seminar
briefing no3

LEADERSHIP, CHANGE AND PRIMARY CARE GROUPS

Report edited by Dr. Louise Locock, Templeton College, University of Oxford.

This report summarises the results of a seminar held on 1st June 1999 at Templeton College. The seminar was sponsored by the NHS Leadership Programme for Chief Executives to promote debate about, and understanding of, the leadership challenges facing Primary Care Groups (PCGs).

Presentations in the plenary session were made by:

Barbara Stocking, Regional Director of the South East Regional Office, NHS Executive.

Sir David Rowland, Chairman of NatWest Group and President of Templeton College.

Keith Ruddle, Associate Fellow in strategic management at Templeton College.

Tessa Brooks, Director of the NHS Leadership Programme for Chief Executives.

In addition a series of workshops were held on key leadership challenges. The chairs and leaders of these sessions are listed on page 16.

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Executive Summary

● A number of important themes emerged, as well as some signals as to the leadership development needs of those charged with ensuring PCGs' success.

The challenges they face are to:

– create shared values and objectives;

– manage ambiguity and uncertainty;

– manage without hierarchy, and without a macho 'hire and fire' culture;

– work in partnerships – which entails making space for partners' agendas too;

– provide patient-focused management;

– get the local organisation right and identify the levers available locally;

– identify the sources of information and use them well;

– achieve national goals, targets and deadlines;

– choose a leadership style suitable for the purpose and the time, and lead by example.

● The real agenda is about long term issues of quality, which both PCG leaders and the Government will want to address. However, the Government also has a short term agenda which involves key structural and operational tasks, and PCG leaders must help them with it. Unresolved structural tensions inherent in the latest set of reforms need to be acknowledged and addressed – for example, the uncertainty surrounding the future role of health authorities, and the tensions between PCGs' roles as commissioners and providers.

● Too often the size of the agenda, the volume of guidance and the range of tasks required threaten to overwhelm NHS leaders with short term anxieties. The one over-riding message from the workshop is to emphasise the vital importance of enabling them to step back from the detail and scan the horizon, as well as take time out to develop themselves.

- To assist the NHSE leadership programme the workshop helped identify a variety of needs to be addressed. These range from the basic technical and managerial skills required to manage boards, where sharing good practice has a strong role to play, to the need for higher level reflection on the nature of leadership, strategy, partnership, culture and motivation. There was consensus that PCG leaders need both; they urgently need help with practical skills, and with developing their understanding of issues such as team building and performance management. However, in meeting the immediate requirements of organisational change, it was important they keep sight of the underlying, longer term, NHS agenda.

- If PCGs are to 'make a difference' to the health of the population, and work across traditional boundaries between groups within the NHS, between agencies, and between professional and patient, there is a need for substantial additional development and learning.

- PCG leaders could benefit enormously from alternative perspectives on leadership that others can offer, from within the NHS, from other public services, and from the private sector. However, the experience of others cannot be lifted directly into a PCG setting. On the contrary, workshop participants emphasized the importance of cultural sensitivity and the need for leaders to reflect on the appropriateness of leadership experiences from elsewhere and on the different theoretical approaches to leadership. An eclectic approach to learning from others and from different theories is needed to find locally appropriate solutions.

- Despite the size of the challenges ahead, there is considerable optimism about the future for PCGs and the contribution they can make to health and health care. This report helps identify ways in which those leading PCGs can best be supported in helping PCGs achieve their goals.

SETTING THE CONTEXT – PCGS AND THE CHANGES ARISING FROM 'THE NEW NHS'

The 1997 White Paper, 'The New NHS' proposed major changes to the organisational structure and focus of the NHS. The key changes are set out in Table 1 below.

PCGs cover populations of 100,000 on average. Unlike GP fundholding, they involve all GP practices in the country in the commissioning process. New ways of working are required to make a reality of partnership and to achieve the necessary practical co-ordination. PCGs, and the individuals who lead them, face a period of intensive personal and organisational development. PCGs have the option of becoming selfstanding Primary Care Trusts, independent of their health authority.

Table 1 **Key changes proposed in 'The New NHS'**

- abolition of the internal market but retention of the separation between commissioning and provision
- abolition of GP fundholding
- introduction of PCGs and transfer of most commissioning activities from health authorities to PCGs
- strengthening of the strategic role of health authorities, which will have responsibility for co-ordinating the production of a local Health Improvement Programme (HImP)
- requirement for all health care organisations to work in partnership rather in competition
- introduction of a number of national initiatives to reduce variation and increase consistency of standards (including the National Institute for Clinical Excellence [NICE], National Service Frameworks [NSFs], the Commission for Health Improvement [CHI], clinical governance, national reference costs, and a national performance management framework
- reorientation of performance management towards quality of standards of care and outcomes, with reduced emphasis on cost and volume.

THE NEW CHALLENGES FOR PRIMARY CARE

Barbara Stocking

Barbara Stocking identified four key objectives which now appear in some form in virtually all policy documents. These are:

- tackling the root causes of ill health;
- breaking down barriers between services;
- ensuring high quality standards and maximising value for money;
- making access to services faster and more convenient.

Tackling the root causes of ill health

She stressed that this applied not just to dealing with common causes of ill health across the population, but also to tackling health inequalities. Although this is a big agenda, there are clear priorities. The White Paper 'Saving Lives: Our Healthier Nation' confirms the Green Paper priorities of tackling cancer, heart disease, mental health and accidents, as well as smoking and teenage pregnancy (on which the Social Exclusion Unit is currently working). The government is seeking to be careful not to keep adding new priorities to its list, but to try to allow those it has already set to take root and develop.

