Bring your options for change and consultation strategy to the Hub at 11:00.

10:25

A national cancer charity publishes a report which alleges many patients with cancer struggle (including those in care homes) to get sufficient palliative care, and sometimes go to accident and emergency units simply to get pain relief. However, because services are not set up to deal with such requests, the cancer patients can find themselves having too many tests and being given inappropriate treatment in the acute hospital.

After discussion within the team, you agree that this does occur at times in your hospitals. You have an opportunity to meet with the local representatives of the charity to discuss how to improve this aspect (and other aspects) of cancer care. What questions will you ask?

Handout 6 contains a summary of best practice in palliative care.

Bring your list of questions to the Hub at 11:15.

10:50

You are contacted by a diabetes support group run by patients. They point out that at times they require urgent treatment for their condition although this could often be avoided if they were given some "expert patient" training and the ability to self-refer.

Handout 7 contains some information on self-referral and diabetes.

You decide to meet with the support group to explore their ideas more fully. Produce an agenda and brief notes of points you want to cover at the meeting.

Bring your agenda and brief notes for you to refer to at the meeting, to the Hub at 11:20.

11:00 Brief Three

The finance directors of the healthcare economy have compared notes on your project, and ask for information on the cost implications of the options.

Your finance sub-group has been collecting information, and is able to provide some baseline information (see Handout 8).

Provide a paper which covers for unscheduled care, major trauma and emergency stroke care:

- the likely savings for each area
- outline the areas where 'one off' costs would occur

Bring your costing paper to the Hub at 12:00.

11:15

The acute hospitals in your region are struggling with the revised Operating Framework requirement* that they will not receive any further payment if a patient is readmitted within 30 days of discharge. They believe that they should improve their rehabilitation and re-enablement services across the whole healthcare economy and ask your steering group if you have any ideas that could help them.

They note that it is possible that major changes may be required, for example responsibility for rehabilitation and re-enablement may need to be moved, or new partnerships formed.

Bring your ideas to the Hub at 11:45.

*Paragraph 31 of the "Revision to the Operating Framework for the NHS in England 2010/11" states:

"…there is an intention to ensure that hospitals are responsible for patients for the 30 days after discharge. It a patient is readmitted within that time, the hospital will not receive any further payment for the additional treatment. This strengthens an existing expectation that avoidable readmissions due to poor quality care are not reimbursed….Making hospitals responsible for a patient's ongoing care after discharge will create more joined-up working between hospitals and community services…"

11:45 Actors' briefing - not given to the teams

A member of the Frontline team goes to each team base and says:

"I am a member of your Communications team. A national celebrity who lives near Marton Hospital has seen local press coverage of your options and has set up a pressure group "Save our A&E". He/she is outside now and wants to ask a couple of questions. Please could one of you step outside and answer them. There is a press journalist with them as well."

The journalist is played by Noel and Gillian.

The celebrity is played by one of the actors - they ask politely but firmly what is going on (think Joanna Lumley in full campaign mode!).

Your schedule should be approximately:

	Actor 1 **Gillian and Jonathon**	**Actor 2** **Noel and Anna**
11:45	Cellar 1	Waterloo
12:00	Cellar 2	Westminster
12:15	Churchill	London
12:30	Meston	Thames
12:45	Chelsea	Albert

All visits must be complete before the 13:00 briefing.

This intervention will not be formally scored but the journalist will come up with a press headline based on the interview – this will be used as the basis of a question at the Town Hall meeting.

12:00 Brief Four

There are concerns about the long term sustainability of the A&E at Marton Hospital. A proposal has been made to down grade the A&E to a minor injuries unit. The chief executives have asked you - the steering group, to undertake a risk assessment of implementing this change in service delivery for unscheduled care within the healthcare economy.

Bring your risk assessment to the Hub at 13:00.

12:10

The meeting with the diabetes support group went well and the PCTs across the healthcare economy agree that self-referral should form an important part of their redesign of services. You realise that introducing self-referral could have an impact on your options for change and your costings and decide to prepare a short paper setting out the implications of self-referral on your project.

Handout 9 contains some information about the level of self-referral and the impact on emergency presentations.

Bring your paper to the Hub at 12:45.

13:00 Brief Five

You have reached the end of your remit and have arranged a Town Hall meeting to explain the changes you are proposing to any interested party including the public and local NHS staff. Prepare a 3 minute presentation clearly setting out:

- the reasons for change
- the process followed
- your decisions

Be prepared for questions.

13:30 – 14:15 – Attend the Town Hall meeting – teams from each break-out room go to the following meeting rooms:

Reading and Writing Room	Gladstone Library
Cellar 1	Waterloo
Cellar 2	Westminster
Churchill	London
Meston	Thames
Chelsea	Albert

14:15 – 15:15 – Participants debrief including "model" answer

15:15 – 15:45 – Assessors feedback to participants

15:45 – 16:15 – Announcement of winning team, presentations and final remarks

16:15 – Drinks reception

Town Hall brief – not seen by the participants

Within the audience for the presentations will be the journalist, a member of the public (played by Frontline who will not ask a question but score the presentation and answers to the questions) and an actor in the role of the celebrity. Each team will be asked 2 questions, based on their presentations. One question will be based on the headline generated after the celebrity interview and will be asked by the journalist; the second question will be asked by the celebrity.

Handout 1 (08:45) – Description of the Healthcare Economy

The healthcare economy comprises 5.1 million residents. There are 5 large cities within the healthcare economy, with populations ranging between 450,000 and 800,000. There is a large rural spread for the remainder of the population, served by market towns. The healthcare economy has good overall health compared to other economies in the United Kingdom. However, there are considerable variations in health status representing a number of challenges to the healthcare economy:

- two million households with single people accounting for 30% of households
- people aged over 65 years are expected to increase to 23% of the total population by 2021
- a rise in hospital admissions for alcohol-related harm
- reducing length of stay in acute trusts for stroke patients by ensuring access to specialist rehabilitation teams within 72 hours of admission

- a year on year rise in accident and emergency attendances at acute hospitals
- approximately 200,000 residents living in wards ranked in the 10% most deprived nationally
- increasing demand for unscheduled care and emergency admissions
- an increase in unscheduled care and emergency re-admissions
- a variation of over ten years for men and seven years for women in life expectancy between different wards across the region
- lack of integration with local authorities
- only 62% of people who have suffered a stroke receive brain imaging within 30 minutes of arrival at hospital
- a higher percentage of uncontrolled diabetes than the rest of England
- lack of comprehensive Patient and Public involvement in service design and delivery of services
- lower than average survival outcomes in major trauma
- significant and increasing levels of obesity in children, which causes concern for their future health
- only 17% of patients dying in the place of choice

The health and social care of the healthcare economy is currently served by the following:

- 6 NHS Foundation Trusts
- 6 District General Hospitals
- 2 Regional Specialist Units – Cardiology and Neurosurgery
- 7 Primary Care Trusts
- 1 Integrated Care Trust (NHS Greymouth)
- 21 Practice Based Commissioning (PBC) clusters
- 8 community trusts (aligned with the 7 PCTs and Integrated Care Trust)
- 7 Mental Health Trusts
- 1 Ambulance trust
- 2 NHS Treatment Centres
- 8 local authorities

One of the PBC clusters has recently won national recognition for its model of demand management for long term conditions.

The Integrated Care Trust is innovative in its approach to delivering care against four key ideas:

- the patient's needs drives everything
- all patients deserve to have a health care team they know and trust
- patients should face no barriers when seeking care

- staff members and supporting infrastructure are vital to success

Commissioners must manage demand, make efficiencies and reduce expenditure significantly by 2014.

The region is served by 3 Major Trauma Centres, 8 Accident and Emergency departments, 6 Minor Injuries Units and 3 walk-in centres.

One of the Major Trauma Centres is under investigation by the Care Quality Commission for its ability to deliver the required surgical services to deal safely with major trauma patients.

