

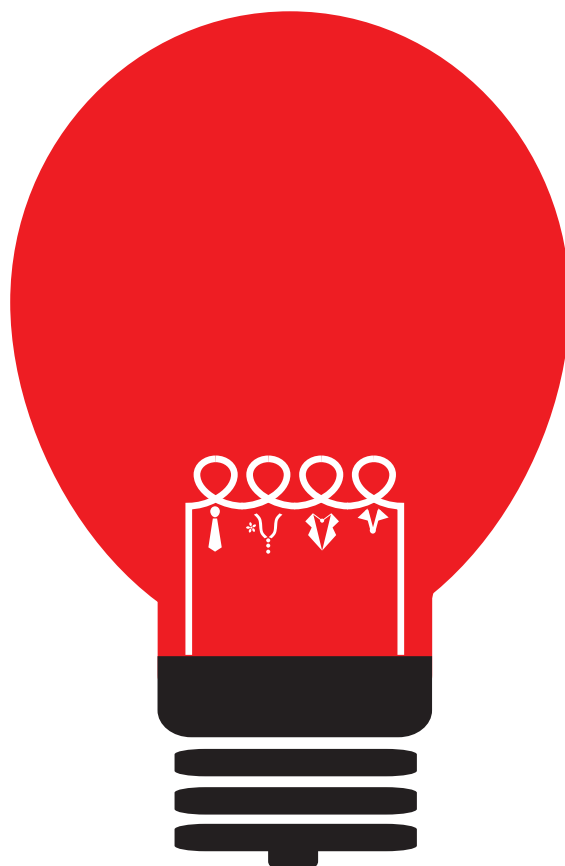
Learning report:

Shared Leadership for Change



*Case studies and learning from a
programme to improve the quality of
care for people from black and minority
ethnic groups*

September 2011



Identify Innovate Demonstrate Encourage

CONTENTS

| | |
|--------------------------------------------------------|----|
| Shared Leadership for Change (BME) | 1 |
| Project: Blackburn with Darwen | 3 |
| Project: Kensington, Chelsea and Westminster | 10 |
| Project: Oldham | 17 |
| Project: Sheffield | 23 |
| Project: Wakefield | 29 |
| Project: Walsall | 35 |
| Learning from all projects | 42 |
| What I learned: reflections from a project team member | 46 |

SHARED LEADERSHIP FOR CHANGE (BME)



By ‘shared leadership’ we mean using interventions, such as tools and activities, that are aimed at whole teams and distributing leadership responsibilities across the team.

It is widely recognised that there are significant health inequalities between people from black and minority ethnic (BME) groups and the UK population as a whole. For example, in 2003 the Department of Health launched a three-year initiative to tackle such inequalities, including a plan to engage and empower local communities to take action to improve the care provided to BME patients.

In 2007, the Department of Health report *Our NHS, our future* set out a vision of an NHS that is ‘equally available to all, taking full account of personal circumstances and diversity’. It also highlighted that ‘the most successful action happens when different agencies work together’.

While the NHS is not always best placed to connect with people in the community, community organisations have unique contact with seldom heard groups that may not have clear access to mainstream services. These community organisations can work with individuals and statutory services to find out what needs to happen to improve access to care, and the quality of that care. They can also raise awareness among members of a community of the services that are available to them.

Our ‘Shared Leadership for Change: Improving the quality of care for people from black and minority ethnic groups’ programme was launched in 2007 with the aim of helping cross-sector groups work together to improve services for local BME communities. The programme funded six shared leadership teams to set up and run projects to meet this aim.

THE SIX PROJECTS

- Blackburn and Darwen – ‘Re-shape’
- Kensington, Chelsea and Westminster – ‘Good Practices for Access and Well-being’
- Oldham – ‘Don’t lose sight of diabetes’
- Sheffield – ‘Enhancing Pathways into Care for African and Caribbean services users (EPIC II)’
- Wakefield – ‘Shared Leadership for Change (Health Inequalities)’
- Walsall – ‘Walsall Shared Leadership Scheme’

Community and voluntary organisations work very differently to statutory ones and finding effective ways of working together can be challenging. To address this, our programme encouraged teams to share responsibility and leadership equally. With the support of a leadership consultant, participants learned new skills and techniques that helped facilitate effective teamwork.

All of the teams’ projects have now concluded, but their impact is still being felt within the communities and the service providers. Reducing health inequalities takes time and changes to the way people access care, and how that care is provided, do not happen quickly. Each team has gained significant learning and continues to benefit from both the shared leadership approach and the new relationships that they have developed with their local communities.

This document provides details of the each project. It explains:

- why the particular healthcare issue and community was chosen
- what the project did to improve the quality of care for that target group
- the learning from the project
- the impact it has had.

Each team has provided practical tips and advice on how to make projects such as theirs successful. These are drawn from the teams’ particular experiences and aim to help other teams and organisations that may wish to take a similar approach.

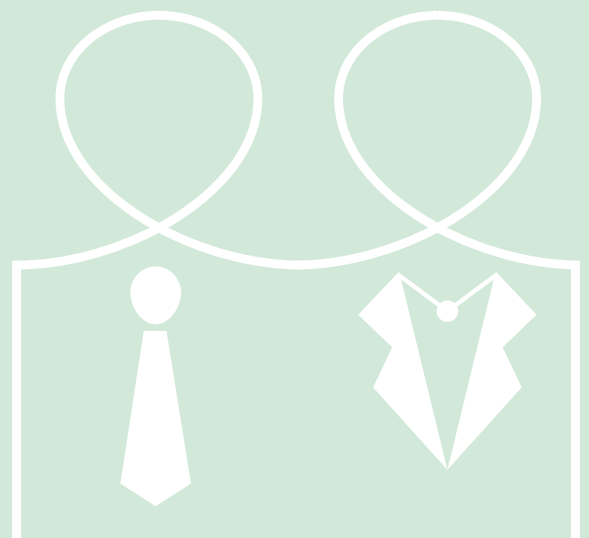
Learning that was common to all projects has also been drawn out. The lessons learned are essential to any team or organisation either planning or implementing similar work to reduce health inequalities for people from BME communities.

This publication is aimed at operational and delivery teams working either within the NHS, social care or community settings. It will also be of use to those with a wider interest in health inequalities and working with BME communities.

For more information about the programme, and reports from the evaluations of each of the projects, visit: www.health.org.uk/areas-of-work/programmes/shared-leadership-for-change-bme

PROJECT: BLACKBURN WITH DARWEN

By raising awareness and providing services more culturally in tune with its community, Blackburn with Darwen's experienced, multi-disciplinary team has increased local South Asian women's participation in sports and leisure activities.



BACKGROUND TO THE PROJECT

In England, South Asian women have the lowest levels of participation in physical activity. And Indian, Pakistani and Bangladeshi women in particular are less likely to participate in physical activity than other ethnic groups.

In Blackburn with Darwen, the local population has one of the lowest levels of physical activity in England, with only 16.3% undertaking 30 minutes' physical activity three times a week.

Blackburn with Darwen is home to a large South Asian community, and health organisations and professionals in the area were concerned about its residents' poor health outcomes. Of particular concern were obesity, heart disease, diabetes and low birth weight babies. There was also poor uptake of preventative and rehabilitation services from this BME group, and a high rate of non-attendance at referral appointments.

To tackle these problems, local health, council and community groups came together to form a shared leadership team. Running from 2007 to 2009, the project focused on the Audley and Queen's Park areas of Blackburn, which have proportionately high South Asian populations and are served by Audley Sports and Community Centre. The project team worked with the staff at the centre and with the local BME community to improve healthy eating and participation in sports services by South Asian women.

PROJECT DETAILS

Project team:

- NHS Blackburn with Darwen
- Blackburn with Darwen Borough Council Healthy Living and Sport
- Blackburn with Darwen Borough Council Neighbourhoods and Learning
- Blackburn with Darwen Healthy Living
- Blackburn with Darwen Community and Voluntary Service
- East Lancashire Hospitals NHS Trust

BME target group:

South Asian women aged 18 to 40 living in Audley and Queen's Park, Blackburn

Aim:

To increase the level of engagement in healthy eating and sports and leisure services provided by Audley Sports Centre

WHAT WE DID

The shared leadership team was made up of seven members, drawn from public and voluntary sector organisations involved in healthcare and sports and leisure services in Blackburn with Darwen.

The project focused on Audley Sports and Community Centre, which is located in the centre of the area's South Asian community and is relatively well used by Asian men and young children but, prior to the project, was used less by South Asian women.

