Clinical Leaders Network

Evaluation of the work of the Clinical Leaders Network in the North West

October 2006

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Contents

Appendices

Executive Summary

Arup were commissioned by the Project Team of the Clinical Leaders Network (CLN) pilot project to evaluate the CLN in the North West with regard to the methodology, benefits to date and impact on uptake of Choose and Book. This was conducted between August and September 2006 using data collection and analysis, evaluation of documentation, visits and structured interviews. The purpose was to analyse methodology and achievements to date and identify any recommendations with the CLN members, NHS North West and other key stakeholders as identified in Appendix A.

The **summary findings** of this study are as follows:

1. All CLN members agreed that membership of the CLN was beneficial and gave them the opportunity to be involved as an integral part of the change process.
2. The SHA felt that the philosophical core of the CLN is correct – a team approach between managers and informed clinicians.
3. External speakers from the DH were totally supportive of the CLN and found members to be enthusiastic, positive and able to express their queries and concerns in a constructive manner.
4. The two distinct recruitment processes have each resulted in selection of members of the appropriate calibre, however, in relation to the 'closed process', CLN members have reported some comments of exclusivity and elitism from non participating colleagues.
5. Information issued to potential members met the needs of some, whereas others would have found further information useful at that stage.
6. The regional meetings and presentations from SHA leads/DH speakers were considered to be of a very high quality and extremely useful to members enabling them to have a far greater understanding of what had to be achieved and why.
7. Action learning sets were reported by some to be rather to slow to gel at first however were now felt to be functioning. The organisational representation and facilitation was identified as being key to prevent "blockages" appearing.
8. Evidence of a broad range of local activities was apparent from the returned activity sheets however the capture and impact using the Manchester Engagement Escalator (MEE) was not sufficient to demonstrate a clear cause and effect on clinical service output – not surprising due to the short life of the CLN. The feedback from members was that the concept of the MEE was appealing.
9. Information, whilst being captured at a number of stages, was not captured using a structured system thus making analysis difficult and restricting appropriate feedback to members. Whilst informality of the group is one of its key benefits, it could potentially be one of its key weaknesses and feedback and monitoring is essential to ensure it contributes to delivery of outcomes. Feedback should include a formal process for recording any impact of the CLN from DH/SHA.
10. The CLN agenda focussed on Choose and Book between March and June 2006. Analysis of Choose and Book referrals since the inaugural meeting of the CLN in January demonstrates a positive shift against comparative sectors. This is of course influenced by a number of factors and the cause and effect of the CLN cannot be conclusive at this point, however data analysis does indicate a sustained change in working patterns. At this stage it is not possible to correlate CLN activity to the performance or draw any substantiated conclusions.

The **summary recommendations** are as follows:

1. Develop an Information Capture System to support reporting processes and identify Key Performance Indicators to enable effective decision making. This should include attendance levels, activity reporting, policy and learning set feedback and positioning against and use of the Manchester Engagement Escalator (MEE). The MEE should be encouraged as a mechanism to measure outcomes for the network.
2. Review the Recruitment Methodology to ensure an open process is supported by an appropriate structured selection process thus ensuring the recruitment of high calibre individuals. Pre appointment information should be reviewed as should the induction process to ensure consistency
3. Marketing information should be developed to raise the profile of the CLN and to assist new members explain their role to and gain support of their managers. For roll out to a new region, a fully "franchised" structure, process and materials should be considered to ensure consistency and efficiency.
4. CLN members should be surveyed to ensure the network is meeting their needs and to enable any issues or ideas to be captured at any early stage. The method(s) and media to facilitate this activity and capture the views should be consulted with participants. The use of facilitators to assist in the feedback of non confidential information from learning sets should be considered.
5. Future development of the group should ensure that outputs are aligned with the objectives of sponsors and organisers. This will require regular review against the key principles of the CLN.

In conclusion:

This study has shown that the pilot project is based on a philosophically sound core and that it has strong support from key individuals within NHS North West and the DH. Clinicians have reported membership to be a positive experience and a large number of personal and organisational benefits are evidenced.

The impact on the uptake of Choose and Book is encouraging, however the reviewed period of six months is to short to confidently to complete statistically significant conclusions. The evidence and opinion gained is useful however in evaluating the effect of topic related, sustained organisational development which may be directly attributable to change brought about by the CLN. As this reflects only one measure of clinical engagement, the use of the Manchester Engagement Escalator to encourage strategic thinking should continue to be promoted.

The evidence gained demonstrates clear enthusiasm and support for cascading the initiative across the country. Stakeholders perceive clear benefits from the initiative and are willing to support the scheme and it's potential deliverables. The recommendations highlighted within the report should be considered prior to any national roll out to ensure future projects gain from the experiences of the methodology and management of the pilot project.

1 Introduction

In order to ensure that the delivery of clinical service development and the system reform agenda is conducted in a safe and care focused way, the Department of Health is keen to expand and sustain the skills of local clinical champions and influential service practitioners. The aim is to ensure full clinical engagement in the planning and delivery of the evolution of patient focused services in the NHS.

The need for increased clinical engagement became apparent as a result of issues relating to wider clinical engagement for the National Programme for IT (NPfIT) led by NHS Connecting for Health (CfH) and particularly in the Choose and Book programme.