Responsibility for some priorities will start with the NHS, which will then bring in relevant partners (for example in cancer); sometimes other agencies will take the lead, and the NHS will have a contribution to make. This is mirrored at national level by greater interaction between government departments. An important point is that it takes two to make a partnership, and both partners will need to be flexible. The NHS need to make space in its own agenda to have the capacity to help partner organisations with their priorities, as well as expecting other agencies to work on NHS priorities.

Breaking down barriers between services

Working in partnership is thus seen as the way to achieve the first priority of tackling the root causes of ill health, replacing the competitive relationships of the internal market. The Government is primarily interested in outcomes, and in seeing evidence of movement towards the first priority. It is less interested in process.

Ensuring high quality standards and maximising value for money

This is not just about tackling poor performance, although that is important, but about ensuring uniformly good standards across the country. National Service Frameworks (NSFs) and clinical governance will be key mechanisms for achieving this, and will be monitored by NHS Executive Regional Offices and by the Commission for Health Improvement (CHI).

Quality is not only about clinical care - ministers are particularly concerned about how people are treated as individuals and how the NHS is viewed by its own staff. They want to foster a culture where taking pride in standards and taking a patient-centred view becomes more instinctive, and more grounded in basic common sense. 'Ministers may be more likely to take an individual patient perspective, and their example can be a salutary reminder'.

Making access to services faster and more convenient

Again, this is an area where NHS managers have probably been slower than ministers to grasp how the public think. Focus groups have consistently found that people think the NHS is difficult and inconvenient to use. Patients feel they have to wait – not just for an operation but for someone to answer the telephone or to make a referral – in a way that is not expected in any other service sector industry. They feel insecure and lost in the system.

The Prime Minister is personally promoting patient-centred initiatives such as the NHS Direct telephone helpline and walk-in clinics. He appears to be firing a warning shot – start thinking along more patient-centred lines and get on board, or we'll put things in place anyway, and go round you.

One criticism of instant access services is that they serve the articulate middle class perspective, and do nothing to tackle inequalities. However, if the NHS is to have a chance of reducing inequalities, it has to remain the primary provider of health care and to do that it has to retain public confidence across all classes. Modernising the NHS and making it more accessible is an important part of maintaining broad social support for it.

How PCGs can contribute

Stocking stated that PCGs were exceptionally well placed to help deliver these key Government objectives, particularly given their local knowledge of population health needs and their ability to influence the delivery of primary care services. They also have a key role to play in clinical governance and in ensuring high quality in primary care, although it will

undoubtedly be challenging to measure quality across practices.

There is a danger the agenda can seem overwhelming, at all levels of the NHS. One way through it is to identify the basic requirements and concentrate on those, allowing other activities to take a lower priority.

> *'What do we have to deliver? What are the basic requirements?*
>
> *Which ones do we really have to motor on?*
>
> *Which of those need strong local action, and which can we allow other people to motor on?*
>
> *Which can we allow to take care of themselves for the time being?'*

'The Prime Minister appears to be firing a warning shot to the NHS – start thinking along more patient-centred lines and get on board, or we'll put things in place anyway, and go round you'.

Barbara Stocking

Getting the organisation right is an important prerequisite for successful change – for example ensuring systems are in place for accountability and public involvement, recruiting the right staff, and engaging health care partners. Internal tensions need resolving. If you are fighting amongst yourselves it is a waste of time and saps your energy.

Discussion themes

Discussion of Barbara Stocking's comments centred on three points.

Hard choices and public involvement. A strong view was that if we want to transform the NHS so that it retains public confidence, we should also share openly with the public the reality that hard choices need to be made and involve them in that process. On the other hand, public involvement is struggling against a 50-year legacy of paternalism amongst NHS doctors and managers. We do have to be more open with the public, but the NHS has kept from them much of the information needed to participate more fully. At the moment, lack of confidence in the NHS tends to mean that, if there is a debate about hard choices, the public see it as a failure of the NHS rather than an inevitable part of managing within limited resources.

Instant access services. It is possible that walk-in clinics will either have insufficient capacity, in that users will have to wait to be seen, or be inefficient, if shorter waits are achieved by building unnecessary slack into the system. However, there is evidence that demand for most health services becomes reasonably predictable once the service has become established, and staffing can be adjusted accordingly.

Incentives. In the absence of direct competition between providers (which the Government does not want to promote), alternative incentives and sanctions will apply. There may still be an element of non-financial competition, in terms of competing to provide the best possible service, although this may have the disadvantage of making people reluctant to share good practice. On the other hand, there is a motivation to do things well for intrinsic satisfaction, for patients and for the professional team. Although performance monitoring will be used to identify under-performance, the main emphasis should be on encouragement to do better. There is also a need to use information more effectively from a variety of different sources, including user surveys. As one workshop participant put it 'if we don't use information effectively – not in isolated chimneys but in connected up flues – we won't do well.'

LEADERSHIP AND CHANGE - A VIEW FROM THE BOARDROOM

David Rowland

David Rowland identified many parallels between the challenges facing PCGs and his experiences in the private service sector – although perhaps the private sector offered more levers to achieve change.

Using illustrations from his own experience in insurance and banking, particularly in rescuing the Lloyds Insurance market from the brink of financial catastrophe, Rowland identified a number of fundamental challenges in the exercise of leadership.

Thinking into the position of others

'Talking about customers as if they were a foreign

country' We can easily become institutionalised into thinking we need user surveys, focus groups and external experts to tell us what customers think and need. These may be important, but we ourselves have so much practical and instinctive knowledge of what it feels like to be a bank customer – or a patient – which we can use to think ourselves into that position.

'At your peril forget what goes on in your head – and everyone else's' In the same way as we can think ourselves into the position of customers or patients, we can think ourselves into the position of staff. We should remember that they think the same kind of thoughts as we did in similar situations to theirs. If we understand their perspective, we are then more likely to be able to capture their imagination and take them with us. One way to capture some of the variety of how different people think is to recruit a diverse team, rather than seeking people who think in the same way as oneself, and to listen to them so as to get the benefit of different views.