The team identified their target group by assessing who would have the most impact on the health of families in the South Asian community. They decided on women aged 18 to 40, as they are likely to be highly influential in the family unit and are likely to be the main providers of food and have strong links to the extended family.

The team held a series of focus groups with the community to uncover the barriers to engagement with the centre and with exercise in general. Over 70 people attended these sessions. Attendees were recruited via community and voluntary groups, and by linking with the local children's centre and schools, recognising that many of the target audience have young children.

Working with the staff and management at the sports centre, the team also looked at what could be done to help make the centre more accessible and appealing to the target women.

The team introduced and helped implement a series of initiatives, including the introduction of women-only exercise and nutrition classes that took place when the centre was closed to men. Between April and November 2009, 244 Asian women attended these sessions.

An interpreter worked with the sports centre staff for six months, helping to address some of the communication issues by translating and re-working important information, for example by introducing diagrammatical ways of explaining important health and safety issues.

The project team worked very closely with the centre for two months, and then continued to oversee the changes, providing telephone support where needed. Once the team and then the interpreter withdrew, the centre continued to maintain the changes and the target community have continued to attend the classes.

OUR LEARNING

Cultural competence

The main issue the team had to overcome was the cultural clash between the women in the BME community and the staff working at the sports centre. Many of the staff members had worked at the centre for many years but had not been given the skills they needed to work with the community around them:

‘The staff said it was really hard to work with women from the South Asian community, and that there were a lot of issues. They were trying to deliver services to people they didn’t understand and without the necessary skills.’

Andrea Madden, Manager, Healthy Living and Sport, Blackburn with Darwen Borough Council

Working with the community via the focus groups and with the centre’s staff, they found that there were issues on both sides:

‘The ladies would come in and come across as hostile because they didn’t speak English. And the staff were seen as racist. There was a cultural and racial clash on both sides.’

In starting to address this, the team first engaged the managers at the centre, as they knew that unless they convinced them that the initiative was worthwhile, the project would flounder as soon as the team withdrew.

The challenge was then to improve cultural awareness among the staff at the centre. This wasn’t something that could be done quickly or easily:

‘Cultural competence isn’t about a half-day training course; it is more than that and it takes time. It was about working with both sides.’

By working with the staff in a very hands-on way, and with the introduction of an interpreter to help with communication, the team helped improve cultural competence at the centre and helped both sides understand each other’s barriers and issues:

‘The staff are now skilled and even when new people come in to work there, the skills and culture are embedded so it continues to work.’

Leadership and team working

The organisations within the project team had worked together previously. However, this shared leadership project saw the group working in a true partnership, in a way they had not done previously.

Much of the first year of the project was spent developing the team and planning. Working with a leadership consultant, they took their original, very broad, aims and learned how to focus on specifics, with realistic aims that took into account the limited resources. They also spent time defining what success would look like and what their success criteria should be.

The team were encouraged to challenge every decision made and to look at everything from a partnership perspective:

'It was incredibly challenging because we were challenged. We were being challenged about the purpose of every decision we made. When we said we were doing things because "it has always been done like that", we were challenged to ask why.'

Individually the team members benefited from this new way of working too:

'It has definitely changed the way I do things. From a leadership perspective, I learned more from doing this project than from any other training I have done before. I learned that there is a difference between management skills and leadership skills. That has been a great learning and has impacted on how I lead my team now.'

IMPACT OF THE PROJECT

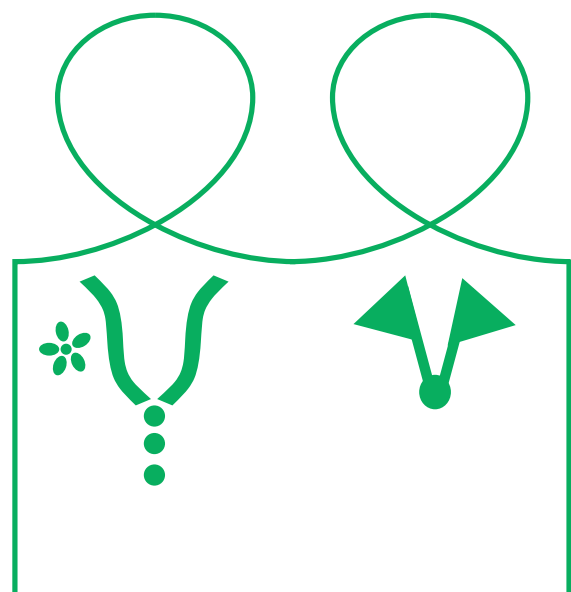
Attendance at the sports centre by South Asian women has increased since the project began. There have also been health improvements in BME communities in the area, although the team acknowledge that it is difficult to attribute that specifically to this project, as it is one element of a wider healthy living programme in Blackburn with Darwen.

The women-only classes have continued and are well attended. During the project the nutrition classes were not as well attended as the exercise classes, but the sports centre has now introduced 'Cook and eat' and weight management classes, which are working well.

Despite being successful in initially re-directing funding for the project, influencing commissioners was an ongoing difficulty:

'Our challenge was that we had a very frontline group of organisations and so sharing our learning strategically was more difficult than operationally. Getting our message out that this method works was very difficult.'

The project proved that rates of physical activity can be improved through community engagement and enhanced cultural awareness. The team are looking at ways to gain funding to replicate the model with other communities and in other areas.



TIPS AND ADVICE

Value challenge

‘There is value in challenge and in not always reaching agreement straight away. Sometimes having to re-think is good and isn’t a waste of time.’

Although the team found this difficult, the end product demonstrated the value of taking the time to plan, focusing on measurable outcomes and ensuring everyone is on board.

Know where your community is

The first step to take when engaging with a community is to take the time to think about where the target people will be, and what is the best way to access them. The team used an extended group of organisations, including community groups, schools and children’s centres, which was an effective way of reaching their target group.

‘We learned previously that if you just stay where you are and expect the community to come to you, nothing happens. Make sure you identify your target group and be inventive as to where they will be.’

Find innovative ways to communicate

‘You can’t feasibly translate everything into every language, so we had to use other methods. Communication is not just verbal and we did a lot of work with the staff on that.’

Using pictures and diagrams to communicate important information was effective in getting health and safety messages across.

Listen to service providers as well as the community

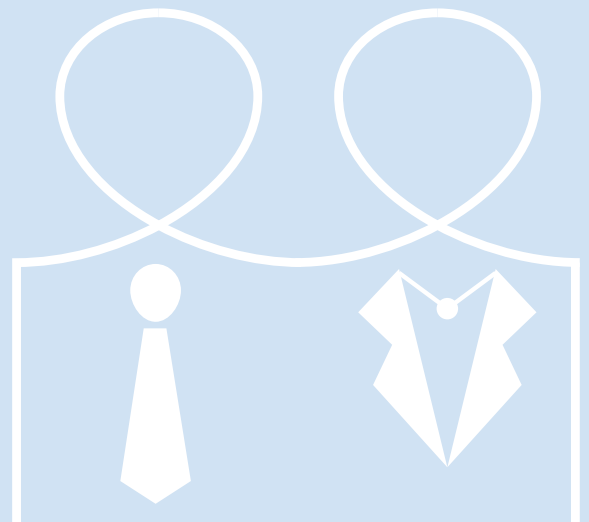
The Blackburn with Darwen team demonstrated the value of listening to both sides of the story and working with both the community and service providers on the ground to break down barriers.

‘Listen to the staff and understand it from their perspective, as well as working with the community.’

This method meant that the team were developing the service with the key people, rather than imposing an initiative on them that they may not be engaged with.

PROJECT: KENSINGTON, CHELSEA AND WESTMINSTER

Working closely with community organisations, an experienced team from Kensington, Chelsea and Westminster has improved access to primary care services for their local BME communities, and has researched and recommended an alternative way of commissioning these services.



BACKGROUND TO THE PROJECT

The City of Westminster is one of London's most ethnically and culturally diverse boroughs. Over 150 languages are spoken and it is estimated that 29% of the population belong to BME groups.

The Royal Borough of Kensington and Chelsea, the most densely populated borough in the UK, is also home to a wide range of BME communities.

There is evidence of significant variation in the health and wellbeing of the different communities in these boroughs, with residents from BME groups tending to suffer poorer health and having lower life expectancy than average.

The BME Health Forum is a collaborative partnership network between statutory, voluntary and community organisations in the two boroughs that aims to improve health and reduce inequalities for the local BME population. It does this by empowering communities to engage effectively with the health service.