Dr A S Rajkumar (Choose and Book National Lead) had already established close links with Dr Andrew Coley (CfH lead for Cheshire and Merseyside SHA) both prior to and in the early stages of CfH – both being acutely aware of the impact of a lack of clinical engagement on the programme. This partnership developed and a strategy document was proposed by Dr Raj Kumar ("Effective Clinical Engagement through Clinical Leadership Networks", September 2005). As a result, the Clinical Leaders Network (CLN) was established as a development within the Access Directorate of the Department of Health in September 2005. The well established working partnership between Drs Raj Kumar and Coley formed a solid foundation upon which to base the pilot project and Dr Steve Henderson, Associate Medical Director, Greater Manchester SHA joined the team thus identifying the pilot project to be the North West. The specific advantage of this was that relationships were already formed and well developed and that the unit was cohesive with all members having a very clear vision of the need for increased clinical engagement and having the skills, drive and enthusiasm to move it forward. The inaugural meeting was held in January 2006 and the pilot area increased to include the former Cumbria and Lancashire SHA, the key clinical representative being Dr Steve Ward. On 1st July 2006, the aforementioned SHAs merged to become NHS North West and hence the pilot project now covers that geographical area.

The CLN identifies and supports key local clinicians who are leading reform to improve patient access to care. In doing this, the aim is to mitigate clinical engagement risks in service reform and IT implementation programmes. The CLN also aims to address the requirement by senior local clinicians to develop collaborative working across local / regional clinical networks and to directly engage, contribute to and influence national policy development and the planning of local service strategy and provision. The final aim is to supplement existing leadership programmes with a framework, network and direct distribution channel of the most senior and influential clinicians within each region.

Potentially the CLN provides a sustainable source of clinical champions who will in turn act as agents of change through a process which could be cascaded across the country.

This document details an evaluation of the process and outcomes of the CLN pilot in the North West to date. It does not intend to document the process in detail and for that information the reader should refer to "An introduction to the Clinical Leaders Network" – September 2006.

2 Project Scope

Arup have been commissioned by the Project Team of the CLN pilot project in the North West to evaluate:

- The methodology used within the pilot project
- The benefits to date for CLN members and their organisations
- The impact on the uptake of Choose and Book in the SHA for the period of Jan to June 2006.

3 Evaluation Methodology

The evaluation was carried out using three methodologies:

- Structured telephone interviews
- Evaluation of documentation
- Data Analysis of the uptake of Choose and Book for the period January to June 2006.

3.1 Structured telephone interviews

Structured telephone interviews were carried out with the project team, key individuals from the SHA, speakers from the DH and members of the CLN. CLN members interviewed were selected to ensure representation from each of the former SHAs and from acute care, primary care and General Practitioners. Equally, members were chosen with different spheres of influence to ensure a comprehensive evaluation was carried out and all pertinent points captured. Details of those interviewed are contained within Appendix A. The interviews were structured as appropriate to capture information, views and opinions on:

- General perception to date
- The appointment process.
- Individuals perception of their role
- The regional meetings
- Local engagement activity
- Action learning sets
- Manchester Engagement Escalator
- Requirements for other resources including personal development needs
- Participants experience to date
- Examples of where input to date has genuinely been felt to have made a significant difference to the implementation of a change process

Whether the CLN will be of benefit to the newly formed NHS North West and why

3.1.1 General perception to date

All CLN members interviewed agreed that the CLN was beneficial and gave the opportunity to include clinicians as an integral part of the change process and that to date the overall benefits they had gained had outweighed their input. It was acknowledged that this was a new initiative, that cultural change does not happen overnight and that as a pilot it was inevitable that refinements may be required as the network starts to truly embed. It was considered to differ from other networks and as it was across organisational boundaries and

had close contact with the Department of Health. This was considered a significant advantage. Personal and organisational benefits are captured in section 3.2.

The project team in the North West were recognised as high quality leaders in this field with a genuine desire to engage with clinicians and to promote work across organisational boundaries in order to achieve the most effective delivery of healthcare.

The SHA felt that the philosophical core of the CLN was correct and that a team approach between managers and clinicians is of paramount importance. This model gives the opportunity for clinicians to sign up to the process as informed individuals with a clear understanding of what they are able to influence, what is outside their sphere of influence and the reasons for it.

External speakers from the DH, when interviewed, were supportive of the CLN and found the CLN members to be very enthusiastic, positive and able to express their queries and concerns. The feedback reflected a perception that participants demonstrated a vocal and cohesive approach to moving forward. Positive challenge was stated as being particularly encouraging. It was cited as an opportunity to move things forward based on the delivery of measurable achievements. The interviewed DH speakers were unanimously very keen to support the concept and its expansion in the future.

3.1.2 Appointment process

Due to the roles and responsibilities expected of participants in the CLN, it is crucial that members hold a senior level post and are recognised within their organisation and locality as having the qualities which will enable them to represent and challenge their colleagues, rapidly develop and be recognised as a driver of change. The quality and perception of a robust appointment process is deemed essential in maintaining the credibility of the candidates, the credibility of the process and the support of stakeholders.

The North West pilot consciously employed two separate and distinct processes to inform future roll out planning:

Cheshire and Merseyside leaders were contacted directly and invited to submit an application based on their input into alternative programmes and other clinical networks.

Greater Manchester leaders were invited to apply through an open application process.

The selection process was applied consistently through the evaluation of CV and covering letter with each applicant then following a structured appointment process.

Evaluation of the two methodologies is somewhat subjective. Attendance rates do not reflect a large distinction in the output of the two styles of recruitment. Using this as a measure at this stage would provide a crude evaluation as the number of sessions held would not be deemed to be statistically significant and the process is in early stages of involvement where a higher rate of regular attendance would be expected. Feedback from participants reflecting their own views and those of their colleagues is equally subjective but a useful reflection of general perceptions.