Healthcare Standards results recently published for acute trusts and the PCTs are benchmarked in the following tables

NHS Acute Trusts

Trust Name	Type of trust	Quality of service	Use of resources	Mortality ratio
T1 – Greymouth Hospital	DGH	Good	Fair	98
T2 – Hamilton Hospital	Neurosurgery unit	Excellent	Excellent	76
T3 – Winton Hospital	DGH	Weak	Fair	106
T4 – Cromwell Hospital	FT	Good	Good	100
T5 – Blenheim Hospital	Cardiology unit	Fair	Fair	94
T6 – Marton Hospital	DGH	Fair	Fair	101
T7 – Wellington Hospital	FT	Good	Good	93
T8 – Wellsford Hospital	DGH	Good	Fair	98
T9 – Napier Hospital	FT	Good	Excellent	91
T10 – Amberley Hospital	FT	Good	Fair	99
T11 – Featherstown Hospital	DGH	Fair	Weak	98
T12 – Queenstown Hospital	DGH	Weak	Weak	107
T13 – Cartertown Hospital	FT	Good	Fair	96
T14 – Nelson Hospital	FT	Excellent	Excellent	91

Note: The mortality rate in the table above compares the expected rate of death in a hospital with the actual rate of death. It looks at those patients with diagnoses that most commonly result in death, for example heart attacks, strokes or broken hips. For each group of patients it is worked out how often, on average, across the whole country, they survive

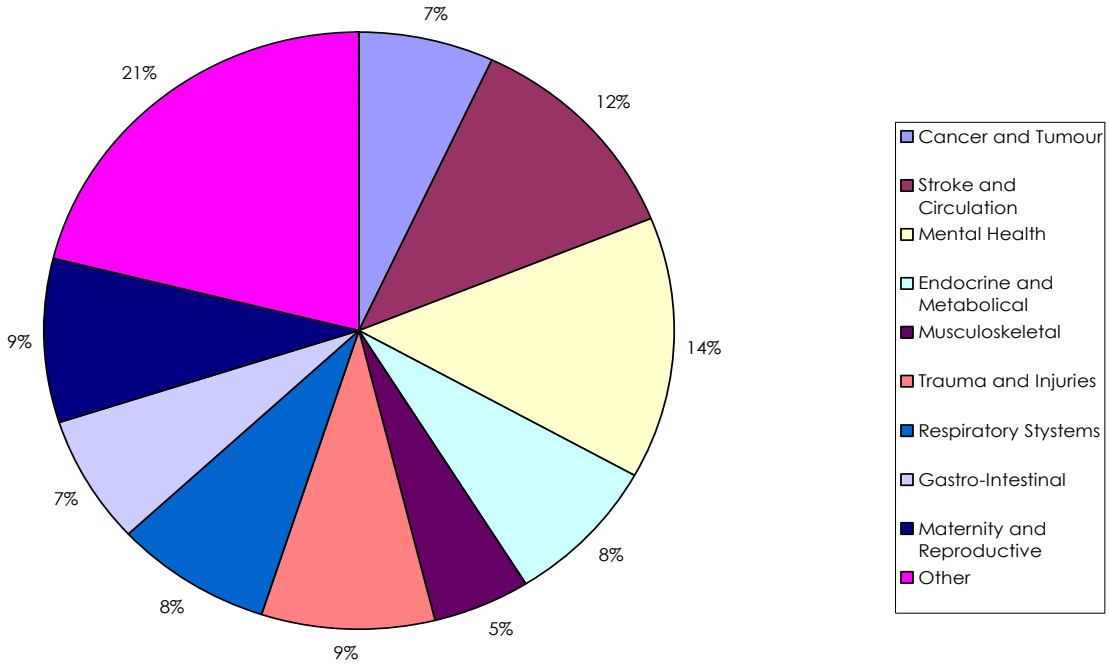
their stay in hospital, and how often they die, taking into account their age, the severity of their illness and other factors, such as whether they live in a more or less deprived area. This calculates how many patients are expected to die at each hospital, which is compared with the number of patients that actually die. If a hospital's actual rate is the same as the expected rate the mortality ratio is 100. If it is higher than would be expected, the ratio is above 100, and if it is below the level expected, the ratio is below 100.

Primary Care Trusts

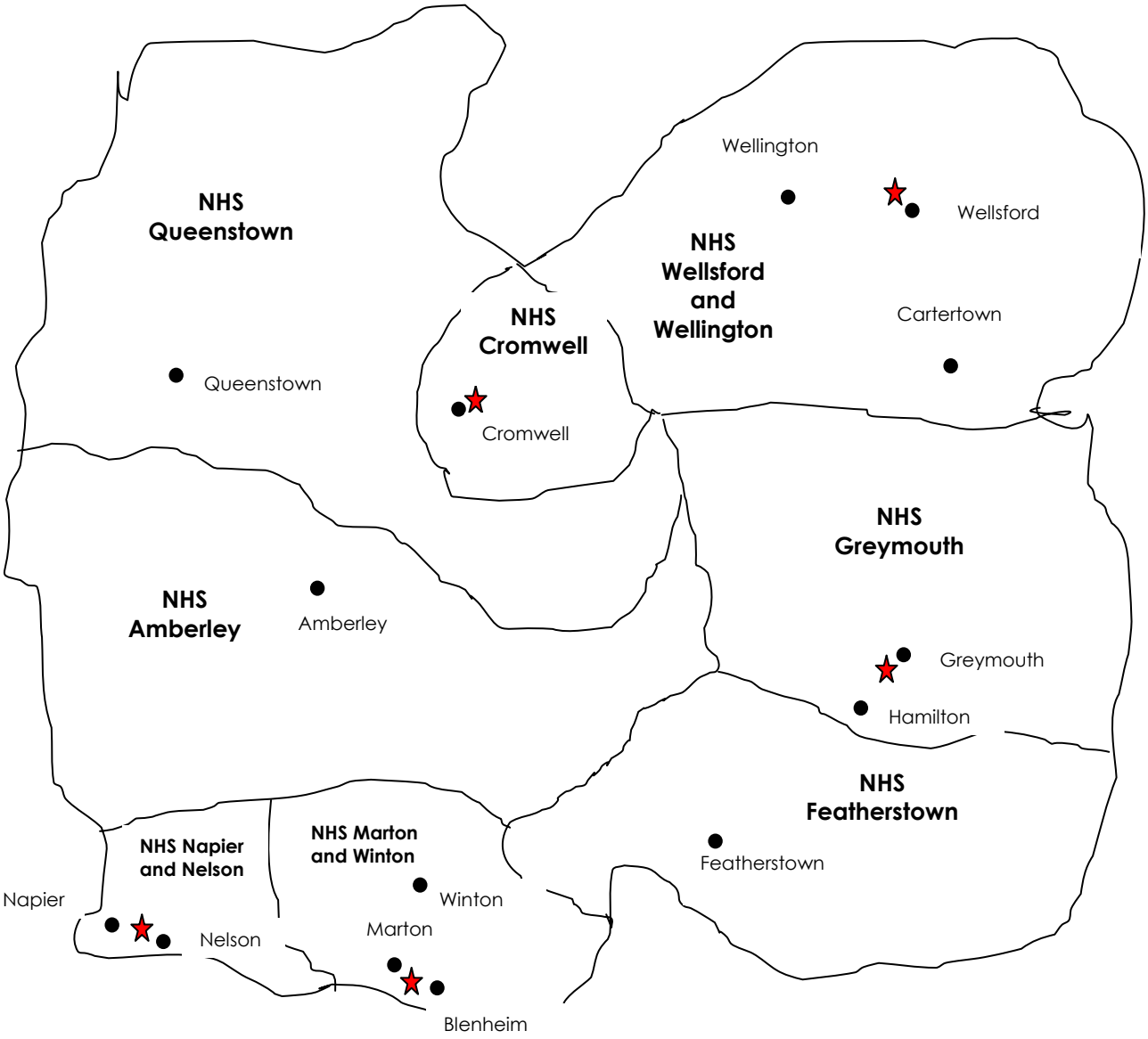
PCT	Overall Quality	Quality of financial management
PCT1 NHS Wellsford & Wellington	Good	Fair
PCT2 NHS Greymouth	Good	Good
PCT3 NHS Marton & Nelson	Fair	Fair
PCT4 NHS Cromwell	Fair	Weak
PCT5 NHS Featherstown	Fair	Weak
PCT6 NHS Queenstown	Weak	Weak
PCT7 NHS Amberley	Good	Fair
PCT8 NHS Napier & Nelson	Excellent	Excellent

A breakdown of expenditure by major programme budgeting areas is shown below.

Programme Budget Expenditure - Healthcare Economy



A Map of the Healthcare Economy is Shown Below



●	**NHS Acute Trust**
★	**City**

Healthcare Economy Priorities

The healthcare economy priorities align with those nationally set out in *'*Equity and excellence: Liberating the NHS'* and all changes that are made within our economy will be in line with these three key principles.