The Forum was aware that people from BME groups in the area often didn't know about the primary care services available to them, and that there were problems surrounding access to these services. In 2007 they commissioned a research project on access to GP services for BME groups, which highlighted significant levels of dissatisfaction. The main issues were around communication, caused by language and cultural barriers; access and use of interpreting services; relationships with GPs and practice staff; and the process of registering with a GP and making appointments.

To follow up on the recommendations in the report, the Forum ran a Good Practices for Access and Wellbeing initiative, which was the focus for its shared leadership project and ran from April 2009 to March 2010.

PROJECT DETAILS

Project team:

BME Health Forum, including:

- NHS Westminster
- NHS Kensington and Chelsea
- six community organisations

BME target group:

BME communities in Kensington, Chelsea and Westminster

Aim:

To improve access to primary care services for BME communities in the area

WHAT WE DID

In early 2009, the Forum invited tenders from local community organisations to be part of the Good Practices for Access and Wellbeing project. They recruited six community organisations and funded each one to implement a series of initiatives aimed at improving access to primary care services for BME communities. The organisations did this through working with patients and primary care providers to develop services and improve relationships, while also increasing the community's knowledge of how to access and use those services.

The six organisations involved were:

- Al-Hasaniya Moroccan Women's Centre
- Chinese National Healthy Living Centre
- Kongolese Centre for Information and Advice
- Midaye Somali Development Network
- Queens Park Bangladeshi Association
- WSPM Agape Community Project.

Each organisation employed an access facilitator, whose purpose was to find out what issues their community have around primary care access; provide feedback to local healthcare providers; raise issues of behalf of the community; and educate the community on how to make effective use of health services. They also provided advocacy support to patients to help them make complaints or raise challenges, and to help overcome cultural or language barriers.

The six organisations co-authored a guide for patients on interpreting services and a guide to NHS services, both of which were translated into community languages. The access facilitators each developed support and referral systems for patients; worked with community members on using clinical consultation more effectively; and conducted focus groups and training sessions to promote better relationships with GPs and practice staff.

Through their work with community organisations and primary care services, the Forum identified examples of best practice that could potentially be mainstreamed across the NHS. In order to investigate how other countries deal with health inequalities, Forum members visited Toronto, Canada, to find out about a different system of delivering healthcare to a diverse population, and to identify learning that could be applicable in the UK. This learning led to the Forum developing a series of recommendations for a significant change to the way that primary care services are commissioned (see 'Learning from Toronto' on page 14).

OUR LEARNING

Community development

The team worked closely with the six community organisations. Some of these relationships were new and some were existing. The project also helped improve capacity within the six organisations.

‘The project should also be about helping organisations to evolve their capacity around health services. The benefits of this are two-way.’

Brian Colman, Head of Equality and Diversity, NHS Westminster

Community organisations are in the strongest position to educate and share information with their communities. The project team utilised the strong links that the community groups have with BME groups to uncover what the barriers to access were, and to seek out ways in which improvements could be made.

Engagement with these community organisations was highly effective and the BME Health Forum provided an existing platform from which to influence providers of care.

A targeted approach

Clinical engagement was a challenge for many of the organisations involved in the project, and for the project team. In particular, the project team found there were specific barriers to engaging GPs in the project.

‘The focus for GPs is, by the very nature of their work, on individuals, whereas we are talking about communities as a whole. There was also difficulty with defining what we meant by ‘access’. Often GPs see this as number of patients and opening hours, whereas it isn’t just about that, it is about the quality of that access and patients receiving care that is tailored to their needs. Getting that message across was difficult.’

The team learned that they had to be more targeted in their approach to engaging with both the service providers and communities.

‘It was vital to take account of where people are and what their agenda is. We became better at that and developed targeted recommendations for each problem. Our recommendations became more focused.’

The team found that once they had practical materials to help them, for example the guides to interpreting, GPs were more likely to be engaged with the project.

‘We could then go back and say we have these practical things; we can help you in your day-to-day work with patients.’

LEARNING FROM TORONTO

Toronto was chosen as a particularly relevant city to the shared leadership project as the Canadian health system shares many similarities with the NHS, and Toronto has a high BME population and an informed health system in terms of BME issues.

Toronto has a network of community health centres (CHCs), which are voluntary organisations that offer local people a number of services, including health services. They are aimed at communities that face barriers to accessing primary care. CHCs are multi-disciplinary; supporting patients not only by providing clinical services, but also dealing with the social, environmental and economic determinants of health.

Evidence suggests that CHCs are cost effective in improving access to healthcare in Canada, as they reduce hospital admissions, reduce inappropriate referrals and make effective use of non-physician clinicians such as nurses.

The CHC model is over 20 years old and the number of CHCs is expanding. The success of CHCs indicates that rather than focusing exclusively on mainstream GP practices as the sole route for access, it may be more cost effective if the NHS were to invest in separate structures that specifically tackle access for vulnerable populations.

The BME Health Forum has made a series of recommendations for changing the way primary care is commissioned in light of their experiences during the Toronto visit.

IMPACT OF THE PROJECT

The project has resulted in an increased awareness of primary care services among BME communities in the area, increased use of formal interpreters and greater awareness of how to access an interpreter.

The access facilitators improved relationships between the communities and the service providers, and their one-to-one work with patients proved highly successful.

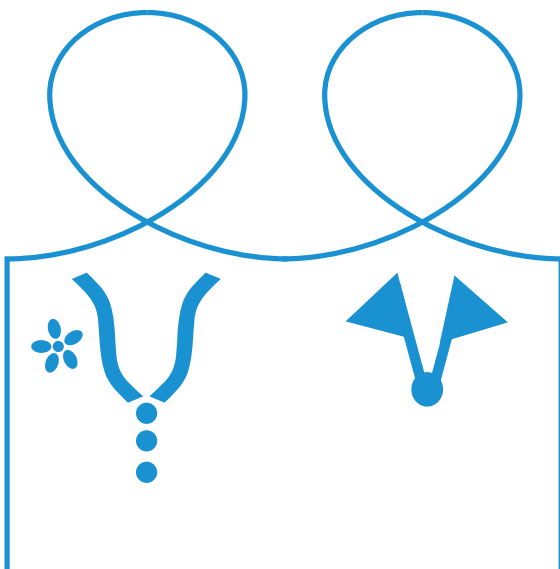
‘Two of the community organisations have managed to source funding to allow the access facilitators to continue with their work.’

The project also raised the profile of the BME Health Forum and it is now being recognised as a model of good practice. The findings of the project, including the CHC model seen in Toronto, have been fed into a series of recommendations for changing the way primary care is commissioned in the area.

The leadership development work that was part of the project has also had a significant impact. The processes and structures put in place have helped to create a stronger, more effective team.

‘The team bonding element has been very important, and will have a lasting effect. It has changed the culture of the team, and that will remain. It has made us work better as a team and everyone is willing to contribute to its success.’

Nafsika Thalassis, Project Coordinator,
BME Health Forum



TIPS AND ADVICE

Take calculated risks

The Forum hadn't worked with some of the community organisations previously, and knew that providing funding when they didn't know how successful they could be was a risk.

'We knew it was risky to use some of the less-developed organisations, but we also knew we had to take risks in order to have an impact. Some of the organisations did better than others, but that was a risk we had to take.'

Have a long-term view

Influencing changes to commissioning takes time, which can be challenging when trying to engage people in the project.

'The outcomes for projects with BME communities tend to be long-term. The idea of investing now for the future can be problematic, particularly in the NHS where decisions are often driven by short-term goals, and are, understandable, very treatment-focused.'

Stick to what you know will work

The Forum had experience of working with the community and so knew that it was the best way to go about this project.

'The project confirmed my belief that it is the right way to go about things, in terms of improving quality of experience, that involving communities themselves is the right approach to take.'

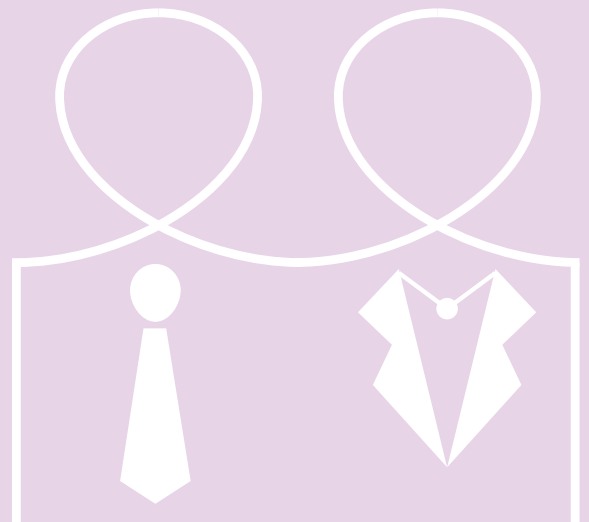
Look behind the figures:

Data on GP consultations can sometimes show that BME groups have high rates of consultations. However, this can hide the real picture.