'Say sorry, please and thank you' Dealing with one's own limitations or problems in carrying out a task by trying to conceal them from everyone else is a recipe for disaster. If, on the other hand, you ask for help when in trouble, people are usually remarkably generous in response. It is impossible to work successfully with people in the future if failings are not dealt with and apologies made.

'Total transparency of information' For example, there may be circumstances when certain skills are required which command higher salaries than those of senior managers. This has to be handled by being totally honest about the situation. Equally there is no point giving false assurances to staff who know there is an impending crisis. Similarly, clients, customers, patients, and the public will respond better to being given an honest picture and then being asked for their continued support.

Luck and judgement

'You need a bit of luck' Although much can be achieved by innovative thinking and team working, luck also has a part to play – and if you find you have a piece of luck, use it and build on it.

'Don't confuse running the railway and playing with the trains' The leader's real job is to run the railway – to determine strategy and get the right people in place to do the job. It is often tempting to spend too much time 'playing with the trains' (focusing on detail). However, some playing with trains is important. It gives signals to the rest of the organisation and sets the atmosphere. For example, dealing with three complaints a day in person, or ensuring directors eat in the canteen with everybody else, sends messages. The trick is not to get seduced into playing trains too much.

Timing and incentives

'The most important thing is timing' A problem for many leaders is that they know where they want to go but timing it can be very difficult. Rowland felt that it was preferable to trust your instinct and get on with a change you know is needed, rather than taking too long to reach your conclusions. In some ways a situation of financial catastrophe (as he experienced when he took over the Lloyd's insurance market) can be relaxing, as it removes timing from the decision tree; it gives the leader an exceptional degree of authority, ceded voluntarily by others desperate for a solution. (This was particularly true of Lloyd's, where there is no hierarchy but rather a set of market partnerships). It is important to be alert to the fact that some of this exceptional authority will be withdrawn again as things return to normal. There

'Trust your instinct and get on with a change you know is needed'.

David Rowland

may also be cases where catastrophic situations initially allow extremists to lead various groups of stakeholders. In such circumstances it may be helpful to buy enough time to allow the weaknesses in the extremist position to become apparent and for them

'The leader's real job is to run the railway – to determine strategy and get the right people in place to do the job. It is often tempting to spend too much time 'playing with the trains".

David Rowland

to be replaced by people willing to negotiate. A hard negotiator is preferable to someone who cannot negotiate at all.

'Marathons, not sprints' Achieving change in the NHS requires time and stamina, particularly given limited autonomy in decision-making compared to the private sector and the need to manage by voluntary consent. PCGs will need to concentrate on areas where they can realistically expect to achieve change.

'Carrots rather than fear' As well as one's own inner personal motivation, reward, fear and optimism can be sharp levers which make things happen faster. However, in most cases fear is more likely to act as a demotivator than a motivator. More can be achieved by positive incentives - the reward of working in a team with a common purpose and knowing you were doing well is more powerful than a fear of losing your job.

LEADERSHIP AND CHANGE - EXTERNAL PERSPECTIVES

Keith Ruddle

Keith Ruddle placed the development of PCGs in the context of wider organisational changes, using illustrations from several private sector organisations, many of which have moved over time from an environment of relative stability to one of growing turbulence and challenge.

Different styles

There is no single magic formula for managing change; different styles will be needed for different kinds of change. One important prior question for organisations to ask themselves is where they are now in their 'journey of change'. Is this the start of a new period of change? Or is it part of a longer term process which began some time ago? There are two major situations for change:

- short term pressure for rapid change to bring radical improvement in a generally predictable environment;

'The NHS has been one step behind, paradoxically introducing hierarchical management mechanisms in the 1980s when the private sector was abandoning them'.

Keith Ruddle

- a need for continual change over time involving a longer term reassessment of the whole value and purpose of an organisation's activity, in a situation of uncertainty and complexity.

What leaders do to make change happen in these circumstances can be by categorised by actions in four areas:

- leadership and top team;
- navigation and measurement;
- ownership;
- enablement.

In the two situations for change, actions in each category can be summarised as in Table 2.

Programmatic leadership, with an emphasis on command and control, may be highly appropriate when fast change is required. Transformational leadership is more appropriate when change is a continuing process, and it is not feasible to tell everyone what to do. At a broader level, there is an overall trend towards more transformational management styles, both in the private and the public sectors, in recognition of the need to equip organisations to cope with an uncertain and complex environment.

Trends in the NHS

Historically, Ruddle argued, the NHS has been one step behind overall trends in leadership styles, paradoxically introducing hierarchical management mechanisms in the 1980s to improve efficiency and effectiveness, when the private sector was abandoning them in favour of less hierarchical leadership mechanisms. The decentralised, competitive model of 'Working for Patients' in the 1990s, based on management by contract, may or may not have worked successfully at the local level, but is not the right mechanism to use for a Government interested in achieving a united, collaborative NHS purpose. Hence a further shift, in 'The New NHS', towards the more transformational style, more typical of contemporary leadership styles elsewhere, founded on management by collaboration and reliant on networks and relationships among many players. To a degree, this gives formal recognition to a style of horizontal working and networking which had already been adopted informally by many people within the NHS. The advantage of formally recognising this position is that it acknowledges the limitations of structural solutions to achieve change.

PCGs face a range of tasks for which a mixture of programmatic and transformational styles will be appropriate. Leadership actions for PCGs to achieve change are summarised in Table 3.