First, patients will be at the heart of everything we do. So they will have more choice and control, helped by easy access to the information they need about the best GPs and hospitals. Patients will be in charge of making decisions about their care.

Second, there will be a relentless focus on clinical outcomes. Success will be measured, not through bureaucratic process targets, but against results that really matter to patients – such as improving cancer and stroke survival rates.

Third, we will empower health professionals. Doctors and nurses must to be able to use their professional judgement about what is right for patients. We will support this by giving front-line staff more control. Healthcare will be run from the bottom up, with ownership and decision-making in the hands of professionals and patients.

It is recognised that the massive deficit and growing debt means there will be some difficult decisions to make and that our healthcare economy is not immune from those challenges. But far from that being reason to abandon reform, it demands that we accelerate it. Only by putting our patients first and trusting professionals will we drive up standards, deliver better value for money and create a healthier economy.

* Reference:

The White Paper - Department of Health (July 2010)
'Equity and excellence: Liberating the NHS' -

Handout 2 (09:15) – Demand Management by GPs[2]

Demand management is about understanding and influencing demand. The process should focus on using planning and forecasting skills to ensure patients receive the most appropriate care in the right setting. It is not just about managing the number and type of referrals. By focusing on outcomes and ensuring that patients receive the right care in the right setting, consistency is increased for similar conditions. This can help to reduce the variation which may cause unnecessary delays.

Approaches to Demand Management

Reducing unplanned hospital admissions to benefit all patients
Reducing inappropriate and unplanned hospital admissions enables services to work at optimum efficiency.

Clinical referral protocols help to increase consistency of referrals
The aim of referral protocols should always be to improve the quality of referrals via the use of shared clinical knowledge and expertise.

Patient-centered commissioning can help to provide services more suited to users' needs
As primary care practices have a much closer relationship with local patients, they can commission services more suited to their needs.

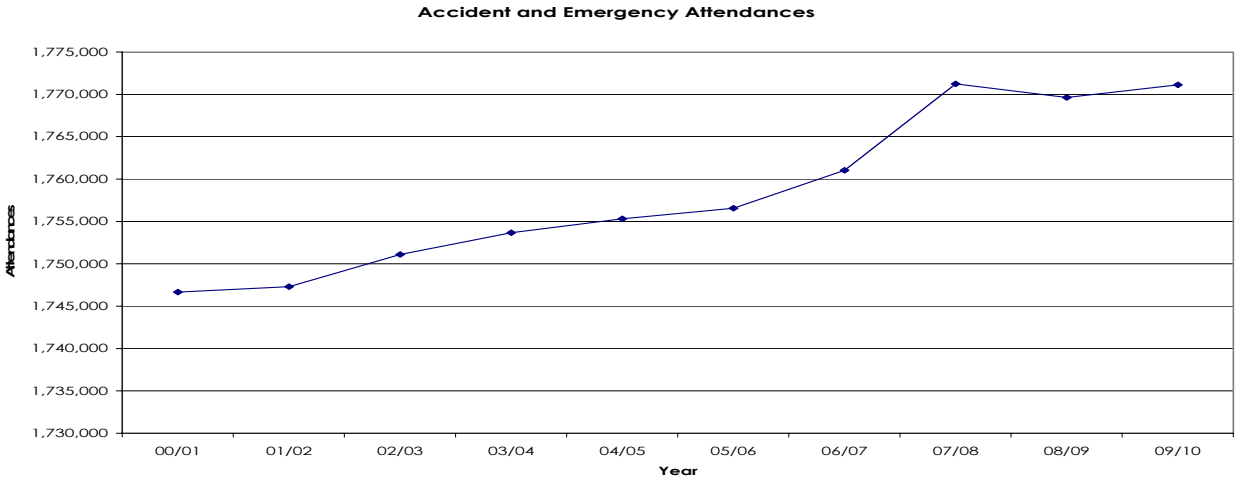
Care and resource utilisation techniques
Two key techniques that can be used in demand management are :

- utilisation management – identifying patients admitted to hospital who could have been treated in an alternative setting
- prior clinical approval – assists commissioners and providers groups of patients to be assessed according to protocols owned by secondary and primary care clinicians

Pre-operative assessment can reduce the demand on hospital services
Before being admitted for surgery, patients are assessed to ensure that they are physically fit and fully prepared for the procedure.

[2] Based on "Demand Management", NHS Institute for Innovation and Improvement, 2008

Demand Information for the Region



Activity rate per 1,000 population by PCT

PCT	Population	Referral Rate	Elective admission rate (inc day cases)	Emergency admission rate
National average		169.3	67.3	72.9
NHS Wellsford & Wellington	500,000	171.5	65.1	71.3
NHS Greymouth	595,000	163.2	63.1	64.8
NHS Marton & Nelson	799,000	167.5	66.9	77.4
NHS Cromwell	800,000	176.3	65.3	69.3
NHS Featherstown	550,000	175.6	64.2	77.8
NHS Queenstown	610,000	177.0	67.3	84.2
NHS Amberley	530,000	168.9	66.7	70.0
NHS Napier & Nelson	716,000	159.4	64.3	67.4

Study by Practice Based Commissioning (PBC) Clusters

A PBC initiative across NHS Greymouth has realised savings by managing demand across two long term conditions pathways. The cost of an emergency admission for diabetes is £2,100 and for COPD £1,718. The PBC group set up a number of social marketing initiatives to interact with users of the service to meet needs of patients in primary care. The early results show a reduction in the number of emergency admissions.

Disease Group	Patients on Register	Admissions 2008/09	Admissions 2009/10	Reduction %
Diabetes	12,459	1,764	1,298	26.4
COPD	7,822	873	453	48.1

Handout 3 (09.15) - The role of GP commissioning consortia[3]

- Consortia of GP practices, working with other health and care professionals, and in partnership with local communities and local authorities, will commission the great majority of NHS services for their patients. They will not be directly responsible for commissioning services that GPs themselves provide, but they will become increasingly influential in driving up the quality of general practice. They will not commission the other family health services of dentistry, community pharmacy and primary ophthalmic services. These will be the responsibility of the NHS Commissioning Board, as will national and regional specialised services, although consortia will have influence and involvement.

- The new NHS Commissioning Board* will calculate practice-level budgets and allocate these directly to consortia. The consortia will hold contracts with providers and may choose to adopt a lead commissioner model, for example in relation to large teaching hospitals.

- GP consortia will include an accountable officer, and the NHS Commissioning Board will be responsible for holding consortia to account for stewardship of NHS resources and for the outcomes they achieve as commissioners. In turn, each consortium will hold its constituent practices to account against these objectives.

- A fundamental principle of the new arrangements is that every GP practice will be a member of a consortium as a corollary of holding a registered list of patients. Practices will have flexibility within the new legislative framework to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality.

- GP consortia will need to have a sufficient geographic focus to be able to take responsibility for agreeing and monitoring contracts for locality-based services (such as urgent care services), to have responsibility for commissioning services for people who are not registered with a GP practice, and to commission services jointly with local authorities. The consortia will also need to be of sufficient size to manage financial risk and allow for accurate allocations.

* The new NHS Commissioning Board will be established at a national level to champion patient and carer involvement and the principle of shared decision making – 'no decision about me without me'

[3] Based on "Equity and excellence: Liberating the NHS" Department of Health, July 2010

- GP consortia will be responsible for managing the combined commissioning budgets of their member GP practices, and using these resources to improve healthcare and health outcomes.

- GP consortia will need to have sufficient freedoms to use resources in ways that achieve the best and most cost-efficient outcomes for patients. Monitor and the NHS Commissioning Board will ensure that commissioning decisions are fair and transparent, and will promote competition.

- GP consortia will have the freedom to decide what commissioning activities they undertake for themselves and for what activities (such as demographic analysis, contract negotiation, performance monitoring and aspects of financial management) they may choose to buy in support from external organisations, including local authorities, private and voluntary sector bodies.

- Consortia will receive a maximum management allowance to reflect the costs associated with commissioning, with a premium for achieving high quality outcomes and for financial performance.

- GP consortia will have a duty to promote equalities and to work in partnership with local authorities, for instance in relation to health and adult social care, early years services, public health, safeguarding, and the wellbeing of local populations.

- GP consortia will have a duty of public and patient involvement, and will need to engage patients and the public in their neighbourhoods in the commissioning process.

Handout 4 (09:30) – summary of ambulance trust research[4]

As people get older, they may fall more often for a variety of reasons including problems with balance, poor vision, and dementia. Up to 30% may fall per year.