'More consultations can also be a measure of poor access as repeat consultations may mean that the patient has had to go a few times to get heard. It is about having fewer sessions that are of better quality.'

PROJECT: OLDHAM

Working across organisational and sector boundaries, Oldham's shared leadership team has improved care for Pakistani and Bangladeshi people living with diabetes by increasing attendance at retinopathy screening appointments, and providing education on screening and lifestyle management.



BACKGROUND TO THE PROJECT

Retinopathy screening can reduce the risk of sight loss among people with diabetes through the early identification of sight-threatening diabetic retinopathy. The Department of Health set a national target that by the end of 2007, diabetic retinopathy screening would be offered to everyone who is living with diabetes.

In Oldham, there are high rates of diabetes and retinopathy screening levels were low, and variable across ethnic groups.

Approximately 13% of the population of Oldham are Pakistani or Bangladeshi. The risk of diabetes for people of South Asian origin is estimated to be four to five times higher than for people of European origin.

The Oldham shared leadership project, Don't lose sight of diabetes, focused on people living in the Coppice and Glodwick areas of Oldham; areas that have comparatively large Pakistani and Bangladeshi communities. Running from 2007 to 2009, the project looked at how to improve access to care for people living with diabetes in these areas, including improving retinopathy screening rates; improving the quality of care provided; and providing education on screening and lifestyle management.

PROJECT DETAILS

Project team:

- NHS Oldham
- Oldham Community Health Service
- Oldham Community Leisure Ltd
- Oldham Diabetes Support Group
- local community organisations

BME target group:

People living with diabetes from Pakistani and Bangladeshi communities in Coppice and Glodwick

Aim:

To improve awareness of, and access to, diabetic retinopathy screening and education on lifestyle management for the target group

WHAT WE DID

The shared leadership project team was made up of NHS, voluntary and community organisations. Some of the organisations had previously worked together, but there were also new partnerships, for example the NHS working with the Diabetes Support Group and the Community Leisure Centre.

At the start of the project, through gathering data from GP practices and the Diabetic Retinopathy Service, the team uncovered a disproportionately high number of non-attendances at retinopathy screening appointments by Pakistani and Bangladeshi people.

The primary care trust had been aware of the general issue of non-attendance at these appointments for some time. However, the project research highlighted how variable uptake of screening is for BME groups; something that wasn't previously known.

In collating the data for the project, the team also highlighted the patchy records of ethnicity that existed in GP practices.

The team chose five GP practices to work with on the project. They selected those with the highest rates of non-attendance at screening appointments, and those with the largest BME populations. The team worked closely with the practices to improve awareness of the importance of retinopathy screening, and to reduce non-attendance.

The letters that are sent out to people with diabetes to tell them about retinopathy screening were translated into several community languages. They also made the language used in these letters simpler and included explanations of any medical terminology.

The project also highlighted the need to improve communication between health services and Pakistani and Bangladeshi people living with diabetes in the area. The team organised drop-in sessions where people had one-to-one meetings with experts and were signposted to appropriate information or support. Over 100 people received information at these sessions, 87% of whom were from a BME group.

OUR LEARNING

Engaging with GPs

The project was successful at engaging with the GP practices involved. Their approach was not to look at GP practices as a whole, but to tailor the approach differently for each practice.

‘Every practice is independent and has their ways of doing things. For example, for some practices it was about going in there and speaking to the practice manager, whereas for others it was about building a relationship with the receptionist.’

Lynne Barlow, Senior clinician and professional advisor for nursing, NHS Oldham

This way of working took a lot of time to investigate, and involved a lot of networking. However, it was an important step to ensuring the GPs were fully on board. The team found that the practices generally responded positively because it was going to help them in the long term.

‘It is about how you sell it into them, about your messaging and tailoring that to the audience, even if the key message is the same.’

Partnership working

The cross-sector working element of the project helped it to be wide-ranging and innovative. In particular, having non-NHS representation was important.

‘If it had been just an NHS project we would have continued to target people in the same way. The other organisations opened our eyes and we looked at other ways of engaging with the community.’

This non-NHS element was also a driver to looking at how the team communicated with each other, and how they communicated with the target communities.

‘It was important to think about how we engaged with each other. The language of the NHS often runs the risk of disengaging people. Although the project was driven by the NHS, it doesn’t mean it is owned by the NHS, and it was important to look at non-NHS ways of working.’

The team included representatives from commissioning, which was effective in ensuring the project findings were fed into commissioning decisions. There were also members of the Professional Executive Committee on the team, which again helped lever influence.

‘It is important to find out who is going to be able to have an impact and lever change. Find out who the people are who have relevant responsibilities in their portfolio.’

IMPACT OF THE PROJECT

There has been a significant reduction in the rate of non-attendance at screening appointments at the five target GP practices since the start of the project.

There is now ongoing work to improve the collation of ethnicity data by GP practices.

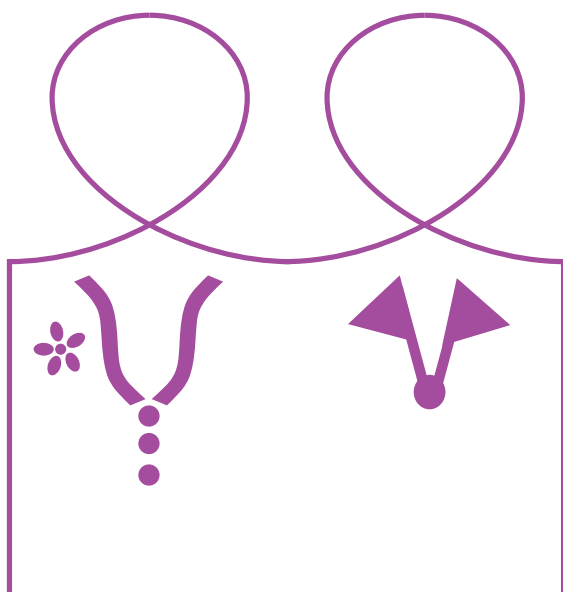
‘There must be an awareness that the data collected are only as good as the skills that the people who collect the data in the first place have.’

Cultural competency training for GP practice staff is also being developed.

The relationships developed between the organisations involved have also had a long-term impact. For example, GPs now have contacts within voluntary organisations involved with diabetes, something that would not have happened prior to the project.

The project had an impact on the leadership skills of the individuals within the team (see ‘What I learned: reflections from a project team member’ on pages 46–49), along with improved cultural awareness.

‘There has been increased cultural competency within the team, and although this hasn’t been measured, many feel it has happened and has spread throughout their teams.’



TIPS AND ADVICE

Tailor your approach to engaging GPs

Give careful thought to how you go about engaging with clinicians. Think about the time of meetings, ie what time suits them; and whether you email, phone or go in and walk around.

‘There was a bit of resistance to going into GP practices and walking around, but it is really important as you can get a feel for the culture and therefore know how to approach them.’

Understand that changes in commissioning take time

Commissioning is a complicated process and change takes a long time. It is therefore important to factor this into outcome measures.

‘People outside of the NHS can get frustrated because things aren’t happening quickly. It is therefore important to identify where your issue is in the commissioning cycle so that you can track its progress. A two-year project indicates that it has a beginning, a middle and an end, but it is often a lot longer term than that.’

Set success measures at the start

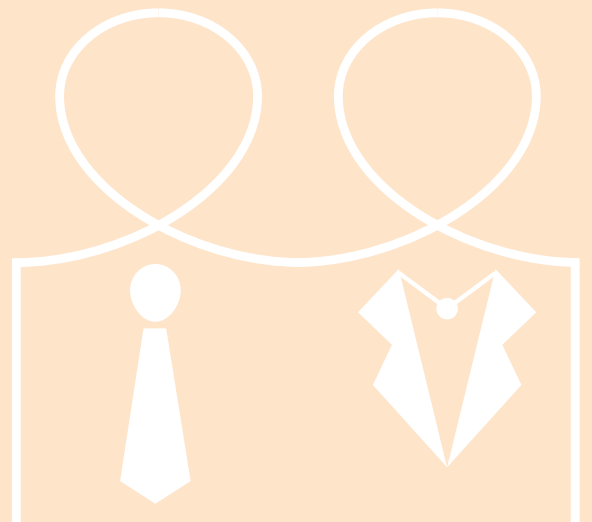
‘Make sure you know how you are going to measure success from the start. We looked at it halfway through, when it should have been there right at the beginning.’