Table 2 **Styles for radical change**

	Programmatic leadership	Transformational leadership
Context	● predictability ● urgency for radical improvement ● short term targets	● uncertainty and flux ● fast-changing sector ● long term need for growth and innovation
Leadership and top team	● planning and monitoring ● detailed hands-on control ● hierarchical command structure	● setting scenarios, intent and direction ● creating values and purpose ● encouragement and coaching
Navigation and measurement	● dedicated full-time project management ● critical path networks ● operational and financial targets ● micro measures	● change as part of normal responsibilities ● co-ordination through communication ● balanced 'scorecards' (outcomes as well as finance) ● macro measures
Ownership	● 'need to know' involvement ● following instructions and procedures ● top-down messages	● extensive involvement ● 'breakthrough' culture of changing attitudes ● self-initiated change and learning
Enablement	● redesign of organisational structure as a lever	● facilitation and knowledge management – let people do it themselves

Table 3 **Leadership actions for PCGs**

Leadership actions	● setting the direction ● articulating the vision ● leading by example ● spending time with the key stakeholders (eg trusts, local authorities, etc.) ● identifying the key change agents and spending time nurturing them
Navigation/ programme management	● creating scorecards and targets for progress/success ● project planning and project management mechanisms ● deadlines, milestones ● steering groups, co-ordination committees ● clear project responsibility for getting things done
Ownership	● listening to staff, GPs ● involving key players in the planning and work of the PCG to get 'buy-in' ● communicating directly and indirectly about PCG intentions and action ● management by walking about ● publicising examples of the right behaviour and new processes
Enablement	● designing and putting in place basic processes and procedures ● training ● reward, incentive and recognition systems ● information and knowledge exchange systems

LEADING PCGS: CHALLENGES AND DEVELOPMENT NEEDS

Tessa Brooks

Tessa Brooks addressed the practical needs facing PCGs. Although there is new enthusiasm for leadership in the NHS, training and development for leadership in the NHS is itself not new; indeed, the core attributes of leadership remain fairly constant. We need to address the specific requirements of PCGs while recognising that they share many of the characteristics of other organisations.

Building the organisation

She identified the following attributes required by leaders when setting up a new organisation:

- clarity
- courage
- imagination
- good networks
- enjoyment of risk
- a sense of humour

There is a need for clarity about:

- organisational purpose (for the NHS as a whole, and for each PCG);
- the values which underpin it;
- roles and responsibilities (especially given possible tension between chair and chief executive roles);
- accountabilities – currently to the health authority, but this will change.

'PCG leaders have time on their side – they are working to a ten-year timescale. Although they may feel pressured, it is important not to rush this reorganisation. There is absolute commitment from above to make it work.'

Tessa Brooks

Building the organisation is not going to be easy, and there will be tensions which must be managed, but PCGs have several advantages on their side:

1. the framework/ground rules are clearly spelt out;

2. there is strong organisational support for the task ahead of them;

3. they have time on their side – they are working to a ten-year timescale. Although they may feel more pressured than that sometimes, it is important not to rush this reorganisation;

4. there is absolute commitment from above to make it work.

Leadership development

Brooks set out three key areas for development:

- technical skills (e.g. finance, information management and technology);
- management skills (e.g. chairing meetings, facilitating, team building);
- leadership skills (strategic and political).

Whilst some of these may seem basic, it is vital to get them right. Leadership is not a single task, but is about building and working in teams. The NHS needs to invest in developing people so that they can work with confidence. It is easier to work on leadership skills once the basic skills are in place – for example, it is easier to learn to develop partnerships at a strategic level if one is already skilled at chairing meetings and presenting in public. It is also important to learn how to communicate effectively at different levels, and with different groups.

Styles of learning

Learning may take place at individual, group and community level. At individual level, PCG leaders should seek out good personal support, not just in terms of useful one-off courses, but also one-to-one help. This could take the form of internal mentoring or external coaching – the latter will cost money, but can be invaluable.

Group learning, as a team, will be important for each PCG, and PCG teams should also see themselves as part of a community with other PCGs. Networking across PCGs will be critically important to their development. They are also part of a wider NHS community and must be wary of allowing primary care to become an organisational silo. PCG leaders should be encouraged to learn from colleagues in health authorities as well as from those in acute and community trusts. Managers who become isolated in one sector may lose confidence, and may lose sight of the common ground they share with other health sectors.

Leadership challenges

Brooks identified specific challenges facing PCG leaders:

- developing strategic vision;

- communicating that vision;
- providing meaning, ownership and belief;
- providing the values base;
- feeding back to staff: listening, reshaping;
- being clear about outcomes;
- developing networks and alliances;
- facilitating joint working and enabling partnerships.

Contribution from the centre

A national steering group is being established to oversee development support for PCGs. The centre will act as a resource, for example offering a database of available courses, other learning activities, coaches and mentors – any enquiries would be welcomed.

The centre will also ensure that there is a consistent approach to leadership development and that all regions have policies which enable development to take place and give it a high priority.

The NHS executive is keen to develop a learning network, and will work on creating an infrastructure to support shared learning. There will be a strong focus on 'whole systems' thinking and working, looking at the interaction between PCGs, trusts, health authorities and social services. The most important task now is to identify the major learning needs.

Workshop 1. Developing effective relationships

Janine Nahapiet and Shaun Brogan

This session was based on Janine Nahapiet's research into how professional service firms (such as law and accountancy firms) manage relationships within the firm and with clients, and on the experience of Shaun Brogan with a Total Purchasing Pilot, now a PCG. The session sought to:

- consider how to categorise relationships;
- review the different contexts within which relationships are embedded;
- identify some key factors in building effective relationships.

How can we categorise relationships?

There are three general paradigms that can be used to look at structuring relationships. These are set out in Figure 1.

The NHS has in theory moved from working on the basis of hierarchical relationships to market relationships and now to network relationships. Each implies a different purchasing style, as set out in Figure 2, and a different leadership style. The reality of the NHS is that all three models coexist, albeit that their relative importance has been changing over time.