Falls in the elderly population represent a serious and increasing issue in the UK:

- one older person dies every five hours as a result of a fall
- falls in older people cost the NHS around three quarter of a billion pounds each year
- 1.25 million falls a year result in hospital admissions

Ambulance services have a key part to play in tackling this issue as they attend this group of patients in their own homes and as a result are able to observe not only the condition of the patients but also their living conditions (hygiene, food, etc).

Local research reinforces the national view and therefore there is a need to pay particular attention to falls. For example, just under half of all deaths from avoidable injury in the region occur in people who are 75 years or older and 51 per cent of all avoidable injury admissions in the region are due to falls.

Other points worth noting are:

- falls in the elderly population have a significant impact on ambulance service provision
- the unadjusted rate of ambulance service responses to females in the 85 and over age group is 480.2 responses per thousand population.
- patients who are 65 years and over account for 66.5 per cent of responses categorised as falls
- patients who are 65 years and over account for 41.4 per cent of all emergency responses

Ambulance staff report that they are frequently called to attend patients in residential nursing homes who have fallen. The data shows that 16.7% of responses for the over 65s are to residential homes, 67.7% within their own homes and 15.6% to non-residential locations. Responses to falls in the over 65s are more frequent during the morning (08:00 to 12:00).

[4] Based on "Falls and Older Persons", research by East Midlands Ambulance Service NHS Trust and "Interventions for Preventing Falls in Older People Living in the Community", Gillespie LD, Robertson MC, Gillespie WJ, Lamb SE, Gates S, Cumming RG, Rowe BH, The Cochrane Collaboration, 2009

Possible interventions include:

- exercise programmes targeting strength, balance, flexibility, or endurance, for example Tai Chi or individually prescribed exercise programmes at home
- multi-factorial interventions to assess an individual person's risk of falling and then carry out or arrange referral for treatment to reduce their risk
- taking vitamin or other nutritional supplements
- interventions to improve home safety, for example removing trip hazards (e.g. rugs) or providing an anti-slip shoe device to wear in icy conditions
- some medications increase the risk of falling - ensuring that medications are reviewed and adjusted may be effective in reducing falls
- surgery, for example cataract removal, insertion of a pacemaker
- fall prevention classes
- bone health assessment and treatment

Handout 5 (10:00) – best practice in unscheduled care, trauma and stroke care

Unscheduled care[5]

Unscheduled care can be defined as health and/or social care which cannot reasonably be foreseen or planned in advance of contact with the relevant professional. It follows that such demand can occur any time and that services to meet this demand must be available 24 hours a day seven days a week.

To deliver more effective healthcare the following principles should be adhered to:

- treat the sickest patients first, no matter how they enter the system
- deliver care within an agreed clinical model using evidence based care, through whole system care pathways
- minimum time to definitive diagnosis, decision, and initiation of treatment
- avoid passing the baton of care more than necessary
- manage patients at home in the community wherever possible with full engagement of local authority services and community teams
- integrate and coordinate service delivery through the use of care coordination systems to effectively manage and govern the delivery of unscheduled care on a 7 day a week basis

The principles of best practice are:

- community wide unscheduled care group with responsibility for the delivery of an the unscheduled care service model which ensures joint working across PCTs, trusts, specialist care networks and local authorities
- services delivered through seven day working without any "In Hours" / "Out of Hours" culture
- areas need wide ranging comprehensive community based services to provide adequate safe care for patients within their own homes. Intensive support teams should be in place to prevent avoidable admissions and to expedite discharge to home

[5] Based on "A Guide to Good Practice: Unscheduled and Emergency Care Services", Halloran F, Robertson-Steel I, National Leadership and Innovation Agency for Healthcare (Welsh Assembly Government)

- prompt assessment on arrival at both acute or community hospitals and agreement of care plans focusing on progression to discharge to enable patients to return home as quickly as possible
- provision of a directory of services, their role and access criteria should be available for all staff/departments
- standardised case documentation for all care handovers between system providers
- the ambulance service should, on the basis of a clinical assessment, refer patients directly to specialist units e.g. coronary care unit, thus bypassing A&E
- enhanced services contracts in primary care to deliver services aimed at admission avoidance and A&E attendance reduction, including minor injury services in general practice and other community locations, where appropriate
- unscheduled care within primary care must be delivered without delay during core hours and patients requiring urgent care should not default to A&E or other services within or outside normal surgery hours
- improved access to, and a wider range of, diagnostics allows more patients to be managed in the community
- out of hours services should be able to access recent results in order to ensure that there is continuity in patient care
- dental, pharmaceutical and ophthalmic services play a major role in overall health care and need to be included in plans

Trauma[6]

The word 'trauma' means wounding due to physical injury. In the UK, trauma is a leading cause of death across all age groups, with over 16,000 deaths due to injury in England and Wales each year. Major trauma admissions to hospital are estimated at 27–33 patients per 100,000 population per year (about 40% of trauma deaths occur at the scene of the incident Major trauma represents less than 1 in every 1,000 emergency department admissions.

Major trauma pathways

The major trauma patient pathway is described as a 'trauma chain of survival'. Trauma patients' lives are saved by immediate pre-hospital interventions and then transfer to specialist surgical facilities in which bleeding can be controlled, traumatic brain injury managed and specialist critical care instituted. Priorities are therefore:

[6] Based on "Regional Trauma Systems: Interim Guidance for Commissioners", The Intercollegiate Group on Trauma Standards, December 2009

- identifying major trauma patients at the scene of the incident who are at risk of death or disability
- immediate interventions to allow safe transport
- rapid dispatch to major trauma centres for surgical management and critical care
- coordinated specialist reconstruction
- targeted rehabilitation and repatriation

Whole healthcare economy trauma systems

A whole healthcare economy trauma system serves a defined population to reduce death and disability following injury. The trauma system includes public health, injury prevention, emergency medical services, all trauma-receiving hospitals, major trauma centres, rehabilitation services, research, education and systems governance.

The trauma system optimises the use of resources, so a trauma patient is treated in the right place at the right time by the right specialists. Major trauma patients are treated at major trauma centres, while other trauma patients are treated at trauma units. This requires optimisation of pre-hospital triage, bypass protocols, development of trauma unit emergency management protocols and rapid inter-hospital major trauma centre transfer capability. Acute rehabilitation services and repatriation pathways allow targeted patient rehabilitation in trauma units or dedicated rehabilitation facilities close to the patient's home.

A major trauma centre (MTC) is a specialist hospital responsible for the care of major trauma patients across the whole healthcare economy. and has a leadership role with responsibility for optimising the pathways and care of major trauma patients. The MTC has all surgical specialties and support services to provide care for major trauma patients regardless of their pattern of injury. It is recommended that the MTC should see at least 400 major trauma patients each year. Major trauma centres with a sufficient volume of work to gain experience in managing these patients have a 15–20% improvement in outcomes. Each MTC should therefore serve a minimum population of approximately 2–3 million people.

A trauma unit (TU) manages injured patients in its local catchment area. A TU is responsible for the management of trauma patients who are not classified as having major trauma. Patients with less severe injuries do no better and may do worse if managed in an MTC. This is in part because they may be de-prioritized compared to the major trauma patients for operations, rehabilitation resources, etc.

Stroke care[7]

A stroke is a 'brain attack' caused by a disturbance to the blood supply to the brain. There are two main types of stroke:

Ischaemic: the most common form of stroke, caused by a clot narrowing or blocking blood vessels so that blood cannot reach the brain, which leads to the death of brain cells due to lack of oxygen.

Haemorrhagic: caused by a bursting of blood vessels producing bleeding into the brain, which causes damage.

Transient ischaemic attacks (TIA), also known as mini strokes, occur when stroke symptoms resolve themselves within 24 hours. A large proportion of an identifiable group of high risk TIAs (those lasting more than 10-15 minutes, raised bp, with diabetes) go on to have full blown stroke – these patients are at greatest risk in first few days therefore starting treatment early is key to preventing a full stroke.

Best practice in stroke care is set out below:

1. People seen by ambulance staff outside hospital, who have sudden onset of neurological symptoms, are screened using a validated tool to diagnose stroke or transient ischaemic attack (TIA). Those people with persisting neurological symptoms who screen positive using a validated tool, in whom hypoglycaemia has been excluded, and who have a possible diagnosis of stroke, are transferred to a specialist acute stroke unit within 1 hour.
2. Patients with acute stroke receive brain imaging within 1 hour of arrival at the hospital if they meet any of the indications for immediate imaging.
3. Patients with suspected stroke are admitted directly to a specialist acute stroke unit and assessed for thrombolysis, receiving it if clinically indicated.
4. Patients with acute stroke have their swallowing screened by a specially trained healthcare professional within 4 hours of admission to hospital, before being given any oral food, fluid or medication, and they have an ongoing management plan for the provision of adequate nutrition.