Make sure everyone understands what collaborative working means

‘The shared leadership approach means holding each other to account and developing the skills to challenge colleagues in a positive way. It is also important to ensure that new members of the team are adequately briefed on what has gone on before otherwise it can be disruptive. Check the team’s assumptions about what the project is about and what we are aiming for, and check this regularly so that everyone is on the same page.’

PROJECT: SHEFFIELD

A cross-sector team in Sheffield has improved access to mental health services and the quality of care for African and Caribbean patients in the area, after research highlighted the community's poor experience of the service.



BACKGROUND TO THE PROJECT

Research has shown that people from BME groups, and in particular African and Caribbean communities, do not believe that mainstream mental health services can offer positive help. They therefore delay accessing these services. This is according to the National Institute for Mental Health in England, who undertook a major consultation exercise on the subject in 2003.

The Sheffield Health and Social Care NHS Foundation Trust (SHSCT) found that their data reflected this national picture. Patients from the local BME communities generally sought help from mental health services later than average, and often only when they had reached a crisis point. There were also relatively high numbers of BME patients on mental health wards in the area, and their experiences on the whole were unsatisfactory.

EPIC I ('Enhanced Pathways Into Care for Black and Ethnic Minorities') is an ongoing programme designed to enhance mental health services for the Pakistani community in Sheffield. Following the success of EPIC I, a group of organisations from the NHS and the voluntary sector came together to form a shared leadership team, with the aim of improving mental health services for the African and Caribbean community. The project, EPIC II, which ran from 2007 to 2009, had a similar approach to EPIC I, but used a shared leadership way of working to introduce initiatives to improve care for the target community.

PROJECT DETAILS

Project team:

- Sheffield Health and Social Care NHS Foundation Trust
- Sheffield African Caribbean Mental Health Association
- Yorkshire and Humber Improvement Partnership

BME target group:

The African and Caribbean community in Sheffield

Aim:

To improve access to mental health services for the target BME group, and to ensure they receive the service most appropriate to their needs

WHAT WE DID

The team at SHSCT worked with the Sheffield African Caribbean Mental Health Association (SACMHA), a voluntary organisation; staff at the Crisis Resolution and Home-based Treatment team (CRHT); and staff on the acute inpatient wards.

The objectives of the project were to ensure people accessed services that were most appropriate to their needs; to improve access and referral information on people using mental health services from African and Caribbean communities; and to address stereotyping and enhance healthcare professional competence when dealing with patients from BME groups.

A link worker, introduced via the project, had day-to-day contact with patients who were referred to the CRHT team or to the ward, and their families.

The link worker's role was to:

- advise ward teams on how care could be more culturally appropriate and what could help facilitate earlier discharge
- create links between the ward and SACMHA
- pick up new referrals for SACMHA
- support individual patients receiving inpatient care, and their families.

One of the key aims was to raise awareness of SACMHA and the services it can provide, and also raise awareness among healthcare professionals of the care pathways for BME patients with mental health problems.

The team produced two leaflets, one for patients and the public and one for healthcare staff, particularly GPs. These leaflets set out the services available and the role of SACMHA and the link workers. The team also carried out an extensive awareness raising campaign that included presentations both within the trust and outside it, and an event arranged for World Mental Health Day. To help staff and patients identify EPIC link workers, they produced t-shirts and name badges, helping to create an identity for the service.

Linked to this was the promotion within the trust of how the EPIC link workers were helping other healthcare staff to recognise the advantages of getting someone involved who has a different clinical approach.

OUR LEARNING

Use of data on BME patients

The trust has an effective data collection system and the team had access to extensive data regarding BME patients, which it was able to use to support the project.

'We looked at information that we had within the organisation about the referrals we were getting. This was information that was being collected but wasn't being used prior to the project.'

Kim Parker, Senior Nurse, Quality Improvement, SHSCT

The project began by focusing on admission rates for the target group. The data showed that African and Caribbean patients are more likely to be admitted to acute wards than to be offered alternative forms of care. However, as the project progressed, the team realised that this didn't tell the whole story, and that length of stay in hospital was more of a problem for this group of patients.

'People from the BME community were spending a longer time in hospital than other ethnic groups. We realised that the admissions to hospital were needed in most cases, but we needed to focus on getting the patients home quicker.'

There were, however, problems associated with using just the data as an outcome measure. The number of African and Caribbean patients is relatively small and so generalisations are not accurate.

There were also difficulties with establishing the baseline, particularly with whether to use the 'untrimmed' or 'trimmed' figures, ie whether patients who had been admitted over longer periods of time were included or excluded. When the data were interrogated in more detail, the project team realised that African and Caribbean patients actually made up a large proportion of the longer-term admission figures, and that previous reliance on 'trimmed' data had presented a more optimistic view of the services provided to this group of patients.

Community partnerships

The partnership between the NHS organisation and the voluntary organisation was central to the project. There were challenges with the partnership during the project, mainly relating to the differences in size of the two organisations.

'We expected too much from the community organisation. We were expecting them to do the same amount of work as us, but they are a very small organisation and we are a very large organisation.'

The team recognised that they had needed to be clearer about what each organisations' responsibilities were from the outset.

Despite this, one of the main achievements of the project is the raised profile of SACMHA. They are now recognised as being part of the care pathway for African and Caribbean patients.

IMPACT OF THE PROJECT

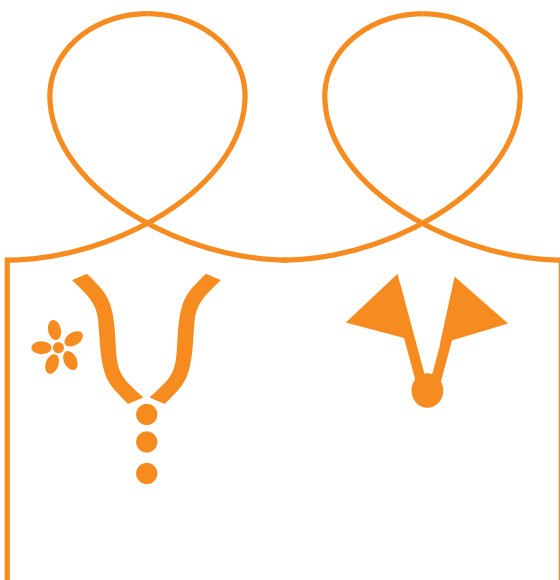
Evaluation of the project showed that after EPIC II, African and Caribbean patients were being offered more home treatment and fewer admissions to acute wards. However, the evaluation also showed that there had not been an impact on length of stay for African and Caribbean patients. The project team have nevertheless seen positive changes happening on the wards and in care for the target group.

‘The impact of projects such as this takes time, especially within large organisations. The project has had an impact on other areas of work at the trust.’

A BME engagement group has now been established, which was influenced by the project. This group has representation from different parts of the trust and focuses on improving the experiences of BME patients. This group will continue to monitor the data with regards to admissions and length of stay of specific BME groups.

‘We have just initiated a piece of work looking at people having multiple re-admissions. We looked at the data and discovered that there is a higher representation of BME patients in the multiple admissions group – the ‘revolving door’ patients. We are looking at alternative pathways of care for this group of people.’

The organisation now funds an EPIC worker to work with South Asian patients, after data showed that there was a particular issue with this group.



TIPS AND ADVICE

Make a noise about good work going on

There was a feeling at the end of the project that the team should have been more prominent in order for the principles to be really embedded into the organisations.

‘Projects have to be threaded into the organisation at a very early stage. There was exceptional work going on but no one knew about it.’

This was particularly relevant when it came to trying to engage commissioning.

‘We should have got them more involved, let them know we were there and furnished them with more information.’

Interrogate available data

The project was successful in the way that it utilised data, and the data are continuing to be analysed by the BME engagement group.

‘It is absolutely critical to have data, otherwise it is all anecdotal evidence. And it is vital to spend time interrogating that data and thinking about what it is telling you. By using the data we were able to highlight that there was a particular group of patients who needed more support.’

Get an executive on board:

It was felt that the project would have had more of an impact had a trust executive been on board.

‘Engage with the executives. Get an executive to support the initiative because you really need that high level support.’

Have an exit strategy

It is vital to have an action plan for what will happen once the project comes to an end.

‘We didn’t have a firm plan as to how we were going to make the initiative mainstream.’

Have SMART goals

SMART goals are specific, measurable, achievable, realistic and time-specific.

‘Our action plan evolved as the goals changed. Our initial goals were too wide-ranging and weren’t achievable. We needed to focus on more specific, measurable goals.’