The ‘closed’ process has generated comments of ‘elitism’ and ‘exclusivity’ from participants within the CLN representing the views of their non participating colleagues. The benefits of this approach should be balanced against the ‘open’ approach to recruitment, especially in the value of clarity, publicity and access to the (rigorous) selection methodology. Members

felt this to be a critical area and it was the first reflection on the credibility and consistency in this 'cultural' change methodology.

Whilst the output of selecting the most capable individuals was essential, the process of inclusion is perceived as of equal importance and value. Open application is also considered to increase opportunities for those individuals with the skills and drive to deliver, but who might not have been otherwise identified.

Interviewed participants recalled receiving some information regarding the role and purpose of the CLN, either prior to appointment or at the first meeting. Some more experienced members found this information to be adequate whereas others would have found documentation giving more clarity useful.

It is suggested that the information available pre appointment is reviewed and revised to ensure it provides clarity for all applicants and their sponsoring organisations / stakeholders, regardless of their previous experience in similar networks. A requirement has been identified for 'marketing information' which could be used by the CLN member to inform their manager/colleagues of their role and hence promote the early formation of internal networks and relationships. The information was reported to have been largely gained by the member as they started to become an active member of the network. It was considered to be more advantageous to circulate more information in the very early stages of induction, where organisational backing and support need to be actively developed and achieved. In addition, this information could also be issued to Chief Executives, PEC chairs etc as members reported it was not apparent that all appeared to be familiar with the CLN or its purpose, even though all local senior managers had been informed and had originally approved the concept. As a productive enhancement to implementation, it is considered advantageous to establish activities which remind Chief Executives of the CLN members within their organisation and the benefits they can gain from using them effectively.

3.1.3 Individuals perception of their role

Despite some members reporting that on appointment to the CLN, their specific role was unclear, at the time of the evaluation all members interviewed were very clear that their primary role in their organisation was to raise awareness of the topic or pending change rather than to actually implement it. It was recognised that depending on the agenda item a member's role could swing significantly into that of implementation as was desired and appropriate.

3.1.4 Regional Meetings

Some members reported attending their first meeting with some trepidation and scepticism and a small number were reported as having subsequently withdrawn from the network, possibly due concerns of a hidden agenda. Feedback clearly reflected that both perception and confidence was generated in the first impressions. Whilst members were supplied in advance with information on learning sets, action learning and the North West pilot, it is considered that further information possibly through an 'information pack' as discussed in section 3.1.2 may be useful. It would give clarity of the personal purpose, role and expectation and would add value in reassurance to a number of members. All members interviewed now reported attending meetings with enthusiasm and an appetite to learn was apparent. The 'induction session' was reported as being valuable but was not consistently delivered as some members fed back that this would be a useful development.

Meeting frequency and location

Meetings are held on the second Thursday of each month (excluding August) in Manchester due to it's central location for the region. Generally, those interviewed agreed the frequency, both now and in the future, was appropriate and to move to less than that could result in a loss of momentum, particularly for those who unavoidably had to miss one session. A move to six weekly was suggested but counterbalanced against the need to keep things

moving. Depending on the position of the member, it was recognised that leading local engagement between regional meetings was challenging and that support may be required (see below).

Agreeing a location which suits all attendees within a large geographical location such as the North West is difficult. Generally it was agreed that the location is easily accessible and the option to rotate the location around the North West was not welcomed due to the increased travel for the majority, when meetings were in outlying areas and the risk of loss of momentum. That said, the travel time for those from Cumbria and Lancashire is significant and attendance at meetings should be monitored to ensure active participation.

Division of the geographical patch to facilitate access of members has been regularly considered and reviewed, however to date the value is cross organisation and former SHA boundary networking has been deemed more advantageous, especially in the early stages of the network.

Meeting attendance

Seven meetings have been held to date with those interviewed stating they had attended up to 6 out of the 7 meetings due to other diary commitments. Attendance records are as below:

% Attendance					
Jan	Feb	March	April	May	June
80	88	75	84	71	56

Fluctuation in attendance is inevitable in meetings such as the CLN, despite dedicated attempts on behalf of the members to attend, other commitments inevitably encroach on availability. Lower attendance figures in June when questioned appeared to be the result of holidays and it is important that attendance rates continue to be monitored to enable trends to be assessed and to enable an understanding of individual's reason for non attendance, be that the day of the meeting, travel distance, scepticism etc. Any cases of perpetual non attendance should be explored to ensure that membership is not potentially being withheld from other capable and interested individuals due to inactive members. The present pilot framework does not have a policy for consistently managing this issue and it is recommended that on is developed.

Attendance rates in themselves serve only as an indicator of engagement. The CLN has been established on clear principles of ownership and participation, embedded within the programmes methodology. Extrapolation of the principle suggests that limited attendance potentially affects the productivity and viability of the individual learning sets and that 'management', if required, should be generated from participants within the learning sets. Independent facilitators are employed to generate the productivity within each learning set and if agreed to be appropriate by participants, the facilitators can provide an independent evaluation of the effect of absence on group productivity for the pilot leads to follow-up. It is recommended that this process is enhanced and an improved reporting and information flow process is established to support decision making and action between the learning sets and the project team.

Diary dates

All appreciated advanced notice of dairy dates. Some members experienced difficulty with the fact that meetings were always held on the same day of the week which did not fit smoothly with clinical commitments. The project team should consider the benefits to be gained from alternating meetings between two days of the week and thus ensuring that any impact on clinical sessions due to attendance at the regional meetings is more evenly distributed across attendees.