[7] Based on "Quality Standard for Stroke", National Institute for Health and Clinical Excellence, June 2010

5. Patients with stroke are assessed and managed by stroke nursing staff and at least one member of the specialist rehabilitation team within 24 hours of admission to hospital, and by all relevant members of the specialist rehabilitation team within 72 hours, with documented multidisciplinary goals agreed within 5 days.
6. Patients who need ongoing inpatient rehabilitation after completion of their acute diagnosis and treatment are treated in a specialist stroke rehabilitation unit.
7. Patients with stroke are offered a minimum of 45 minutes of each active therapy that is required, for a minimum of 5 days a week, at a level that enables the patient to meet their rehabilitation goals for as long as they are continuing to benefit from the therapy and are able to tolerate it.
8. Patients with stroke who have continued loss of bladder control 2 weeks after diagnosis are reassessed to identify the cause of incontinence, and have an ongoing treatment plan involving both patients and carers.
9. All patients after stroke are screened within 6 weeks of diagnosis, using a validated tool, to identify mood disturbance and cognitive impairment.
10. All patients discharged from hospital who have residual stroke-related problems are followed up within 72 hours by specialist stroke rehabilitation services for assessment and ongoing management.
11. Carers of patients with stroke are provided with a named point of contact for stroke information, written information about the patient's diagnosis and management plan, and sufficient practical training to enable them to provide care.

Handout 6 (10:25) – best practice in palliative care[8]

The World Health Organisation's definition of palliative care includes relief of suffering, enhanced quality of life, and support for patients and families. It enumerates the following goals and principles:

- to regard death as part of life and a normal process
- neither to hasten nor to delay death
- to use a team approach to address the needs of patients and their families, including bereavement
- to initiate palliative care early in a patient's illness, even when he or she is still receiving life-prolonging treatments such as chemotherapy or radiation therapy

Care should be underpinned by the following principles:

- an active and compassionate approach to care that ensures respect for and dignity of the patient and family
- partnership in care between patient, family and health and social care professionals
- regular and systematic assessment of patient/carer needs incorporating patient consent at all times
- anticipation and management of deterioration in the patient's state of health and well-being
- advance care planning in accordance with patient preferences
- patient choice about place of care and death
- sensitivity to personal, cultural and spiritual beliefs and practices
- effective coordination of care across all teams and providers (in statutory, voluntary and independent sectors) who are involved in the care of patient and family

A standard service model could include:

- a range of specialist supportive and palliative care services for people with complex needs with access according to need
- a supplementary range of community services (non-specialist but discrete) to provide institutional care for people with less complex needs and support at home
- a health and social care workforce able to provide general supportive and palliative care

[8] Based on "Putting Evidence into Practice: Palliative Care", Brunnhuber K, Nash S, Meier DE, Weissman DE, Woodcock J, BMJ Group, Spring 2008; "End of Life Care: A Commissioning Perspective", The National Council for Palliative Care, February 2007 and "Improving Access to Palliative Care Medicine", Isle of Wight PCT, July 2006

- an expert resource that is able to facilitate the introduction of generic tools such as the Liverpool Care Pathway, the Gold Standards Framework and Preferred Place of Care document and to provide education and training for the workforce as a whole
- a mechanism that would provide effective coordination of these elements

The specialist palliative care services required are:

- in-patient services provided by hospices and NHS specialist units
- hospital support teams and community support teams
- day therapy/out-patient centres
- psychological and rehabilitation services

The additional community services required are:

- nurse-led in-patient care for people with less complex needs, provided mainly in community hospitals, care homes and hospices
- support for people at home that is supplementary to the specialist palliative care team e.g. nursing support, rapid response, out of hours support
- social support – practical support, sitting services, day care
- equipment for use at home

Access to pain relief

The effective management of pain and other symptoms is an essential element of palliative care. A key factor that has had a negative impact on palliative care patients and their families is poor access to appropriate medication, in particular diamorphine for the management of pain. Palliative care patients also often experience new or worsening symptoms outside of doctors' normal working hours. The provision of specialist palliative care and the availability of palliative care medicines within the community can present major problems.

To ensure that common symptoms which may be experienced at the end of life are anticipated (e.g. pain, nausea, excessive secretions and agitation), it is possible that small quantities of appropriate medicines can be prescribed for the patient and stored in a special container, within the patient's home. Carers and patients are reassured that the prescribed medicines have been prescribed 'just in case' and may not be needed. This supports the principles of the "Gold Standards Framework" and the Liverpool Care Pathway.

Handout 7 (10:50) – information on self-referral and diabetes

Self-referral[9]

Self-referral can be defined as patients being able to refer themselves to a therapist without having to see anyone else first, or without being told to refer themselves by a health professional. This can relate to telephone, IT or face-to-face services.

The usual process is that the patient completes an application form, after which an appointment for assessment is made, reducing the need for an appointment with a GP and avoiding an additional step in the process. Many patients only need a single appointment, having discussed their health issues with a health professional for the first time. At this appointment patients can be signposted to other NHS, social services, private or third sector services. Treatment plans are agreed for those requiring specific interventions.

Patients with long term chronic conditions tend to have a very good understanding of the appropriate management for their disease, and which services they need to access.

Case studies have shown that direct access service models can reduce pressure on health professionals and deliver clear clinical benefits. In particular, the evidence shows that direct access:

- increases patient choice
- delivers more timely patient management
- delivers better quality of care for patients
- reduces workload pressure on GPs and other health professionals
- cuts the level of missed appointments
- reduces waiting times for treatments
- realises cost savings at primary and acute care settings

Not allowing self-referral is likely to impose unnecessary personal, clinical and financial costs:

To the patient

- attending a GP's surgery just to be referred onwards can cause frustration and inconvenience and delay the start of treatment

[9] Based on "Self-referral to Physiotherapy Services", The Chartered Society of Physiotherapists, September 2004 and "Self-referral pilots to musculoskeletal physiotherapy and the implications for improving access to other AHP services", Department of Health, October 2008

- delays in treatment may aggravate symptoms, causing unnecessary complications and prolonging treatment with less than optimum results
- patients may perceive the NHS as bureaucratic and unresponsive and not seek treatment

To budgets

- GPs are often more expensive per hour than the services that the patients are referred on to
- complications caused by a delay in the commencement of treatment can result in more costly, prolonged treatment
- the involvement of so many health professionals and their budgets may mitigate against efficient service planning

To health professionals

- patients have unnecessary contacts with GP or consultants adding to the workload of critical healthcare staff
- this contributes to the reduction of GP consulting time per patient
- surgeons undertake procedures that could have been avoided by an earlier intervention

Diabetes[10]

Diabetes mellitus is one of the most common chronic disorders in the UK, affecting people of all age groups. The prevalence of diabetes increases with age – at least one in ten older people resident within the UK have diabetes. Diabetes is also more common in people of South Asian, African and African Caribbean origin.

Diabetes is a leading cause of blindness, kidney failure and limb amputation and greatly increases the risk of coronary heart disease and stroke. It can threaten the successful outcome of pregnancy. People with diabetes are much more susceptible to foot problems – including damage to the nerves leading to loss of feeling, or poor blood flow which can lead to a risk of ulcers and gangrene. Diabetes accounts for at least 5 per cent of healthcare costs. Up to 10 per cent of hospital inpatient resources are used to care for people with diabetes.

Diabetes mellitus is caused by a deficiency of, or insensitivity to, the hormone insulin, resulting in an inability to control the use and storage of glucose - blood glucose levels therefore rise.

There are two main types of diabetes:

[10] Based on "Recommendations for the provision of services in primary care for people with diabetes" published by Diabetes UK

- type 1 diabetes, which results from an absolute deficiency of insulin and more commonly presents acutely before the age of 30, although it can occur at any age
- type 2 diabetes, which results from a relative deficiency of, and/or insensitivity to, insulin and is more commonly diagnosed over the age of 40 although it is increasingly being diagnosed in younger people, even children

Although the onset of Type 2 diabetes is usually less dramatic than that of Type 1 diabetes, the long-term effects are similar and equally devastating.