PROJECT: WAKEFIELD

By engaging with the community and increasing the cultural awareness of healthcare professionals, Wakefield's strategic-level shared leadership team has worked with frontline staff to improve access to mental health services for BME communities in the area.



BACKGROUND TO THE PROJECT

Although there is a relatively small BME community in Wakefield (approximately 3% of the population), health and social services were aware of mental health issues in the community, specifically regarding domestic violence and substance misuse.

A Mental Health Trans-cultural Focus Group was established in Wakefield in 2003 following the Race Relations (Amendment) Act 2000, in which it was acknowledged that there is a duty to provide services that are ethnically, culturally and religiously aware.

The Trans-cultural Focus Group addresses issues regarding mental health services for BME communities, including asylum seekers and refugees. The group consists of health professionals, community development workers, community mental health teams, equality and diversity staff, psychotherapists, and voluntary and community group representatives.

To improve awareness of, and access to, mental health services for BME communities in the area, representatives from the local NHS and the council came together to form a shared leadership project team. Supported by the Trans-cultural Focus Group, the team worked directly with BME communities to uncover the barriers to access, and to put in place initiatives to improve the mental health of people from BME communities.

PROJECT DETAILS

Project team:

- NHS Wakefield District
- Wakefield Council
- Wakefield Substance Misuse Services
- The Mid Yorkshire Hospitals NHS Trust
- South West Yorkshire Partnership NHS Foundation Trust

BME target group:

BME communities in the Wakefield area

Aim:

To improve understanding of, and access to, mental health services among the target communities

WHAT WE DID

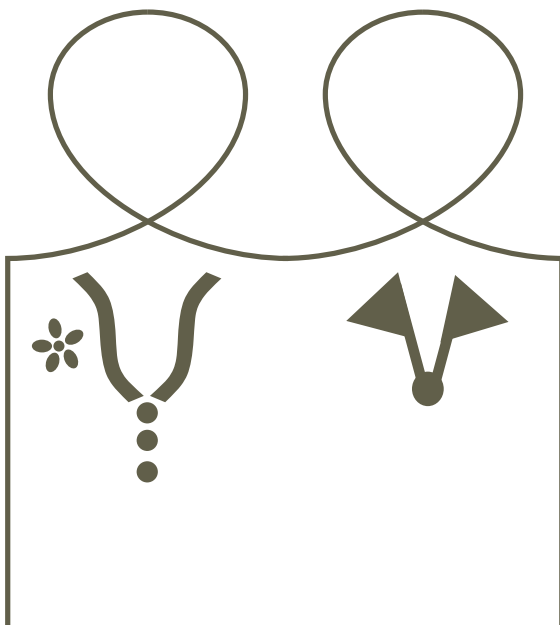
The project team, which was a mix of NHS, local council and drug service representatives, began by looking at data on referrals from GPs to specialist services, and investigated the level of awareness around what services are available to people from BME groups who have mental health issues.

The project team then oversaw the implementation of a series of initiatives, including a mental health promotion campaign directed at the target community. This involved a series of mental health awareness sessions that were held at a local mosque.

They also introduced equality and diversity workers, who were based at the mosque and the substance misuse service. They worked with the service providers and the community to help make services more accessible and to raise awareness about the services available.

The team was made up of strategic-level people from the various organisations, including commissioners. They worked with the Mental Health Trans-cultural Focus Group to implement the changes identified. The focus group members are mainly frontline staff and so were able to work with the shared leadership team on ensuring cultural and religious perspectives are included in mental health provision.

The project team also introduced cultural competency training for staff working within the mental health service, and worked with the mosque leaders to deliver training on NHS services and mental health issues.



OUR LEARNING

Community and clinical engagement

The team organised awareness-raising sessions at a local mosque in order to engage with the BME community. This is an approach that hadn't been done previously and feedback from those who took part in the sessions was very good.

'We knew that the barriers to accessing mental health services are often cultural or religious. We engaged with the religious leaders at the mosque and they were very receptive to the idea of holding the sessions there.'

Ruksana Sardar-Akram, Public Health,
NHS Wakefield District

The team also ensured they had support from clinicians, and in particular GPs. It was vital that they understood the barriers the BME communities felt, and the cultural and religious issues regarding mental health issues.

'We had a group of GPs who were our clinical champions. We also worked with GPs on raising awareness of the clinical pathway for BME patients with mental health issues. Not all GPs were aware of the pathways and we needed to work on communicating with them about this.'

Working with service providers

The Wakefield shared leadership team was made up of strategic-level people. This meant there were the people there who could make the decisions and instigate the changes needed, but they also needed frontline service providers to take the work forward. By working with the Mental Health Trans-cultural Focus Group, the team had access to a wide range of professionals working on the frontline. They worked with them to find out what their needs were and how they thought services could be more accessible.

'We asked the frontline staff what the gaps are in services and what their needs are in order to take this forward. The atmosphere was fantastic during those meetings as there were strategic, high-level people being challenged, and frontline staff really feeling listened to.'

IMPACT OF THE PROJECT

An independent evaluation of the project was carried out by the University of Leeds, and an evaluation report was published in February 2010. This looked at the effect of the project on rates of referral to primary and secondary mental health services. Results showed that the number of BME patients being seen by Wakefield mental health teams had increased by 22%.

However, the effects of the project on mental health outcomes for BME communities will be longer term and more wide-ranging.

'We are seeing the best outcomes now, compared to what we saw to begin with. And health professionals are definitely more aware of BME groups now. They were quite hidden previously; no one really knew what their issues were. That has been our biggest achievement; that we managed to mainstream it.'

The innovative approach of holding awareness sessions at the mosque has now been replicated in six other mosques in the area.

'Now that we have set the infrastructure up, and have developed relationships with the religious leaders, it is easier for other parts of the NHS to use this method of raising awareness.'

The Trans-cultural Focus Group has also benefited from the project.

'The group has more accountability now and so is having more impact. The focus of the group has been strengthened because of the project.'

The group is now looking at ways to improve access to mental health services for young people, and will look to replicate some of the ways of working from the shared leadership project.

TIPS AND ADVICE

Improve monitoring of ethnicity

The BME population of Wakefield is relatively small and lack of ethnic monitoring was a key issue.

'We had barriers in terms of not having baseline information or accurate ethnicity data. This is something we are now working on improving, by working with GP practices.'

Put the team together carefully

The project team was wide ranging in terms of the organisations involved.

'When approaching people to be part of the project, I looked at all the main organisations in Wakefield that had a remit in mental health, and ensured they were all involved.'

Focus on outcome measures

The leadership consultant helped the team to really focus on outcomes.

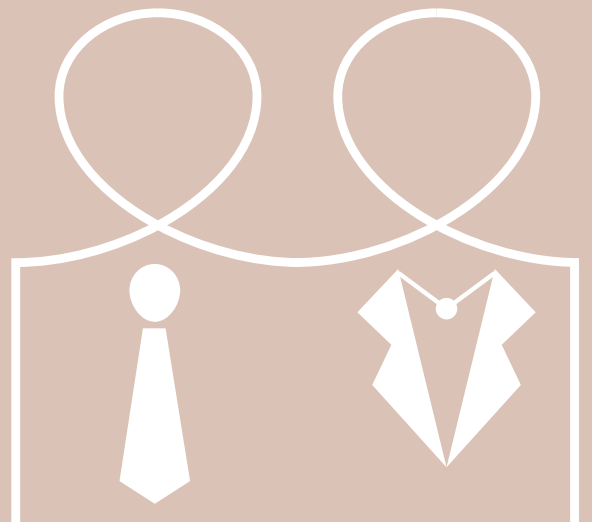
'We wanted to achieve everything, and everyone came with their own agendas. But the consultant helped us to focus on outcome measures. It was a very different way of working and it took us months to focus, but once we started recognising that it is necessary, it was quite easy.'

See frontline staff as ambassadors

'Staff need to feel part of change, and to have ownership of it and feel empowered. We really listened to their needs, as well as the needs of the community. We looked at our staff as ambassadors and encouraged them to go out into the community.'

PROJECT: WALSTALL

By radically re-designing services, engaging with the community and developing an innovative partnership approach, a multi-disciplinary team in Walsall has significantly improved maternity care for their local BME population.



BACKGROUND TO THE PROJECT

In Walsall, figures had shown that significant health inequalities existed in the area, particularly with regards to the health outcomes of newborn babies. For example, between 2001 and 2006, 15% of births in Walsall were to Muslim women, but over 25% of the total stillbirths and infant deaths were from this BME group.

Of the 3,600 babies born each year in Walsall, 32% are born to mothers from BME groups. Those working with local mothers and families were aware that certain BME groups in the area needed additional antenatal and postnatal support.