Agenda

Generally participants were comfortable with the agenda. Some concern was raised over how the agendas were set with some individuals stating they had not been asked for any input. The relevance of topics to those clinical leaders on the network was also seen as a key point for the future. One interviewee stated that the sessions on C&B had been prolonged and too numerous. Brief slots (10 minutes) on strategic developments, which are interesting, but not of direct impact were reported as being useful as general information.

Participants valued the opportunity to engage directly with policy leads and have the ability and time to review in the company and confidentiality of their networks and learning set groups.

Speakers

All presentations were considered to be of very high quality and extremely useful giving members the opportunity to have an insight into the 'black box' of policy, tease out and voice their concerns and discuss and increase their knowledge of the nuances of policy and service development strategies. This enabled members to have a far clearer and more mature picture of what had to be achieved and why. This was reported to greatly enhance their ability to market, sell, negotiate effectively and support colleagues. The potential opportunity to influence upwards was welcomed and reported to promote a feeling of inclusively. The lack of any mechanism for feedback to report if the CLN had helped shape policy in any way presented a gap in the learning loop and it is suggested that a feedback mechanism is introduced. The whole process was reported as helping to bring together the pieces of the jigsaw regarding policy implementation.

It was considered very beneficial for the speakers to sit in on the Action Learning Sets after their presentation, giving them the opportunity to capture other key points arising out of those discussions. A formal mechanism of capturing that information in the absence of the key speaker was not apparent and should be developed, as should a feedback mechanism as detailed above.

Local speakers were also considered to be extremely useful and of excellent quality. Applicability of topics to the entire audience may need some consideration with allocated time being comparable to the topic. They were seen to be particularly useful to re-emphasise the challenges of the gulf between the PCT and secondary care and the necessity to work to a common aim whilst being mindful of the fact that money is for the entire health economy and not a specific PCT/Acute Trust.

3.1.5 Action Learning Sets (ALS)

ALS was a new learning experience for some, whereas others had previously participated in either the same or a similar methodology. Some members reported their ALS had been rather slow to progress at the first meetings however acknowledged that the time required for a group to 'gel' will be in part dependant on the members of the group. Others reported they had gelled at the first meeting and felt free to share confidential information, highs and lows, insecurities etc and were now communicating regularly by email. All agreed that the learning sets were now functioning in terms of participants feeling that they were getting value for their time and contribution.

The evaluation supports the need to consider group membership in the future, particularly as SHAs and PCTs reconfigure and inevitably people move into new roles. Geographical and organisational representation from the health economy will be important as will the impact of introducing new members to a group, which has already gelled and is operating effectively. A tendency for discussion to focus on blockages rather than solutions reportedly emerged when the ratio of participants from the same health economy increased in any single group. This should be closely monitored in the future with group facilitators having a key role in both removing the blockages and reporting to the project team.

From participants, the quality of facilitators was generally considered to be very good and they were reported as being perceptive as to the appropriate level of response, varying from empathy to challenge. Previous healthcare experience was considered to be valuable. It is recommended that this area is further reviewed to establish a process that provides more consistent and regular feedback between the facilitators and the management team, whilst preserving the anonymity of individuals within the learning sets. Such a reporting and information sharing mechanism would enable points raised in the paragraph above to be captured and actioned as necessary.

As at the time of evaluation, the feedback from each learning set group has been sporadic and unstructured. Whilst there is a requirement to provide feedback to evaluate the productivity and value of the sessions, retaining confidentiality is also paramount. As a result, feedback and evidence has not been sufficient to the management team to aid decision-making in agenda setting, performance evaluation and demonstration of delivery. It is suggested that a method of capturing issues and providing feedback to the organisers on participant's experiences, requirements and expectations is established. Equally a mechanism to ensure that appropriate non-confidential information from the ALS is fed back to key speakers was not apparent and a formal method to achieve this should be developed.

3.1.6 Manchester Engagement Escalator (Local Engagement)

The evidence from the returned activity sheets indicates that a broad range of activities are carried out within the local engagement sessions, however the capture and impact of this activity is not sufficient at present to demonstrate a clear cause and effect on clinical service output. This is not surprising due to the relatively short life of the CLN to date and the fact that any measurable impact on clinical service outcomes will take time.

The number of activity reports returned appears relatively low in comparison to attendees and, without running the risk of making this a paper driven process, it is recommended that attendees are actively encouraged to complete activity reports. Reminders to members of the reasons for the reporting process may be useful, as may some feedback to the group on what has been achieved, perhaps on a quarterly basis. An opportunity to have one session per year where members present briefly on achievements to date may be an option to consider. In parallel to the reporting, the claiming of expenses has been comparatively low. The structure of requiring an activity form with each expense claim is considered good practice. However, as the return rates for both are low it is recommended that the participants are consulted on a more productive means of capturing information. The feedback also indicates that awareness levels amongst participants as to why this information is needed, i.e. to demonstrate outputs and facilitate wider national roll out, are low or not considered personally important at this stage.

However, the feedback has demonstrated that the concept of reporting engagement level using the Manchester Engagement Methodology is generally appealing, indicating that the framework is understood and appreciated amongst participants. It was reported as being good for focussing minds and considered to be a very useful tool as it provides an analytical framework to the clinical engagement evaluation process. In practice, 44% of those members who completed the activity reports assessed and scored their perception of the

current level of engagement. It was suggested that monthly assessment using the Manchester Engagement Escalator might be too frequent. Progress can often be frustratingly slow and not moving forward on the score sheet may be disheartening. A move to quarterly assessment was suggested. The advantages of such a step would need to be balanced against the potential loss of momentum and loss of focus.