There is increasing evidence that the onset of Type 2 diabetes can be prevented or delayed by maintaining a healthy weight and increasing physical activity levels – this is particularly important in those at increased risk of developing Type 2 diabetes.

Meticulous metabolic control can prevent or delay the onset of the complications of diabetes. The impact of these complications can also be greatly reduced if they are detected early and appropriately managed.

Thus, regular surveillance for and early diagnosis of the complications of diabetes are important. It is also generally accepted that early diagnosis and treatment of people with Type 2 diabetes can also help reduce their likelihood of developing long-term complications and the costs associated with diabetes. In view of the high risk of cardiovascular disease in people with diabetes, particularly those with Type 2 diabetes, the careful management of other cardiovascular risk factors, including smoking, physical inactivity and especially hypertension, is also essential.

The provision of diabetes services is complex – care is provided by a wide range of professionals, including general practitioners (GPs) and other primary healthcare professionals and specialist diabetes teams, as well as people with diabetes and their carers.

Handout 8 (11:00) – baseline costing information

Throughout 2009/10 the finance sub-group has collected activity and costing information for accident and emergency, minor injuries and walk in centres across the healthcare economy.

Activity and costings – 2009/10

Annual Costing and Activity Summary

	Accident & Emergency		Minor Injuries Unit		Walk in centre	
	Attendances	Cost per attendance £	Attendances	Cost per attendance £	Attendances	Cost per attendance £
Greymouth Hospital	163,998	67.32				
Hamilton Hospital	176,542	69.65				
Winton Hospital			73,498	34.65		
Cromwell Hospital	132,865	63.00				
Blenheim Hospital	175,487	67.65				
Marton Hospital	76,734	72.89				
Wellington Hospital	185,091	67.99				
Wellsford Hospital			88,111	24.76	23,762	12.90
Napier Hospital	164,654	59.78				
Amberley Hospital			76,529	36.76	54,623	14.50
Featherstown Hospital			43,834	36.54		
Queenstown Hospital	193,740	61.46			42,098	13.25
Cartertown Hospital			64,887	21.34		
Nelson Hospital			35,726	23.89		

Unit	**Average cost per patient £**
Accident and Emergency	66.22
Minor Injuries Unit	29.66
Walk in centre	13.55

The admissions and cost per patient for stroke and major trauma admissions has also been collated across the healthcare economy along with some benchmarking data.

Admissions and costings 2009/10

	Stroke		Major Trauma	
	Admissions	**Cost - per patient £**	**Admissions**	**Cost - per patient £**
Greymouth Hospital	1,543	2,950	501	4,107
Hamilton Hospital	1,333	3,113		
Winton Hospital	943	2,875		
Cromwell Hospital	2,055	2,999		
Blenheim Hospital	1,777	2,871	487	3,449
Marton Hospital	1,665	4,187		
Wellington Hospital	2,843	3,054		
Wellsford Hospital	57	1,276		
Napier Hospital	1,733	3,098		
Amberley Hospital	873	2,540		
Featherstown Hospital	932	3,276		
Queenstown Hospital	1,002	2,887	298	5,543
Cartertown Hospital	237	2,943		
Nelson Hospital	911	3,133		

The finance sub-group has benchmarked the cost per patient across the healthcare economy and against national comparative benchmarked data. The benchmarks compare the average cost per patient and the lower quartile based on cost per patient.

	Cost per patient £			
	Healthcare Economy		National	
	Average	Lower Quartile	Average	Lower Quartile
Stroke	2,943	2,878	2,914	2,754
Major Trauma	4,366	3,778	4,032	3,765

Handout 9 (12:10) – Information on the effect of self-referral

The diabetes support group has been working with some pilot PCTs to implement a self referral scheme across some of their constituent practices.

The outcomes of the pilot are to:

- reduce the number and rate of admissions to acute hospital settings
- increase the %age of patients able to access services through self referral
- ensure patients get access to services quicker, reducing the need for prolonged follow-up care
- improving efficiency of service provision in terms of access and quality of care
- reduce burden on GP appointments
- improve the flow of patients through the diabetes pathway
- improve self-management of care

Initial data for 2009/10 has been collected across PCT's in the healthcare economy to evaluate the self referral pilot.

PCT	% Diabetes patients self - referring	Diabetes admission rate (1,000 population)	Average number of follow – up interventions per referral	Number of GP appointments saved
NHS Wellsford & Wellington	3	4.0	4	32
NHS Greymouth	21	2.4	1.5	376
NHS Marton and Nelson	4	4.2	3.6	54
NHS Cromwell	12	3.3	2.3	187
NHS Featherstown	7	5.6	3.6	76
NHS Queenstown	25	2.6	1.1	438
NHS Amberley	2	5.1	4	65
NHS Napier & Nelson	3	4.7	2.8	98

Appendix 3 Assessment tools

Designed by Frontline for Department of Health

Sample assessors briefing pack

Introduction

Thank you for agreeing to be an assessor in the National Final of the 2010 Allied Health Professions (AHP) Leadership Challenge.

You are participating in an event in which the winners of ten SHA-based events will compete to be the national winner of the AHP Leadership Challenge. The challenges are training simulations based on fictional, but realistic scenarios in a variety of health and social care economies. The aim in 2010 has been to build on the success of the 2009 AHP Leadership Challenge, incorporating the learning gained from running the programme last year.

Key objectives of the events are:

- to enable AHPs to recognise, utilise and acknowledge their existing transferable skills to other "arenas" in health & social care, resulting in increased leadership capability and capacity, thereby improving services for users
- **to develop AHPs' understanding of the realities and boundaries of working in a patient led, evidence based, contestable system, with powerful, informed commissioners and a plurality of providers**
- **to help AHPs to identify their development needs to continue in their leadership careers**

The challenges require the teams to demonstrate leadership behaviours and to competently manage a fast moving situation. Ability to discern interrelationships and work across internal boundaries will be required, or teams will not be successful in achieving the challenges set. These challenges explore the leadership process as a whole and, among other things, how important it is for leaders to develop out of inward-looking, functional roles and overcome barriers to co-operation.

The role of the assessors is crucial to the success of these events, and this pack has been prepared to provide you with as much information as possible in advance to underpin the briefing and training that you will receive at the event.

Outline of the Leadership Challenge National Final Event

The agenda for the National Final event is attached as Appendix 1. This is largely self explanatory, but it is worth emphasising the importance of the afternoon and evening of day one in preparing both the participants and the assessors for the challenges of the following day. Although the 'development session and group exercise' are not part of the competitive challenge, the group exercise provides a 'warm-up' opportunity for teams to work together again in addressing a task, and for the assessors to practice the use of the scoring tools that they will apply in earnest the following day.

On day two, the teams will be assessed on how they respond to a series of challenges set by means of a scenario that unfolds as the morning progresses. All the teams will address the same scenario. The scenario will generally follow the same format as those faced by the teams at their respective regional events. The scenario developed for the national final will however be more challenging. To illustrate the kind of challenges that the teams will be faced with, an example scenario developed for one of this year's regional events is attached at Appendix 2.

In order to give assessors an opportunity to familiarise themselves in advance with the actual scenario on which the teams will be assessed on the second day of the event, they will be provided with a copy in strict confidence towards the close of day one.

Role of the Assessors

The contribution of the assessors is to observe the AHP teams as they address the challenges set and to score their performance against certain leadership behaviours using the 'tool kit' described later in this pack.

This toolkit was developed initially for the 2009 AHP Leadership Challenge and incorporates leadership behavioural indicators drawn from the NHS Leadership Qualities Framework (LQF). The toolkit was shown to be effective from the evaluation of last year's events and has again been successfully used for the 2010 regional events.

Consideration was given to modifying the tool for the National Final to incorporate competencies from the new Clinical Leadership Competency Framework being developed by the NHS Institute for Innovation and Improvement. However, it was felt that that there were unlikely to be

significant benefits for the event or the participants from amending the assessment tool at this stage, and as the new Clinical Leadership Competencies Framework has not yet been formally promulgated, it was decided to retain the assessment tool based on the LQF.

There will be ten assessors, matching the number of AHP teams competing in the challenge. Each assessor will be assigned as 'Lead Assessor' for one AHP team. Each assessor will also be 'paired' with another assessor. The two assessors will observe and score their own, and their colleague's, team at various stages throughout the challenge scenario so that there are two assessor scores for each AHP team.