Improving maternity care requires work across organisational boundaries, so professionals from the primary care trust, the hospital and a children's centre got together to form a shared leadership team.

Running from 2007 to 2009, the project focused on improving antenatal and postnatal services for Miripuri, Indian, Gujarati and Bangladeshi families living in Palfrey in South Walsall, an area with a large BME population.

PROJECT DETAILS

Project team:

- NHS Walsall
- Walsall Hospitals NHS Trust
- Sure Start Palfrey Children's Centre

BME target group:

Miripuri, Indian, Gujarati and Bangladeshi families of child-bearing age living in Palfrey, Walsall

Aim:

To improve access to culturally competent antenatal and postnatal maternity services for the target community

WHAT WE DID

The project team was made up of representatives from NHS Walsall, maternity services, health visiting services and Sure Start Palfrey Children's Centre.

The team identified specific objectives for the project, including pregnant women booking-in with maternity services earlier, increasing rates of breastfeeding and increasing inter-pregnancy spacing.

The team then looked at how services could be re-designed to make them more accessible and effective. They introduced measures such as extending the duration of appointments at maternity clinics from 15 minutes to 30 minutes for new appointments, and from five minutes to 15 minutes for follow-up appointments. This helped mothers-to-be have the time to address all their concerns.

To encourage fathers' involvement in pregnancy, the team enhanced the existing role of the Father's Worker. To help make maternity services more accessible, the role of the maternity support workers was also better defined. These support workers are multi-lingual and their cultural awareness, as well as language skills, helps them engage with the community and provide an accessible, frontline service for pregnant women from BME groups.

The project team introduced new education classes, including postnatal classes at the children's centre, educational sessions for fathers, and classes specifically for the Bangladeshi population. However, introducing these classes alone was not enough; the team were acutely aware that they needed to get out into the community and a major part of the project was community engagement.

They also organised community consultation events, one of which was held in the local mosque. These sessions were two-way: to raise awareness of the health resources and services available, and for community members to feedback to the health service about what their concerns and barriers to access are. The main themes that came out of these sessions were education, communication and resources.

Another initiative was to improve healthcare professional training on breastfeeding so that staff could help encourage breastfeeding among the community. The team also produced culturally appropriate resources on healthy eating during pregnancy, weaning and contraception, aimed at mothers and father-to-be from BME communities.

OUR LEARNING

Community engagement

Holding the community event at the local mosque was a new way of working for the NHS organisations in the team: going out to the community rather than holding these events on NHS premises had not been done before.

‘The events were community driven, and so had to be held in the community. If you don’t have it in the community, you risk not having community representation and so risk losing focus.’

Glenda Clark, Family Support Coordinator,
Sure Start Palfrey

The team were very clear that any decisions that were made regarding the re-design of services had to be made with the input of the communities themselves. The impact of this approach was more significant than the team had initially envisaged.

‘The community consultation really opened doors for us. Everything is by word of mouth so the messages spread to people who didn’t attend the meetings. All of a sudden men started appearing at antenatal appointments with their wives, and they weren’t necessarily the same men that had attended the sessions.’

Project team member, Shared
Leadership Walsall

The team found that it wasn’t a case of the fathers-to-be not being interested, but that they felt the health services were not accessible to them.

‘It was about changing things so that men felt included and breaking down the myths. They were interested all along but didn’t feel there was an opportunity for them to be involved and to have a role.’

Project team member, Shared
Leadership Walsall

The project was successful in creating a rapport between the community and the service providers. It enabled the community to have a voice and to take ownership of where and how services are developed.

Partnership working

The project involved the public sector (the primary care trust) and the voluntary sector (Sure Start) working closely together. Although cross-sector working was not a new concept in Walsall, as there was already joint working going on, the project highlighted the impact that working together as partners using a shared leadership approach can have. The two sectors have very different ways of working and they learned from each other.

'We [at Sure Start] can be creative in the different ways we work with families. We have the freedom to explore new areas of work and new procedures. This helped us to join up the services and show that it can be done in a different way, for example by going out to the community.'

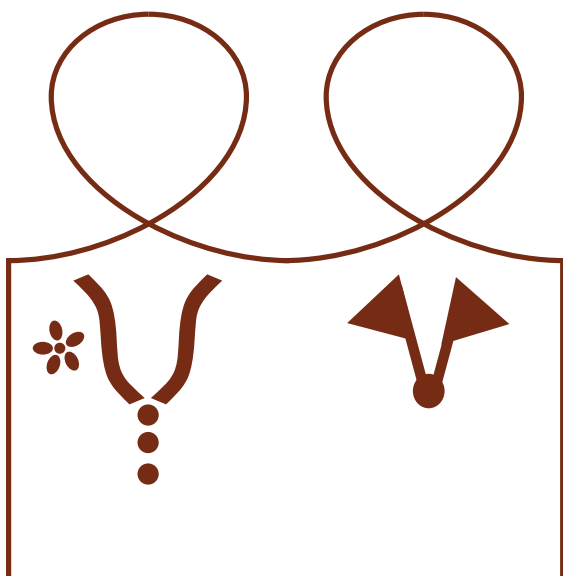
Glenda Clark, Family Support Coordinator,
Sure Start Palfrey

The team used the non-NHS element of the group to their advantage and found it was useful for Sure Start to be the 'way in' to other parts of the NHS, for example GPs.

'It can be difficult to challenge health services when you are part of the same organisation: the NHS. We used our team member from Sure Start to engage with GPs. We found this was more successful as she was seen as representing the community.'

Suni Desai, Equality and Diversity
Coordinator, NHS Walsall

Team members also took significant individual learning from the project; for some it was their first exposure to leadership skills training and they found that useful.



IMPACT OF THE PROJECT

The team achieved many of their overarching objectives: there has been an increase in the overall percentage of expectant mothers booking-in within six to eight weeks of learning they are pregnant (an improvement from 12–13 weeks); an increase in attendance at postnatal clinics; and an increase in breastfeeding rates.

The impact of the shared leadership project is still being felt in many areas of the health service in Walsall. A new genetic screening service in the area has been influenced by the project, and it took on board some of the lessons learned about language used when communicating to BME communities. The service has been designed to take into account community needs and barriers.

‘This model can be lifted and taken to other areas, as it is not just about the project outcomes, but about the processes used to get there.’

Suni Desai, Equality and Diversity Coordinator, NHS Walsall

A better relationship has been formed between the GPs and the midwives since the start of the project, and the role of the midwife is felt to be more valued now. The postnatal classes that were introduced in Palfrey are now being rolled out borough-wide, and other Sure Start centres are looking to get involved in similar partnerships with maternity services in their areas.

The idea of going out into the community has subsequently been replicated and other areas of healthcare have now held events in local mosques.

SURE START SUCCESS

Sure Start Palfrey Children’s Centre had an Ofsted inspection in July 2010. The centre was assessed on their contribution to facilitating access to early childhood services, maximising the benefit of those services, and improving the wellbeing of young children.

‘We had to demonstrate evidence of the work that we are doing and that it is having an impact and is sustainable.’

Glenda Clark, Family Support Coordinator, Sure Start Palfrey

The involvement in the shared leadership project is one example of where the centre has excelled in working with the community and with partner organisations to improve outcomes for children.

The centre was the only children’s centre in the UK to achieve ‘outstanding’ in every category.

TIPS AND ADVICE

Engage with GPs by finding the right way in

‘A woman’s first port of call is her GP so it was vital to consult with the GPs. It was also important to realise that all GPs are different with their own ways of working.’

Sure Start already had good relationships with the GPs in the area, so it was important that the team used these existing links.

Have the right people on board

The project team was made up of members who had strong cultural awareness of the health needs of the target community. Having a wide range of people was important as each member brought a different perspective to the issues.

‘We worked well together because we recognised that each of us has different skills. Everyone may have different agendas but we are all trying to reach the same outcome, so needed to work together.’

Exploit the fact that it is an external programme

The fact it was not NHS funded and had three different organisations working together helped when it came to engaging people and organisations with the project.

Start small

It is important to identify clearly defined and measurable outcomes at the outset, so that value can be demonstrated.

‘We learned that we needed to be more focused on what is achievable. Achieving small goals is an achievement itself. Celebrate small things.’

Get to know your community and listen to them

Take time to build relationships with the community and build trust.

‘It is about understanding how communities work, and knowing the way in. Trust in the people who know the community.’

The team engaged with the Imam at the local mosque, which proved to be an effective way in.

‘It was important that he was involved in the project. He spoke in a very personal way. No one else could have done that.’