Figure 1 **Models of coordinating relationships**

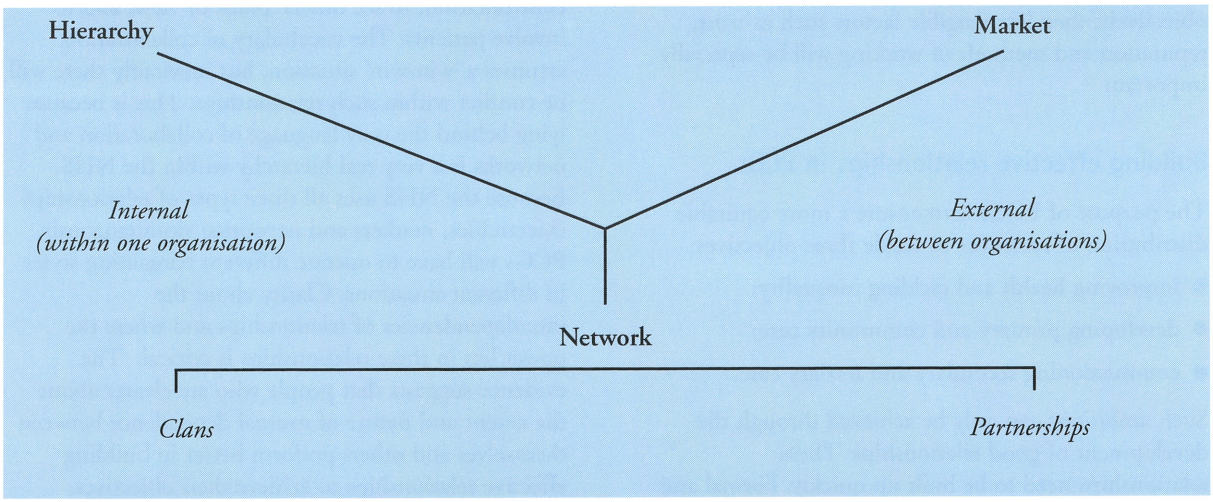
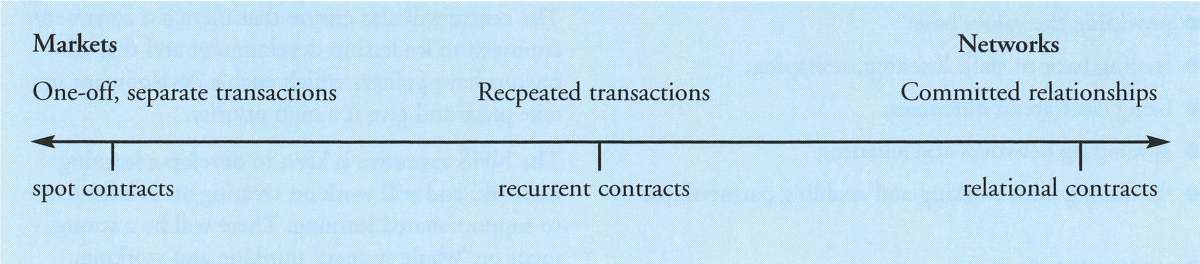


Figure 2 **Continuum of purchasing styles**



The context within which relationships are developed

Network relationships are typically complex, and involve longer term commitments and a close knowledge of each partner. Strong network relationships require personal relationships to be built. This in turn requires a great deal of time to be invested by both parties.

Trust is a key issue in building and sustaining relationships. Research shows that it takes time and regular interaction to build trust. Trust involves a willingness to be vulnerable to another party, a willingness based on confidence in four aspects of the other party's motives and behaviour:

- belief in the good intent of the parties;
- belief in their competence and capability;
- belief in their reliability;
- belief in their perceived openness.

Cooperative relationships need to be negotiated, in the sense of ensuring that expectations of the relationships are clear on both sides. Commitments must be made a reality in the way people work both through their formal roles and through informal personal relationships.

In a context of high ambiguity and complexity, where efficiency and effectiveness are hard to measure objectively, then less tangible factors such as trust, reputation and methods of working will be especially important.

Building effective relationships in PCGs

The purpose of PCGs is to ensure a more equitable distribution of resources to tackle three objectives:

- improving health and tackling inequality;
- developing primary and community care;
- commissioning secondary and tertiary care.

Such ambitions can only be achieved through the development of good relationships. These relationships need to be built up quickly. Formal and informal relationships are both critical. Relationships with the following are especially important: different professional groups and constituent practices within the PCG, the health authority, providers, patients and other stakeholders (e.g. social services, district councils, voluntary agencies, Community Health Councils).

'The NHS has in theory taken a journey from working on the basis of hierarchical relationships to market relationships and now to network relationships. Each implies a different leadership style'.

Janine Nahapiet

The way in which these relationships can be made to work effectively includes developing a health agenda, as distinct from a health services agenda, for example, developing referral systems for non-NHS services such as carer support, benefits advice and home repairs and working with other agencies to develop services such as young people's sexual health clinics and drugs action groups.

The challenges are to ensure collaboration, not confrontation; to see others' point of view; and to involve patients. The vocabulary of collaboration assumes a 'win-win' situation, but inevitably there will be conflict within such relationships. This is because lying behind the cosy language of collaboration and networks is a very real hierarchy within the NHS. Because the NHS uses all three types of relationships (hierarchies, markets and networks) simultaneously, PCGs will have to operate different bargaining styles in different situations. Clarity about the interdependencies of relationships and where the power lies in these relationships is critical. The evidence suggests that people who are clearer about the extent and nature of mutual dependence between themselves and others perform better in building effective relationships to achieve their objectives.