Each 'pair' of assessors will be expected to confer at various stages during the course of the challenge as a mechanism for 'sense-checking' and moderating their scores. This does not mean that both sets of scores for an AHP team should be identical – it is simply a process to enable the two assessors to discuss their respective observations and to have another set of views to draw upon in helping them decide on their personal scoring for each of the two teams they have observed. Both assessors' scores will be taken into account in determining the overall placing of each team.

The AHP Leads from each SHA will also be attending the event and will be 'circulating' among the teams to observe them at work, but they will not be involved in the assessment and scoring process.

The assessors will also be required, at the end of day two, to provide feedback to the AHP team for which they are lead assessor on how they handled the challenges of the competitive scenario. The aim will be to highlight the strengths shown by the team and any areas for development. The feedback will be to the AHP team as a whole, and not to the individuals in it.

Process for Identifying the Winning team

The performances of the AHP teams in addressing the scenario challenges will be scored over four elements as follows:

Element	Maximum Score
Demonstration of leadership behaviours	(2 x 160) 320
Response to interaction with a key stakeholder	30
Final Presentations	30
Content of written outputs to the challenges set	100
Total	480

The assessors will only be required to score the leadership behaviours aspect of the AHP teams' performance. The scoring of the teams' interaction with a key stakeholder will be undertaken by actors/specialists who will be role-playing during the scenario. The content of the various written outputs required from the scenario and the team presentations will be scored by members of the Frontline and DH teams who will be facilitating the event.

The collation of the various scoring elements will be undertaken on the afternoon of day two. The winning team has to be identified on the day, and collation of the scores needs to be completed within an hour-long window.

Because of the limited time available for the final collation of the scores, it is extremely important that all those contributing to the process have completed their individual scoring prior to the commencement of that session. To facilitate this, a timetable has been drawn up which allocates times during the day for assessors to confer with their partners on their respective perceptions of AHP team performance and to complete the requisite scoring documentation, as well as ensuring adequate periods for observing each team. The timetable is attached as Appendix 3

The collation of team scores should only happen at the session allocated for that purpose. Pairs of assessors should not seek to 'average' their scores before then. Every assessor's scores will be noted individually, and they should be prepared to justify and evidence the scores they have awarded with reference to examples and quotes.

Through a process of plenary discussion (and challenge) among the assessors at the scoring collation session, the winning team will be identified. This is obviously not a scientific process, but a systematic one that goes some way to addressing the subjectivity and inevitable variation in scoring standards between assessors. The process has been effective in achieving consensus among the assessors on the winning team at all of the 2009 events and all of the 2010 regional events.

In addition to reaching consensus on the winning team, there will also be a discussion to succinctly capture the outstanding features of that team's performance that can be shared with all the participants when announcing the winner.

Allocating Assessors to Teams

The event facilitators will seek to allocate the lead assessors to teams and to determine the 'pairing' of assessors in advance of the event. The proposals for this will be discussed, and any necessary adjustments agreed, at the initial assessor briefing on day one of the event.

To help with this, each assessor will be provided with details of the membership of each AHP team prior to the event and will be asked indicate any teams that they would feel uncomfortable about assessing because of circumstances such as knowing any team members well, or having a direct managerial relationship with team members. Obviously the aim is to avoid any perceptions of bias in the assessment process.

The allocation of the lead assessors and the pairing of assessors will only apply for the assessed scenario on day two. The observation of the group exercise on day one will be by a different assessor from those observing and scoring the team on day two.

Providing Feedback

The assessors will be required to provide feedback to teams on two occasions during each event. The first will be to provide informal feedback

over dinner in the evening of day one to the team that they have observed during the group exercise that afternoon. The aim here will be to offer constructive feedback on how the team operated and to provide some pointers that might be helpful for the team in tackling the assessed scenario on day two.

The second episode of feedback will be by each lead assessor to his/her allocated team at the end of day two. The experience from all of the AHP Leadership Challenge events to date has been that the teams really valued feedback from their assessors on where they had done well and where they should focus future development. The event programme has been designed to ensure that this is accommodated, and assessors are expected to do all they can to make best use of this time for the benefit of the teams that they assessed. To assist with this, a template has been prepared on which assessors can prepare and note the feedback they wish to give, and Appendix 4 provides guidance on the principles of giving helpful feedback.

The Scoring System for Leadership Qualities

As explained earlier in this pack, the approach to assessing the teams' performance in relation to leadership behaviours has been developed using the NHS Leadership Qualities Framework. The 'toolkit' that you will use is attached at Appendix 5. This comprises:

- a note explaining the leadership qualities to be assessed and how these link to the NHS LQF
- a sheet for assessors to record their observations and (later) to insert notes against these on how they should be scored
- a scoring tool which provides a framework for scoring over five key elements:
  - collaborative working
  - effective and Strategic influencing
  - intellectual flexibility
  - political astuteness
  - managing the scenario

  Each of these has four indicators with a score rating of 1 – 8
- a matrix to summarise a team's scores across the five elements and produce a total score. There is also space for recording the key points which have been most influential for you in deciding your scoring

- the feedback template for assessors to use when giving qualitative feedback to their primary team at the end of the event

Supplies of these working documents will be provided for your use at the event.

And finally …..

We look forward to meeting you at the event, where further briefing will be provided. If in the meantime you have any questions arising from this pack that you wish to discuss please do not hesitate to get in touch with the contact named in the covering letter.

We would like thank you again for participating in the National Final of the AHP Leadership Challenge 2010, which we hope will again provide an enriching experience for everyone involved.

Sample assessors timetable

2010 AHP Leadership Challenge National Final
Assessor Timetable – Day Two – 27 July

Indicative Timings	Lead Assessor For Team A	Partner (Lead Assessor for Team B)
08.30 – 08.45	Welcome and Keynote Speaker	
08.45 – 10.00	Observe Team A	Observe Team B
10.00 – 11.00	Observe Team B	Observe Team A
11.00 – 11.15	Compare notes on relative strengths and development needs for teams	
11.15 – 12.00	Observe Team A	Observe Team B
12.00 – 12.15	Compare notes on relative strengths and development needs for teams	
12.15 – 13.00	Observe Team B	Observe Team A
13.00 – 13.30	Lunch, compare notes and complete scoring documentation	
13.30 – 14.15	Observe team presentations and make final adjustments to scoring	
14.15 – 15.15	Collation of scoring – attended by all assessors and facilitated by Frontline	
15.15 – 15.45	Lead assessors provide feedback to their respective teams	
15.45 – 16.15	Announcement of winning team and presentation Event Closure and final remarks	
16.15	Drinks reception and meet the teams	

Sample assessor briefing pack

Guidance on Providing Helpful Feedback

Feedback is an essential part of training and development activities. Feedback helps 'learners' to maximise their potential through raising their awareness of their strengths and areas for improvement, and thereby to help identify actions that can be taken to improve performance.

It is important to ensure that the feedback given is aligned with the overall learning objectives of the programme, event or activities in which the 'learners' have been engaged. Kolb (1984) proposed that learning happens in a circular fashion that it is experiential ('learning by doing'), and that ideas are formed and modified through experiences. These ideas underpin the notion of reflective practice, which occurs as part of professional and personal development.

It is generally accepted that when giving feedback to individuals or groups, an interactive approach is most effective. This helps to develop a dialogue between the learner(s) and person giving feedback and builds on the learners own self-assessment. It is collaborative and helps learners to think about and take responsibility for their own future learning and development.

The following are some key principles for giving helpful feedback:

- check that the 'learners' are happy to receive the feedback you can offer
- be clear about what you are giving feedback on and link this to the learners' overall development or intended outcomes of the event
- focus on some of the positive aspects before the areas for improvement
- talk about and describe behaviours, giving examples where possible, and do not evaluate or assume motives
- use and give your experience of the behaviour eg "When you said …., I thought that you were …….
- negative feedback should also be specific and non-judgemental
- focus on behaviours that can be changed, not personality traits
- when giving negative feedback, suggest alternative behaviours, eg – "Have you thought of approaching that kind of task in a different way?"