Whilst the number of responses cannot be considered representative due to the low volume, the findings are none the less useful and indicative. Members with a large circle of influence outside the CLN encountered fewer challenges regarding having sufficient time and resources to carry out local engagement activity, and in effect incorporated the local activity into their position and into other formal and informal networks. Those without the contacts found local engagement more difficult, but either had or gained the knowledge, skills and confidence to make those contacts. Some assistance from the project team would prove useful in the early days of appointment as discussed in 3.1.2. Any requirements for support etc again were dependant on the role of the individual and a brief questionnaire issued to members after perhaps six months of membership may be useful to capture this information and identify whether members are encountering stumbling blocks, which they personally were not able to resolve. All members interviewed were conscious of the current climate of change regarding PCT and SHA reconfiguration and of the potential impact of that on their availability for local engagement activity.

3.1.7 Finance

The Department of Health in combination with NHS Connecting for Health established the CLN North West pilot with funding of £75,000 and £25,000 respectively, supplemented by a contribution of £15,000 from each of the (former) SHAs. The principle established at the initiation of the pilot was to secure provision of monthly group sessions from central funds with local engagement session being financially covered by the contribution of the SHAs.

Whilst the funding has been fundamental in initiating the pilot project, significant work and time has been carried out without reimbursement, both by the project team and by members of the CLN.

On present forecast, the North West CLN pilot has sufficient funding to continue until January 2007 assuming present expenditure patterns. The North West experience is valuable in structuring proposals for funding wider rollout of the programme. However, it is recommended that financial planning of other areas assumes that there will be a full reimbursement factor for clinical sessions undertaken and that the business case demonstrates the full cost of clinical sessions for all participants.

3.2 The benefits to date

3.2.1 Benefits to CLN members

CLN members interviewed all agreed they had and were continuing to benefit from being a member of the CLN. Specific comments included:

"Being a member of a cohesive group within an action learning set which encourages sharing of confidential information and the freedom to share good and bad experiences and tease out potential ways forward is enormously beneficial and can be likened to "passing around a baton which gives first class support when needed"

"As a result of the knowledge, experience and confidence I have gained within the CLN, doors have opened for me enabling me to exert my influence in arenas which would never have been possible in the past."

"An enormous benefit is the opportunity to learn from very experienced high calibre clinical colleagues outside my local health economy"

"The geographical spread of members together with the opportunity to discuss concerns and opportunities with key individual from the SHA and DH sets this network apart from others."

"My understanding of policy has increased enormously and the Q&A sessions with representatives from the DH and SHA has been particularly beneficial. It has increased my confidence, given me a more mature approach to the issues. I feel empowered and able to carry out informed debate and negotiation with other clinical colleagues locally."

"This structure includes clinicians as a principle constituent of the NHS – not as an appendage as has been the case in the past. This can only benefit me personally and then inevitably my organisation and the wider government agenda"

"I now feel empowered and informed to enable me to investigate, discuss and agree actions – can only be beneficial for all"

"Gives a feeling of inclusivity and the opportunity to influence at the highest level"

3.2.2 Benefits to CLN members organisations

Specific comments below give further evidence of how members and ultimately service provision has and will continue to benefit:

"Identifying the lead in secondary care with responsibility for achieving the 18 week target, breaking down preconceived barriers and establishing an open effective working relationship in order to enable progression"

"Raising awareness of Choose and Book within their own team and helping colleagues 'entrenched' in their own problems 'step outside' and gain a clearer understanding of how things can be moved forward."

"Has opened doors and raised my profile considerably across primary and secondary care and I am now finding a genuine enthusiasm and willingness from colleagues who are all working to the same goal but often by a different route to work together as a team."

"My membership of the CLN and resulting increased knowledge of Choose and Book has enabled me to meet with Senior Managers, have an informed discussion and put the message across in such a way to enable us to agree a target way forward and actually start to implement that. To achieve this required knowledge, confidence and assertiveness I would not have had without CLN membership."

"My CLN position has had a great impact on our approach to meeting the eighteen week target. Through a sequence of discussions and meetings within the Trust I have changed the emphasis on our approach from waiting lists to capacity management. The effect of this is change of approach is now starting to become apparent."

"Too early to comment as yet, it will take time, benefits will be in the future"

3.2.3 Benefits to NHS North West

Mike Farrar, CBE, Chief executive NHS North West, Joe Rafferty Director of Commissioning and Performance NHS North West and Ruth Hussey Director of Public Health and Clinical Engagement NHS North West have all been interviewed as part of the evaluation process. They have all expressed that they are

"100% behind the project and will continue to be so and would be very keen to see it rolled out across the country."

Mike Farrar stated:

"The benefits of the CLN for the future are enormous, strong clinical engagement is paramount and needs to be part of our culture, not just through formal structures or through individuals as champions but as an ethos and the CLN is instrumental in promoting that. Clinicians can no longer have a role only in rubberstamping, they must be fully engaged in all stages of the change process, through a clinicians view of change. That is how we will deliver service reform."

Joe Rafferty stated:

"The CLN is enormously beneficial to NHS North West, it is well atuned to what needs to be achieved, is responsive to the needs of the SHA and is a very important vehicle for achieving clinical engagement and therefore delivering change in partnership with Managers"

Ruth Hussey stated:

"Involving clinicians in the improvement of health care commissioning and delivery of services is not optional, it's essential; CLN provides a tested method of securing clinical leadership that will be of interest to PCTs and Trusts."