WORKSHOP 2. Building a collaborative culture

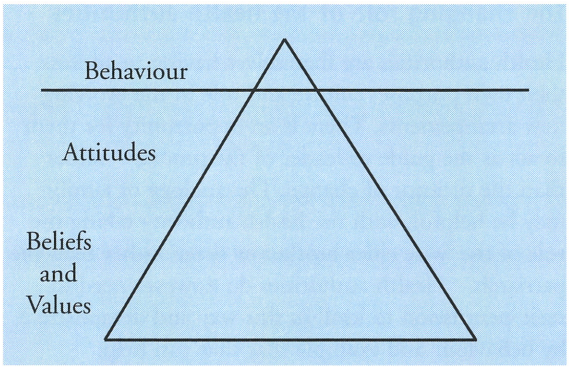
Chris Outram

The culture of PCGs

Organisation culture or 'the way we do things around here' must first be understood as something which is largely invisible and almost impossible to measure. The commonly held and relatively stable beliefs and values which underlie it are hard to define, to articulate and, once established, to change. These beliefs underpin both attitudes and behaviour. The former is reportable but only the latter is observable. We can portray this as an iceberg as in Figure 3.

Culture evolves, is handed down and manifests itself through language, stories, symbols, myths, legends,

Figure 3 **Behaviour, attitudes and beliefs**



rituals and ceremonies. It cannot be changed through a 'programme and steering committee for cultural change'. Often the top management of an organisation may espouse desired behaviours that are inconsistent and out of alignment with the real attitudes and behaviours of those working in the organisation. In these circumstances the desired behaviour will not occur.

In looking at the formation of PCGs we see no established culture, a mixed group of professionals with different backgrounds and styles, many individuals used to high professional autonomy, and little formal control or power over their members. Making a difference, however, will mean changing behaviours between these parties. There is a real need to motivate and create some early success. PCGs need to be more than a group of individuals banding together – they need common values and behaviours to unite people in pursuit of agreed objectives.

How to influence and change culture

Culture takes years to develop and change often happens informally, by example rather than by prescription. Leading cultural change requires time and energy and is more likely to be successful if accompanied by changes in structure, systems and processes. Leaders can manage or influence PCG culture in four ways:

1. developing values, which need to reflect a shared view of reality and cannot simply be an invention;

2. creating genuine teamworking. Teams can be seen to go through four development stages of 'forming, storming, norming and performing'. Many PCGs have really only got to the first two stages. Teams need to strive for group cohesiveness, which is most easily achieved when members work in close proximity, perform similar tasks, are homogeneous, respond to external threats, are small, carry out tasks that encourage co-operative working and are led democratically or charismatically. Some of these are conditions not found in PCGs and their component practices – hence there is a major challenge. Teams need a balance of task leaders and maintenance/ consensus seekers;

3. choosing the right management style. PCG leaders need to choose between formal and informal styles, autocratic and democratic styles, and between being open and keeping people in the dark;

4. rewards and incentives. People might be looking for money, power, status or seeking higher level goals of changing things for the better, taking control of their own destiny and improving primary care. A positive motivation cycle, of effort leading to performance leading to reward, is key. Incentives need to build trust between professionals, and with management.

The need to understand the starting point

To work towards a new agenda it is first essential to understand the starting point. The many different players in the health system (such as GP practices and social services) have different cultures and mindsets. PCGs themselves will differ in maturity, shape and style across the country (for example PCGs will have many more single handed practices in London than elsewhere).

Building a new culture involves recognising the diversity of the component parts of PCGs and the vested interests of which they are comprised. There may be a reluctance on the part of many members to break faith with old allegiances, together with a fear of losing hard won gains (in terms of autonomy and

resources) from the past. Individuals may fear loss of the status or power vested in their position within the old culture.

Expectations for change have been created in this new period of change for the NHS. These expectations need to be managed to ensure people have a realistic view of how long it will all take and so to avoid disappointments amongst the different stakeholders and groups.

The importance of a new collaborative culture across the health system

While one discussion might be about the challenge of creating a new culture within PCGs, the real opportunity with this initiative is to establish a new style of working for health care across the health system, with primary care as a key lever. The key is to establish a collective, collaborative set of expectations. Common agreement is needed to find a way of working together which accepts that a degree of ambiguity and even misunderstanding will be inevitable. Reaching such an understanding is highly dependent on relationships based on trust.

'So far, PCGs are organisations with no established culture comprising a mixed group of professionals with different backgrounds and styles, many of whom are used to high professional autonomy, and with little formal control or power over their members'.

Chris Outram

The role of processes, levers and other leadership interventions

There is a role for both formal and informal leadership processes in trying to establish collaboration and common purpose. Mechanisms such as regular working groups and meeting outside the formal structure may help key strategic thinkers from across the different parties work together on ideas and future direction. However, it is critical to ensure any such informal process has legitimacy and is tied into the formal power base and structure in some way. Clashes in leadership style need to be watched – command and control may exist at one level but at another level there may be attempts to create a transformational style. Inevitably progress will be in small steps but each step is critical.

The changing role of the health authorities

Health authorities are themselves having to address their own purpose, culture and role in the evolving new arrangements. There is an opportunity for them to act as the guide or leader of the process – rather than the dictator of change. The analogy of family may be helpful, with the health authority taking the role of the 'wise elder brother or sister' rather than the patriarch. Health authorities do however need to seek 'permission to lead' in this way and demonstrate by behaviour and example that they can help.

Workshop 3. Creating an effective board

Dominic Sefton

Based on experiences so far in one PCG, this session explored a range of roles, actions and relationships which need to be considered in creating an effective PCG board.

As the 'responsible officer' for the PCG budget, the PCG chair's role includes the following:

- financial stewardship and control; probity in managing a delegated budget;
- advice to the PCG board;
- best use of commissioning funds and avoidance of waste and extravagance;
- developing services and promotion of health according to need;
- following through national guidance (NHS Executive, NICE, CHI).

The PCG chair will be both a visible figurehead, for example taking the lead on negotiations with key stakeholders, and a visible 'target' for the press, pharmaceutical companies, other practices and other agencies. He or she will have overall responsibility for the PCG, and will have a key role in prioritising the agenda and delegating responsibilities. The chair will provide the crucial link between the PCG board and the PCG management team.