- feedback is for the recipient(s), not the giver, so be sensitive to the impact of your message
- consider the content of your message, the process of giving the feedback and the congruence between your verbal and non-verbal messages
- encourage reflection – this should involve posing open questions such as:
  - did that go as planned? If not why not?
  - if you were doing the same again, are there things that you would differently, and why?
  - how did you feel during ……? How would you feel about doing it again
  - what are the key things that you feel learned from that experience?
- keep the dialogue moving with open-ended questions which can be followed up with more probing questions
- do not overload the session, and aim to summarise two or three key messages at the end
- bear in mind the following **barriers to effective feedback**
  - being so concerned with not upsetting the 'learners' that the feedback provided is sterile and meaningless
  - resistance or defensiveness of the learners to receiving criticism – be alert to the reaction to negative feedback and manage this constructively where necessary
  - feedback that is too generalised and not related to specific facts or observations
  - feedback that does not incorporate suggestions/guidance on how to achieve more effective behaviours
  - feedback that is inconsistent

To assist assessor's in the Allied Health Professionals Leadership Challenge to prepare for and structure their feedback to participants, a Feedback Template has been provided at the end of the Assessors' Toolkit contained in Appendix 5.

Sample assessors toolkit

Confidential

AHP Leadership Challenge – Competencies to be Assessed

Introduction

In considering the areas of competence to be assessed in the AHP Leadership Challenge, emphasis has been placed on the scoring of teams' performance in demonstrating leadership behaviours, rather than

management skills. The starting point for identifying the behaviours to be assessed was the well-established and recognised NHS Leadership Qualities Framework (LQF):

It would be unrealistic to expect all of the dimensions of the LQF to be assessed in the leadership challenge, both in terms of what would be measurable within the limitations of the events themselves, and in terms of

the range of behaviours that assessors could reasonably be expected to evaluate on the day.

Having regard to these criteria, the assessment process is based on four of the qualities from the LQF drawn from the clusters *Setting Direction* and *Delivering the Service.* The four leadership qualities are:

- Collaborative Working
  Being committed to working and engaging constructively with internal and external stakeholders.

- Effective and Strategic Influencing
  Being able and prepared to adopt a number of ways to gain support and influence diverse parties, with the aim of securing health improvements.

- Intellectual Flexibility
  The facility to embrace and cut through ambiguity and complexity and to be open to creativity in leading and developing services.

- Political Astuteness
  Showing commitment and ability to understand diverse interest groups and power bases within organisations and the wider community, and the dynamic between them so as to lead health services more effectively.

In addition, there is a fifth element in the assessment process entitled 'Managing the Scenario'. This will assess how well the groups organise themselves and manage their approach and resources in addressing the challenge scenarios set. This element also draws upon indicators from both the 'Self Management' and 'Drive for Results' qualities within the LQF.

Within each quality in the LQF, levels are described, and for each level behavioural examples are provided. The AHP Leadership Challenge assessment tool is based on scoring a selection of these examples that should realistically be demonstrated by teams of participants in addressing the scenarios set. For the purposes of the AHP Leadership Challenge assessment process, these selected examples are referred to as "the indicators". Four indicators have been selected for each of the above four LQF Leadership Qualities.

The Indicators

Below are the indicators on which the assessment process is based. Each indicator is listed under the Leadership Quality to which it is attributed in the LQF. For simplicity, the behavioural level to which the indicator is attributed in the LQF is not indicated. However, in the event of a tie in the scoring between two or more teams the behavioural levels will be employed to apply a 'weighting' to the scores for the indicators from the higher LQF behavioural levels.

Collaborative Working

- acknowledges and respects others' diverse perspectives
- shares information with partners when appropriate
- summarises progress, taking account of differing viewpoints, so as to clarify understanding and to establish common ground
- ensures that the strategy for health improvement is developed in a cohesive and 'joined up' manner

Effective and Strategic Influencing

- points out the costs and benefits associated with a particular course of action
- persuades others by presenting a clear and well reasoned case
- deliberately plans an approach, or steps, in an 'argument', that will be successful with a particular audience or interest group
- understands the need to use informal persuasion and provision of information, to influence others over whom they have no formal authority

Intellectual Flexibility

- responds positively to new information and alternative views, including those from other professional areas
- modifies own thinking, and sets of assumptions, to take account of new and diverse viewpoints
- is adept at moving between significant detail on the ground and the big picture
- crystallises key points from a mass of disparate information and makes sense of complex situations

Political Astuteness

- identifies key people inside and outside the organisation who can help to influence or get things done
- understands what is and is not possible in a given local or national climate, in terms of health service provision
- understands the 'politics' – with both a small and a large 'p' – of the health and social care context
- understands the underlying social, political and historical factors shaping local and national realities of health services, and uses this understanding to get things done

Managing the Scenario

These indicators are not exclusive to one Leadership Quality within the LQF. They reflect some of the practical management skills needed to address the Challenge scenarios effectively:

- identifies and sets priorities and manages time effectively
- sets goals and standards
- shows determination to meet objectives set
- carefully manages own responses and reactions when under pressure

Frontline Consultants

May 2010

Sample assessor notes

AHP Leadership Challenge

Assessor Notes

Assessor **Name:**	**Team** **Observed:**	**Page:**

Observation Notes	**Notes on scoring**

Sample scoring tool

AHP Leadership Challenge Scoring Tool

Assessor:		**Team Assessed:**	
Leadership Quality: COLLABORATIVE WORKING			
Key to scoring	**1 – 4: Further development required**	**5/6: Developing well**	**7/8: Exceptional**

Leadership Quality Indicator	Score 1	2	3	4	5	6	7	8	**Comments**
• acknowledges and respects others' diverse perspectives									
• shares information with partners when appropriate									
• summarises progress, taking account of differing viewpoints, so as to clarify understanding and to establish common ground									
• ensures that the strategy for health improvement is developed in a cohesive and 'joined up' manner									
Collaborative Working composite score	**/32**								

Additional Comments:

Leadership Quality: EFFECTIVE AND STRATEGIC INFLUENCING									
Key to scoring	**1 – 4: Further development required**				**5/6: Developing well**			**7/8: Exceptional**	
Leadership Quality Indicator	Score 1	2	3	4	5	6	7	8	**Comments**
• points out the costs and benefits associated with a particular course of action									
• persuades others by presenting a clear and well reasoned case									
• deliberately plans an approach, or steps, in an 'argument', that will be successful with a particular audience or interest group									
• understands the need to use informal persuasion and provision of information, to influence others over whom they have no formal authority									
Effective and Strategic Influencing composite score	**/32**								
Additional Comments:									

Leadership Quality: INTELLECTUAL FLEXIBILITY									
Key to scoring	**1 – 4: Further development required**			**5/6: Developing well**				**7/8: Exceptional**	
Leadership Quality Indicator	Score								**Comments**
	1	2	3	4	5	6	7	8	
• responds positively to new information and alternative views, including those from other professional areas									
• modifies own thinking, and sets of assumptions, to take account of new and diverse viewpoints									
• is adept at moving between significant detail on the ground and the big picture									
• crystallizes key points from a mass of disparate information and makes sense of complex situations									
Intellectual Flexibility composite score	**/32**								
Additional Comments:									

Leadership Quality: POLITICAL ASTUTENESS									
Key to scoring	**1 – 4: Further development required**				**5/6: Developing well**			**7/8: Exceptional**	
Leadership Quality Indicator	Score 1	2	3	4	5	6	7	8	**Comments**
• identifies key people inside and outside the organisation who can help to influence or get things done									
• understands what is and is not possible in a given local or national climate, in terms of health service provision									
• understands the 'politics' – with both a small and a large 'p' – of the health and social care context									
• understands the underlying social, political and historical factors shaping local and national realities of health services, and uses this understanding to get things done									
Political Astuteness composite score	**/32**								
Additional Comments:									

Leadership Quality: MANAGING THE SCENARIO									
Key to scoring	**1 – 4: Further development required**				**5/6: Developing well**			**7/8: Exceptional**	
Leadership Quality Indicator	Score 1	2	3	4	5	6	7	8	**Comments**
• identifies and sets priorities and manages time effectively									
• sets goals and standards									
• shows determination to meet objectives set									
• carefully manages own responses and reactions when under pressure									
Managing the Scenario composite score	**/32**								
Additional Comments:									

AHP Leadership Challenge

Total Score Matrix

Assessor **Name:**	**Team** **Observed:**	
Leadership Quality	**Score**	**Max Possible**
Collaborative Working		**32**
Effective and Strategic Influencing		**32**
Intellectual Flexibility		**32**
Political Astuteness		**32**
Managing the Scenario		**32**
Total Team Score		**160**
Comments:		

Sample assessor feedback from

AHP Leadership Challenge

Template for Assessor Feedback

AREA OF FEEDBACK	KEY MESSAGES	BEHAVIOURAL EVIDENCE
Collaborative Working		
Effective and Strategic Influencing		
Intellectual Flexibility		
Political Astuteness		
Managing the Scenario