3.2.4 Benefits to Department of Health

Philippa Robinson 18 week National Implementation Director has presented to the CLN. Her perception of the meeting and the CLN can be summarised as:

"A cohesive vocal group of very knowledgeable and enthusiastic clinicians with a real willingness to raise awareness of and deliver change. It is a fundamental part of achieving clinical engagement and I fully support cascading the CLN across the country."

David Colin-Thome, National Clinical Director for Primary Care has also presented at a Regional CLN meeting. His view can be summarised as:

"I was and remain very supportive of the concept and am very keen to see the model developed, Clinical Engagement is essential in order to deliver against the NHS reform agenda. The CLN members in the North West are very well informed and generally positive regarding the future. This model presents the opportunity for then to air their queries and concerns, become informed and involved at the core centre"

Jane Cummings , Programme Director for Choice and Choose and Book within the Department of Health states:

"The principles of the CLN are vital; sustainable change can only be delivered by a true partnership between managers and lead clinicians who are recognised in their field as leaders with the skills, enthusiasm, knowledge and commitment to drive reform forward. The methodology of the CLN offers a supportive but challenging environment for clinicians to develop within a multi-professional group and achieve positive outcomes"

3.2.5 NHS Connecting for Health

Professor Michael Thick, Chief Clinical Director for NHS Connecting for Health and previous Medical Director for CFH Choose and Book has been involved in the development of the CLN, and his comments are:

"The NHS Clinical Leaders Network has utilised and demonstrated a unique methodology to encourage clinical engagement with grassroots clinicians. The success of this exciting project and its subsequent national roll-out will benefit the mainstream reform agendas of both Connecting for Health and the Department of Health. Furthermore, this would enable "front line" local clinicians to feel that they

have been consulted about CFH initiatives, and had a direct say in how local solutions should look and feel."

Dr Mark Davies, Primary Care Medical Director, Choose and Book programme, NHS Connecting for Health is very supportive of the CLN and states:

"There is a pressing need to develop sustainable networks of clinical leaders at regional level if we are to see the benefits from health reform. The Clinical Leaders Network has delivered just that in the North West with a methodology that is rooted in local action. The Choose and Book agenda in the area has benefited enormously from this approach and we would like to see similar networks in other parts of country."

3.3 The impact of Choose and Book uptake within the SHA

The CLN was established with a clear objective of combining clinical engagement with tangible delivery output. This however needs to be maturely reviewed in the context of short term influence on performance measures and long term mainstream delivery. The CLN agenda focused on the increased awareness and participation of its members on the Choice and Choose and Book agendas between March and June 2006.

The cause and effect of the CLN on the agenda is not conclusive at this point in time. However, as part of this evaluation it is important to clarify points of discussion and further investigation to ascertain the value of clinical engagement and the CLN on performance measured areas of service delivery.

Figure 1 shows the high level Choose and Book performance of the North West in comparison to other clusters during the evaluation period.

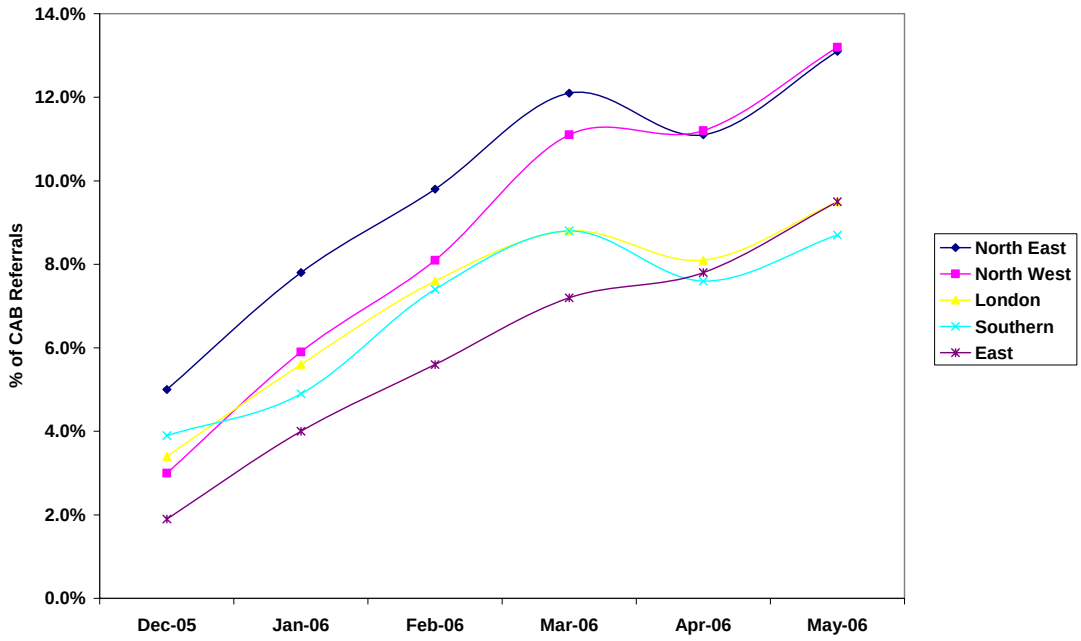

Figure 1. Choose and Book Referrals. Dec – May 2006. CfH cluster level

The graph demonstrates a significant positive shift in performance against comparative sectors. However, this of course is influenced by a number of factors. Figure 2, provides a further insight into the comparison in performance between the PCTs represented by CLN members against the national PCT average.