LEARNING FROM ALL PROJECTS

The teams focused on a variety of healthcare issues and target groups, but some learning has been common to all.

The lessons learned are essential to any team or organisation either planning or implementing similar work to reduce health inequalities for people from black and minority ethnic communities.

WHAT WE LEARNED

Work with the community and frontline staff

Improving care for specific communities requires work with the community and with those who deliver the care to break down barriers and improve access. The team in Blackburn with Darwen, for example, found that by talking to both community members and service providers they were able to help make both sides more aware of each other's concerns and assumptions. In Wakefield, the team positioned frontline staff as 'ambassadors' and ensured they worked alongside them when developing changes to services.

Be innovative about how to access your target community

Getting out into the community was key to all of the projects, and the teams all agreed that sitting back and waiting for the community to come to you is not going to work. Innovative methods were used to access seldom heard communities. For example, two sites used the local mosque as a way of engaging with their BME community. It is important to think about where the target community will be and therefore how you can access them. For example, the Blackburn with Darwen team engaged with a children's centre and schools as their target group was women who were likely to have young children.

Take the long-term view

Each site fed back that the impact of their project would be felt more in the long term than in the life of the project, as the changes introduced take time to mainstream. Both Kensington, Chelsea and Westminster, and Oldham, were aware that their recommended changes to commissioning would take time to be agreed and implemented. And they pointed out the importance of this long-term outcome measure being included in the planning and reiterated with the team so that morale is not damaged by an apparent lack of impact in the short term.

Get personal

Those sites that were successful in engaging with difficult-to-reach groups, such as GPs and commissioners, took a targeted, individual approach, rather than a 'one size fits all'. The Oldham team spent time investigating what was the best way to engage with each individual GP practice, including ascertaining what the preferred method of communication was. It is also important to be armed with effective information when targeting groups such as these. For example, the team in Sheffield discovered the importance of using referral data when engaging clinicians and commissioners.

Take advantage of the multi-disciplinary make-up of the team

Each of the teams learned from working with organisations from different sectors, for example the voluntary or community sector. They found it important to be open-minded about utilising the different perspective this can bring to the project. For example, in Walsall, the children's centre provided the NHS part of the team with ideas as to how to be creative in working with the community, and they found that the non-NHS element worked to their advantage when engaging with clinicians. At Kensington, Chelsea and Westminster, they found it was worth taking the risk of working with smaller, less developed community organisations, as their access to seldom heard communities was invaluable to the project's success at improving care for those communities.

WHAT NEXT?



For the Health Foundation, leadership is integral to improving the quality and safety of care. We have designed and commissioned various leadership development programmes, including Shared Leadership for Change.

Other programmes include:

Our pioneering leadership development programme, **Generation Q**, is designed to develop a new generation of skilled and effective leaders for quality improvement in healthcare, and has been validated as a postgraduate academic qualification.

www.health.org.uk/generationq

The **Quality Improvement Fellowships** programme provides the opportunity for clinically qualified senior NHS professionals to become equipped with the tools and techniques of quality improvement by spending a year at the Institute for Healthcare Improvement in the US.

www.health.org.uk/qif

For more information about how to get involved in our leadership schemes, or other programmes of work on improving the quality of healthcare, visit www.health.org.uk or email us at info@health.org.uk

WHAT I LEARNED: REFLECTIONS FROM A PROJECT TEAM MEMBER

Lynne Barlow, Senior clinician and professional advisor for nursing, NHS Oldham, and member of the Oldham Shared Leadership for Change (BME) project team, reflects on her experience of a Shared Leadership for Change project.

It has been nearly 12 months since the shared leadership work formally ended and I am now, more than ever, able to see and feel the impact the project has had on me personally, my leadership skills and, ultimately, the care provided to the patients within my clinical community.

As a nurse, caring for patients has always been my passion and in my junior days I believed this meant simply doing my very best from the start of my shift to the end of my shift.

My involvement with the Shared Leadership for Change project has challenged me to build on my daily patient contact and consider how I can turn these contacts into real changes in how care is delivered and commissioned on a much wider level. My nursing career has taken me on a journey over the past 18 years and I now recognise that doing my very best for my individual patients and the wider community goes far beyond the start and finish of my shift.

There have been many influences during my nursing career that have led to my realisation that I, along with other clinicians, have the opportunity to shape the direction of travel and influence the quality of care delivered to all patients and communities. However, my learning and development has been expedited over the past two years through my involvement with the project and my exposure to the skills, teachings, feedback and challenges the leadership development work provided.

How the project has impacted on my daily work

The value of the learning log and broad scanning

I have always kept a log of meetings and actions required from discussions and meetings I have attended. Up until being involved in the shared leadership project, I had a few different notebooks depending on which meeting I was attending and this seemed to work well, or so I thought. It became apparent soon after joining the project that I needed to make changes to my approach to note taking. I became aware of the potential impact I could have by triangulating information, knowledge and learning from one environment and meeting to another.

Simple as it seems, this small change has resulted in my ability to influence change.

I developed a system of having one notebook for all meetings and discussions. I also used my notebook to briefly log anonymous key patient feedback and experiences. I was able to trial this new approach within the project group and see the impact that sharing real patient stories had, along with the linking up of different parts of the organisation with a view of making sense of issues and providing context.

An example of this was during a recent home visit where I discovered multiple amounts of half-used boxes of medicines in a patient's house. My colleagues and I had been aware of compliance issues in the past with this patient and believed we had helped solve this problem. Her condition, however, was not improving despite the high doses of prescribed medication. It was this that led me to visit her at home in order to find out whether there were issues I had not considered. The leadership coach for the project would refer to this approach as 'drive for improvement'.

The home visit highlighted that the system was not working for this patient and so further changes were made. Not that long ago, I may have thought I had done a good job here and made a difference. However, I recognised there was potential to turn this one patient's experience into learning for the organisation and wider health economy. I made brief anonymised notes about this case study in my notebook. I then discussed this case study in a clinical executive meeting and with the pharmacy leads of the PCT, with a view to addressing the waste and spend on medicines and improving systems to increase compliance. Prior to my involvement with the project, I would not have understood the importance of broad scanning. In addition, I would almost certainly have missed the opportunity to share this powerful case study with senior management, who are in a position to make positive changes on a large scale.

Sharing my learning

The leadership development consultant for the project often carried small, brightly coloured laminated cards that were shared and used as discussion topics. The cards were a combination of inspirational quotes and theories such as Kolb's reflective cycle.

One of the changes I have made as a direct result of this exposure is to replicate this approach within clinical team meetings and discussions. I too now have small laminated cards that I use to prompt myself and others to return to the leadership theory that supports the behaviours and changes proposed.

I am open in highlighting within groups that I hold myself to account and am proactive in building into discussions how we can hold each other to account also. The approach of using these cards with other people has proven to be a useful, non-threatening way of empowering others to influence leadership.

The value of mentorship coaching

Of course I have attempted to use some skills which have not worked so effectively. I was inspired by the group discussions around an assertive communication model. This theory was new to me and I was inspired to read more on the topic. I then chose to practice my new skill with a difficult situation I was involved in at the time. I considered all the theory and chose my approach very carefully. The result, however, did not lead to the desired outcome and did not fit into the nicely packaged theory I had been reading the previous evening.

What did result from this experience was that I was able to further recognise the importance of having access to a leadership development coach at that time. I was able to reflect on what went well, what did not go so well and what I would do next time to be even more effective.

I now have formal mentorship which provides similar support and challenge to working with the leadership development consultant, and this mentorship has allowed me to build upon my self-belief, self-awareness and self-management. In addition, I am open and transparent about accessing mentorship and the benefits it brings, which in turn has influenced the culture within the organisation to seek such support.

I agreed to participate in the Shared Leadership project as I recognised I was unlikely to have this opportunity again in my career. The impact the project has had on me as an individual has been significant and wide-ranging.

The Health Foundation is an independent charity working to continuously improve the quality of healthcare in the UK.

We want the UK to have a healthcare system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable. We believe that in order to achieve this, health services need to continually improve the way they work.

We are here to inspire and create the space for people, teams, organisations and systems to make lasting improvements to health services.

Working at every level of the healthcare system, we aim to develop the technical skills, leadership, capacity, knowledge, and the will for change, that are essential for real and lasting improvement.

The Health Foundation
90 Long Acre
London WC2E 9RA
T 020 7257 8000
F 020 7257 8001
E info@health.org.uk

Registered charity number: 286967
Registered company number: 1714937

www.health.org.uk

Follow us on Twitter: www.twitter.com/HealthFdn

© 2011 The Health Foundation