He or she will need the following:

- time;
- considerate partners (domestic and business);
- the will to succeed;
- dynamism;
- vision for the future direction of the PCG;
- awareness of the whole agenda, ability to prioritise the agenda and to promote the agenda at every opportunity.

They should also be alert to the difficulties of keeping an eye on what is happening within their own practice as well as the overall picture.

It is vital to consider the legacy the first chair leaves behind for subsequent chairs – it would be unhelpful to set a pattern which cannot be sustained, for example devoting many hours of unpaid time to the job. This could create unrealistic expectations. However the chair's role will undoubtedly change over time and the time commitment required may diminish once the initial set-up phase is complete.

' "Making a difference" should be seen as the guiding philosophy... PCG boards will be much more hands-on than a typical health authority board'

Dominic Sefton

Although unity between the chair and the chief executive will be essential, it is important the relationship does not become too cosy and make others feel excluded. Chief executives will also act as a link between the board and the management team, as well as carrying out day-to-day management of the PCG, monitoring national policy and guidance, and maintaining links with other PCGs and the health authority.

In creating an effective board, it is important to emphasise new beginnings, to 'put the past behind us', and to meet regularly and often – formally, informally and socially. Facilitated awaydays can help to generate purpose, culture and values, and to think about strategy. Other practical suggestions include:

- running effective meetings with action points;
- recognising individual skills and empowering individuals;
- valuing all members;
- delegating responsibility;
- having board members sponsor papers to the board;
- ensuring GPs have a majority on the board;
- arranging one-to-one meetings with each board member and the chair, to discuss their views and responsibilities.

The creation of an active sub-group culture will help spread workload and ownership. This could include both standing sub-groups (e.g. on clinical governance and public involvement), which would report back to formal board meetings, and ad hoc project groups (e.g. to develop a communications strategy), which would report back to informal meetings. Key strategy could also be debated at informal meetings, and the outcome reported to the formal board.

Linking back to constituent practices is a key issue; boards need to clarify that board members are not there to represent their own patch but to make corporate decisions. One solution is to have a lead GP group, consisting of one person from each practice, who would be paid to attend briefing meetings and link back to their practice.

It can be valuable to include top-level board members such as the local Director of Social Services. However, there is an issue about how regularly they will be able to attend and whether PCG boards will allow members to send deputies in their absence. There are difficult decisions to be made about how much different members should be paid, and for what, and how much it is reasonable to expect them to do without further payment.

PCGs should aim to generate a culture of honesty, openness and 'no surprises'; 'making a difference' should be seen as the guiding philosophy. PCGs should also work hard to publicise their achievements.

It can be expected that PCG boards will be much more hands-on than a typical health authority board, not least because the chair will continue to be a practising GP. One disadvantage of moving to trust status could be that the increased extent of management responsibilities will make it harder to combine clinical practice and management at this level. As a result, active practitioners might be less directly involved in managing and in setting the wider health agenda.

It is unclear how desirable a hands-on board is. One view is that this may prevent it from fulfilling the proper role of a board, namely to plan and delegate, not to do the work itself – 'to sit and think about the marathon, not the sprint'. An alternative view is that PCGs should not necessarily aim to follow this model of what a board ought to be; they will be different precisely because they are made up of practitioners who are actively engaged in turning the board's decisions into reality. However, there is a potential problem if such an operational focus is not sustainable in the long term.

Workshop 4. Taking responsibility for clinical governance

David Colin-Thomé

The role of clinical governance

The essence of clinical governance is achieving high quality in clinical practice through the use of:

- research evidence on what is good clinical practice;
- audit to ensure that good clinical practice is being followed;
- managerial action to hold clinicians accountable for improving the quality of their clinical practice.

It is part of good professional behaviour. It should not be regarded as an externally imposed burden. Clinical governance also includes the responsibility to refer patients to consultants who are competent and for doctors to be able to know that they are doing this.

There are many dimensions of service that are valued by patients. These have been surveyed by the NHS Primary Care Research and Development Centre and include:

- availability and accessibility;
- technical competence;
- communication skills;
- continuity of care;
- co-ordination of care.

Hence clinical governance has to be put in the context of strategies to deliver a better service from the point of view of the patient, which is about more than technical competence. However, clinicians have traditionally not been comfortable with being part of a 'service' organisation, which presents a challenge to PCGs.

Leadership in clinical governance

Clinical governance is an organisational development initiative. The GP practice is the building block of the PCG in clinical governance as in other areas. The PCG is therefore an enabler. The PCG leaders on clinical governance need to provide transformational leadership, focussing on the vision of raising the quality of clinical care whilst also:

- identifying the key systems that need to be put in place;
- building a consensus to introduce them;
- establishing project planning mechanisms to ensure they are introduced.

They need to encourage reflective thinking, a learning culture, and develop systems that provide accountability for individual clinicians, the practice and the PCG.

Clinical governance may also help to identify expensive, inappropriate practice that if stopped releases resources for other, more effective, interventions.

Clinical governance is not therefore primarily about tracking 'bad apples'. It is not about introducing burdens on doctors that put off able doctors. It is about helping all GPs improve the quality of the clinical care they deliver. Hence the emphasis is on learning and on systems at practice level that enable doctors to monitor their performance. Inevitably clinical governance systems will identify some GPs whose quality of clinical care is so poor that disciplinary measures may be appropriate. Indeed the public expects that clinical governance will tackle poor technical competence. This is not where most of the improvements in the quality of clinical care will come from, however. They will come from spreading knowledge of good practice and the use of monitoring systems to reduce the variations in clinical practice that currently occur, narrowing the range around good clinical practice.

'Clinical governance is part of good professional behaviour. It should not be regarded as an externally imposed burden'.