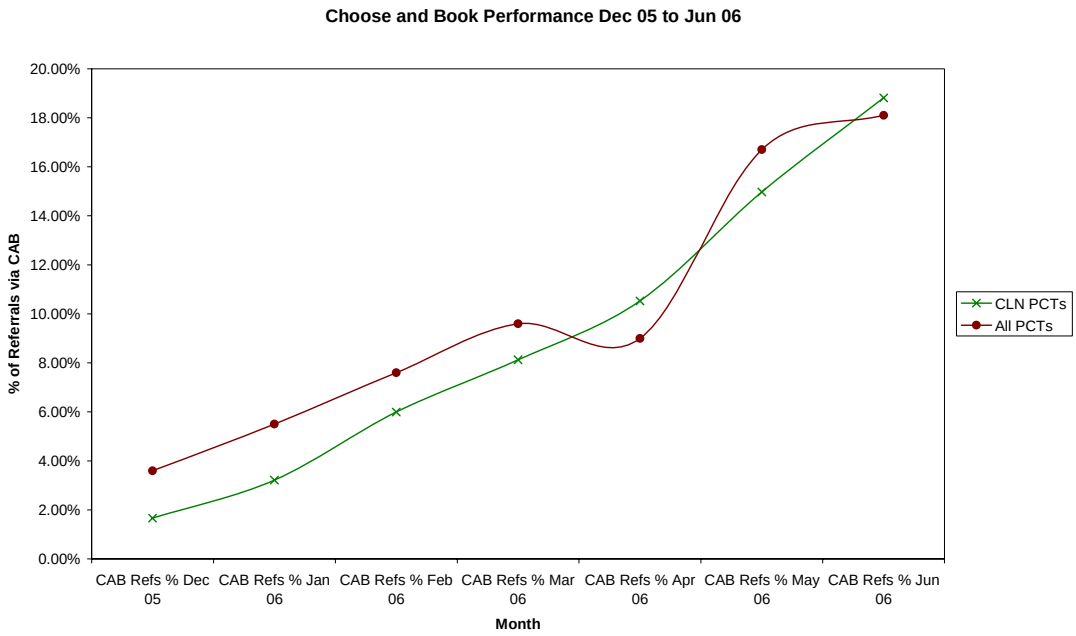

Figure 2 Choose and Book Referrals Dec – June 2006. PCT level

The comparison demonstrates a more consistently progressive performance achievement of CLN member PCTs than those of the national average, especially during the April technology issue. This is indicative but not conclusive of a sustained change in working patterns. There is not sufficient evidence to correlate CLN activity to the performance output or to draw any substantiated conclusions. This is a major gap for the CLN management team to address in this stage in the programmes life cycle, prior to the planning of wider roll out.

It is recommended that Choose and Book performance within the SHA continues to be monitored to ascertain if the increase continues at the current rate. The hypothesis that as local clinical engagement continues and the background knowledge and subsequent willingness to change permeates from the CLN members through other established networks and informal communication channels, the increase will continue to escalate, needs to be monitored.

A number of individual PCTs were shown to have increased C&B uptake very significantly during this period.

3.4 Concerns Identified

During the interview process, individuals were asked to identify any concerns or perceived weaknesses of the CLN from their perspective. Few were identified, some of these have been incorporate within section 3.1, others are as below.

- ***Feedback on any impact of the CLN from DH/SHA needs to be formalised***
- ***Informality and lack of structure to the group is considered a key benefit but also potentially a key weakness. The balance needs to be carefully monitored to ensure it contributes to the delivery of outcomes.***
- ***CLN needs to give more clarity and strength to the role of Clinical Leader and consider its position in relation to finance, management, service design and commissioning.***
- ***Need clarity regarding provision of focussed training.***

- ***Initial tension with colleagues due to the selective appointment process.***
- ***Resourcing could become an issue in the future – depends on changes to roles etc.***
- ***Representation issue to consider – organisational, geographical, male:female ratio etc.***
- ***Possible tensions with the Local Medical Committee as the initiative is led by primary care.***
- ***Need to ensure it empowers members to have confidence to stop and redesign services when necessary not always just modify at the edges.***

4 Recommendations

To date, the CLN has received strong support from all areas of NHS healthcare clinical service teams, providers and management. The process and methodologies behind the CLN are well selected for the purpose and participant group, reflecting a balance of structure, autonomy and innovation. There are however a number of areas where improvements in the process management and information reporting will promote greater decision making, impact on performance measures and engagement from external stakeholders.

Information Capture System:

The management team are advised to develop a small number of Key Performance Indicators and supporting information capture and reporting processes to enable them to make decisions effectively and demonstrate the value of the pilot to themselves and external stakeholders.

The findings of the evaluation would suggest the management team and participants should be aware of:

- Attendance levels
- Activity reporting return percentages
- Key issues form activity reporting
- Positioning against and use of the Manchester Engagement Escalator.
- Comparative output performance of CLN organisations and non CLN organisation in the selected topic areas.
- Key issues relating to policy and learning set feedback.

A range of data now exists, but this activity has not been structured into a form / system enabling the management team to pick up on issues or plan strategies, other than through a more intense evaluation process. It is thought that the development of an information management process / system will greatly benefit the evaluation of CLN activity and value on an ongoing basis.

Access to information is an important factor and a system should be introduced to collate information from Activity reports in such a way that it can be use as a source of reference to other members of the group and therefore ensure maximum benefit to group members.

The breadth of scope in information capture will require ongoing, focused effort and administration in order to provide information for management, strategic and reporting purposes. Without a strengthened information capture and reporting process, the development of the initiative is at risk of supporting instinct based decisions with anecdotal and ad hoc demonstration of progress.