David Colin-Thomé

Making progress

It will be important to concentrate on a few key things and to make progress in these areas.

Within two years the objective should be to have put in place systems at the practice level that monitor at least some key aspects of clinical care quality and to have instituted effective arrangements for intra-practice education. Enabling doctors and practices to learn from one another and learn together from an external source will be extremely important. Single-handed practitioners will need assistance from the PCG in bringing them together with other GPs for similar opportunities for shared learning.

Some resources are available including:

- post graduate tutors;
- the Medical and Dental Education Levy;
- PGEA time;

- NMET;
- Medical Audit Advisory Group;
- health authority advisors.

Clinicians are accountable for the quality of the clinical care they deliver to the practice, the PCG, the health authority, their patients and their professional bodies, the General Medical Council (GMC) for regulatory purposes and the Royal College of General Practitioners (RCGP) for education purposes. Re-certification by the GMC is an important aspect of raising quality and the RCGP has an important role to play in producing educational material – although less than half of GPs are members. PCG clinical governance initiatives should also cover nursing and other professions allied to medicine where they are employed by GP practices to deliver care.

Workshop 5. Setting objectives and measuring success

Mike Bellamy

PCGs were invented to allow government to fulfil its commitment to phase out GP fundholding, but are potentially powerful clinically led organisations, which will develop in different ways and at different speeds to deliver the Government's key objectives. They form a key part of Government plans to modernise the NHS, as part of its aim to modernise public services and indeed to modernise Britain. The emphasis will be on delivering outcomes – not the detail of process or structure – which in any case will need to vary to meet different local circumstances.

Performance management of PCGs should be based on accountability agreements, setting out both long and short term objectives/targets. Some short-term objectives are needed both to meet the Government's 'must dos' and to deliver real service gains early on for local constituents – especially the GPs and the patients – to show that PCGs can make a difference and to maintain enthusiasm. Short term targets should include control of prescribing costs. Long term aims should include developing the organisation, working in partnerships to promote health gain, educating the public and managing demand.

The idea of narrowly focused annual accountability agreements should be strongly resisted. Instead the successful development of PCGs would be better fostered by such annual agreements being within triannual development agreements, to counter short termism and foster organisational and individual development. There should be clear agreement between the health authority and PCGs about their respective roles, to ensure appropriate devolution and reconfiguration by health authorities. PCGs must not be simply additions to the existing structure.

Although there is a danger of creating another level of management, it is important for PCGs to work together collaboratively as part of a single system.

'Annual accountability agreements should be strongly resisted. The successful development of PCGs would be better determined via triannual development agreements, to counter short termism'.

Mike Bellamy

Given the size of the agenda and the overall reduction in management resources, collaboration is the best way to maximise their capacity to achieve change.

Having the skills and time to cope is a real issue, given the increasing pace and volume of change. PCGs can see huge opportunities to make improvements, but they are being asked to tackle some of the most difficult issues, including health inequalities, variation in standards and managing poor performance, before they have developed as competent organisations. They will need help in developing the skills to handle these.

In addition to specific outcome and developmental objectives, there need to be supporting strategies about the workforce, capital investment and information. Investing in developing people and systems is a pre-requisite for achieving change.

The increasing ability of the centre to use information to monitor and benchmark performance is an important contribution to reducing unacceptable variation. The danger, however, is that local risk-taking and innovation could become increasingly unacceptable, unless health authorities are prepared to develop a protective 'umbrella' function, to shield PCGs. On the other hand the ability to measure professional performance is an important lever in improving standards.

Workshop leaders and chairs

Developing effective relationships

Leads: Janine Nahapiet, Fellow in Strategic Management and Director, Oxford Institute of Strategic and International Management, Templeton College

Shaun Brogan, Chief Executive, Ridgeway PCG

Chair: Dr Sue Dopson, Fellow in Organisational Behaviour, Templeton College

Building a collaborative culture

Lead: Chris Outram, Chief Executive, Enfield and Haringey Health Authority

Chair: Keith Ruddle, Associate Fellow, Templeton College

Creating an effective board

Lead: Dr Dominic Sefton, Chair, Northampton PCG

Chair: Dr Rosemary Stewart, Emeritus Fellow, Templeton College

Taking responsibility for clinical governance

Lead: Dr David Colin-Thomé, Director of Primary Care, London Region, NHS Executive

Chair: Adrian Towse, Director, Office of Health Economics

Setting objectives and measuring success

Lead: Mike Bellamy, Chief Executive, Ealing, Hammersmith and Hounslow Health Authority

Chair: Bob Nicholls, Associate Fellow, Templeton College

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Templeton College and leadership

Complex challenges demand new kinds of leaders. They must have the personal vision to secure far-sighted strategic decisions. Above all, they must be clear in their own thinking about the new tasks involved. Templeton programmes are designed to expose participants to a far broader span of leadership experience than they might have encountered and also to equip them with new ways to analyse and interpret the experience of leadership. In so doing it sets out to help them find their own answers to a range of crucial questions:

- How relevant are concepts such as power, authority, values, ambiguity and motivation?
- How can leaders best think strategically and holistically about the future of their enterprises?
- How should leaders approach the demanding role of leading change?
- What can heightened self-awareness contribute to leaders and what feedback methods best provide this?

OHCMI

The Oxford Healthcare Management Institute at Templeton (OHCMI) aims to foster constructive dialogue between the academic, business, clinical and professional sectors to advance effective healthcare management. Recent research has included studies on getting clinical research evidence into practice, the effectiveness of NHS commissioning and the effects of structural reform in the NHS.

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Office of Health Economics

The Office of Health Economics (OHE) was founded in 1962. Its terms of reference are to:

- commission and undertake research on the economics of health and health care;
- collect and analyse health and health care data from the UK and other countries;
- disseminate the results of this work and stimulate discussion of them and their policy implications.

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