Recruitment Methodology

The recruitment methodology should be reviewed to ensure that an open process is supported by a structured selection procedure which ensures CLN members are high calibre individuals with the experience and skills required to improve clinical engagement locally – as is the case in the pilot project. Further information regarding the role and expectations of participants is required at application stage and should be available for the benefit of individuals and to assist them in engaging their organisations to support their application.

Upon selection, the CLN should employ processes to confirm status and expectations to successful individuals and their organisational leaders. As the CLN is geographically based, it would be advisable to present the concept at a regional CEO meeting to help promote organisational buy-in and support as part of the recruitment process.

An induction 'learning set' session has proven to be a valuable use of time in establishing the group networks and in helping individuals establish the expectations and value of their participation. Consistent delivery to all new members should be ensured.

Marketing Information

'Marketing information' would be very useful; both to raise the profile of the CLN and also to assist new members explain their role to and gain support from managers.

Consideration should be given to issuing "reminders" to Chief Executives regarding who their CLN members are in the organisation, future agenda topics and the advantages of membership to the organisation.

For roll-out activity into a new region, a full 'franchised' structure, process and materials supported by training for administrative staff would facilitate effective, consistent and efficient set up and delivery.

Members Surveys and Feedback

Members should be surveyed to ensure the CLN is delivering what they require and to consult over future topics etc. This will ensure the member's needs are being met and will enable any ideas or issue to be captured at an early stage.

Formal feedback mechanisms should be introduced to update members of any outcome from Q&A sessions with DH speakers and to ensure that appropriate non-confidential information from Activity Learning Sets is captured and passed on as necessary. The use of facilitators could be considered for this task

Use of the Manchester Engagement Escalator should be encouraged as a mechanism to measure outcome for the network.

The method(s) and media used to facilitate this activity and capture the views and information required should be consulted with participants. There are a significant range of cost effective methods and processes available, but the selection should be made on ease of use and access by CLN members.

Future Development

To ensure that the group outputs are aligned with the objectives of the sponsors and organisers, the framework will require clarity and ongoing, measurable review of the following key principles:

- There is a clear understanding of the overall need and a desire to contribute by the participants
- There is a clear understanding and articulation of the requirements of the participants
- Responsibility for ongoing commitment is delegated to participant groups

- Measures of success are collaboratively agreed upon and focused on outcomes in the form of benefits.
- Sponsoring organisational managers are maturely engaged and offered contribution into the direction and construction of the programme.

5 Conclusions

The evaluation of the pilot project has shown it to be based on a philosophically sound core. It has strong support from the Chief Executive (Mike Farrar CBE), Director of Commissioning and Performance of NHS North West (Joe Rafferty) and Director of Public Health and Clinical Engagement NHS North West (Ruth Hussey) and from representatives of the DH. Clinicians reported membership to be a positive experience and were enthusiastic to participate. Speakers at regional meetings were very well received and the opportunity for members to be involved in policy at all stages welcomed. A large number of personal and organisational benefits are evidenced.

Establishing the network, forming cohesive learning groups and changing a culture takes time and six months from the inaugural meeting is too early to be in a position to identify and measure outcomes directly attributable to change brought about by the CLN. That said, the impact on Choose and Book referrals is very encouraging at this stage and monitoring should continue. That is however only one measure of engagement and therefore use of the Manchester Engagement Escalator to encourage strategic thinking should be encouraged to enable analysis of the benefits of the CLN at a strategic level.

The evidence gained demonstrates clear enthusiasm and support for cascading the initiative across the country. Stakeholders perceive clear benefits from the initiative and are willing to support the scheme and it's potential deliverables. The recommendations highlighted within the report should be considered prior to any national roll out to ensure future projects gain from the experiences of the methodology and management of the pilot project.

As the CLN matures, the challenges it will face include keeping in touch with ongoing policy development and gaining the attention of influential clinicians who are less willing to contribute outside their traditional organisational boundaries.

Appendix A

Personnel Interviewed

A1 Personnel Interviewed

Core Project Team (National & SHA)

Dr Raj Kumar	National Co-ordinator for the CLN team, National Clinical Lead for Choose and Book, NHS Connecting For Health
Dr Andrew Coley	Clinical Lead, Cheshire and Merseyside SHA
Dr Steve Henderson	Clinical Lead, Greater Manchester SHA (Associate Director – NHS North West)
Dr Steve Ward	Clinical Lead, Cumbria and Lancashire SHA

SHA Personnel

Mike Farrar CBE	Chief Executive NHS North West
Joe Rafferty	Director of Commissioning and Performance, NHS North West
Ruth Hussey	Medical Director for Public Health and Clinical Engagement , NHS North West

Department of Health Personnel

Philippa Robinson	18 week National Implementation Director
David Colin-Thomes	National Clinical Director for Primary Care
Jane Cummings	National Director – Choice and Choose and Book Programme

CLN Members

Mr Stephen Hodgson	Clinical Lead, Trauma and Orthopaedic Surgery, Royal Bolton Hospitals NHS Trust
Dr Venkata Narayama	Chair PEC, Burnley, Pendle and Rossendale PCT
Dr Peter Madden	PEC GP member, East Cheshire PCT
Debbie Tysver	Breast Care Consultant Nurse, Blackpool Fylde and Wyre NHS Trust
Dr Amir Hannan	PEC GP member, IM&T Lead, Tameside and Glossop PCT
Dr Maurice Smith	Chair PEC, South Liverpool PCT
Mr David Rowlands	Clinical Director Womens Services, Wirral Hospitals NHS Trust