The Improver Podcast | Episode 4 | Recognising your sphere of influence

Intro (00:00)
Welcome to The Improver, the podcast that explores ideas in healthcare improvements and participatory change, hosted by Dr. Na'eem Ahmed and Lara Mott.

Lara Mott (00:15)
Hello, and welcome to Episode Four of "The Improver". I'm Lara, CEO and co-founder of ImproveWell.

Na'eem Ahmed (00:22)
I'm Na'eem, Clinical Lead and co-founder of ImproveWell.

Lara Mott (00:25)
We are delighted to welcome Dr Dominique Allwood to the show. Dominique is Deputy Director of Strategy and Improvement at Imperial College Healthcare and she is Assistant Director of Improvement at the Health Foundation. She was recently seconded to the NHS Nightingale Hospital, London where she was Medical Director for Nightingale Two. Dominique was also named one of HSJ's Rising Stars in 2015. She is a Darzi Fellow and is also a Prepare to Lead Alumni. So, Dom, welcome and thank you for joining us.

Dominique Allwood (01:00)
Thanks for having me. It's really exciting to be here.

Lara Mott (01:03)
I wanted to start by saying I don't know out of you and Na'eem who wears more hats at this stage, but you certainly wear a few and you've had a really interesting career journey to date. So, it would be great to start by hearing a little bit about what has brought you here today and all of the hats that you have worn and continue to wear.

Dominique Allwood (01:25)
Yeah sure, I like to chat a little bit about my juggling multiple plates. But I think hats is just as relevant a metaphor. So, I have a bit of a portfolio career. I am not a typical medic or a typical manager or a typical healthcare leader, I guess. So, my background is in medicine and I trained in public health but I've had roles including management consultancy and healthcare leadership and clinical management and have worked in a range of organisations including hospitals and commissioning organisations, think tanks, academic organisations, policy. So I have managed to gather, I think, quite a rich experience of working in healthcare and understanding healthcare from different perspectives and thinking about how best to deliver healthcare. So I'm really passionate about doing that across boundaries and spanning different ways of working and thinking. So, I think that that is mirrored in my style in which I've got these multiple roles of, on the one hand working very much in practice in NHS organisation part of my week, and then on the other hand contributing to national policy, thought leadership and getting through that pipeline that spans policy to practice is really exciting.

(02:42)
It has all got a common thread and a bit of a lens that relates to population health and improvement and patient and staff engagement. But I am really keen that we as doctors, particularly clinical leaders, find lots of different ways in which we can do our roles. And if that means doing them across organisations, across teams, and with different lenses, I think that provides this richer way of working in many ways.

Na'eem Ahmed (03:09)
That kind of clinical and bringing the clinical insight to leadership - have you found this whole thing about moving to the 'dark side', I mean you hear it less and less now, but what are the types of barriers that you've you faced and how have you overcome them?

Dominique Allwood (03:24)
Yeah, I did get given that label a couple of times, early on in my career. So, I guess the first one was choosing to go into public health, which is a very hands-off specialty - it's not clinical. So people were occasionally sort of questioning me on my choices about 'well you trained as a doctor, why don't you want to see patients anymore'. But I think my experience of working in the NHS has definitely been, over the last 10 or 15 years, that managers and clinicians have really worked well together in many roles that I've had. So, it hasn't been as recent I'm hoping for sort of saying going over the 'dark side'. I also think there's more understanding now that doctors in particular want to get experience in management, leadership, quality improvement, policy, safety, or entrepreneurship - wider roles outside of clinical medicine. So, I think that the 'dark side' phrase is less used now. And I'm glad about that, because it kind of polarises things and makes you think you have to choose either or, and I don't think that should be the case.

(04:24)
Health care management is a particular profession in itself. People train often through training schemes, graduate management training schemes and other things. And I think it is often underestimated as a set of skills and an approach. So, some of the managers early on that I worked with, were a little bit sceptical about potentially what I could add as a clinician and I think they were right to be and I learnt a lot about working with them. And they have learnt to trust me and think about what I could bring as a clinician into today's managerial post. But I think when you're coming in new to a profession, where people have already worked for a long time - built up expertise - it's natural that they're going to think, 'well, who are you and what have you got to offer'. But I've overwhelmingly been very fortunate to work with very, very good managers and clinicians alike and have had some really strong relationships across both of those professions.

Na'eem Ahmed (05:09)
I think for me, particularly Dominique, because you have led the way in terms of this clinician leadership hybrid, and we have looked at you and we have looked at a few others such as Emma Stanton and Claire Lemer. There is a whole group of you that have really set the pace and inspired a lot of us to tread this path. Do you think that it is something that you would recommend to others?

(05:37)
Obviously, for me as an ethnic minority, British Bangladeshi, I have faced some challenges, but for you as a female leader - and this is what we were talking to Lara about - there are some unique kind of challenges that you faced. Is there anything that you could share with others that are considering it, but also some of these challenges that you faced and how you've navigated them?

Dominique Allwood (06:01)
Well, I guess the first thing to say is, I'm really flattered to be held up with some absolutely amazing role models, people like Claire Lemer and Emma and others really did forge the way of managing to balance developing clinical careers with going into leadership. And, in fact, they set up a lot of the schemes that have evolved into what many people now recognise as the Faculty of Medical Leadership and Management Training Scheme, they were CMO Fellows before that, and Prepare to Lead, and other schemes that developed doctors and gave people opportunities to go and formalise their leadership and management experience in a way that I don't think was possible a number of years ago. So, very flattering to be held up in that bucket and I absolutely looked to them when I was pursuing a career in this space.

(06:50)
I guess to me, one of the things was having that formal training and education in leadership and understanding what it means to be a leader and that very important question of, what's it like to be on the receiving end of me? And it's a question I asked myself often and ask of others to give me feedback. That was very formative for me through my training. And I think those things have really stood with me around leadership, but also understanding how you can support colleagues and others to have the same opportunity. So, I supervise fellows from the Faculty of Medical Leadership Scheme, public health trainees, and I do mentoring and coaching because I was afforded a lot of opportunities from having some really great mentors, coaches, supervisors, and role models. I think it's really important in our careers, to be able to do that, pass it on - medicine is built on that kind of apprenticeship model. And being able to support people in positions in the earlier development of their career is really important. So, I have been fortunate to have that support, and then be able to do the same for others, which is great.

(07:53)
I guess in terms of being a woman from a BAME background and being female, if I'm really honest, it wasn't something I particularly considered early in my career. I just assumed people were treated equally, I was very naive about the way in which people got jobs, got placements, got picked for things. I didn't really understand that anything happened other than this was just a process that went on in a very fair and transparent way. But as I've gone through understanding more about the world, and how things work - not just in hospital and medical roles but more widely - it's become obvious that people do have disadvantage and not everyone's afforded the same opportunities, and people are treated differently. I guess actually, I noticed it more as I got more senior in my career. And particularly, as I'm a woman that looks a little bit younger, which is fortunate I guess for me, but I have been mistaken for being an administrative assistant in rooms where I'm actually there to chair meetings or expert advisory groups - just because I'm a woman and I look younger. So I think that's very unfortunate and I have called it out in a way that is trying to be kind and considerate to people who potentially have those biases. I think it is really important that people do understand that these things aren't always fair or equal.

(09:14)
I've been really lucky that I've had some opportunities that have been specifically designed to help forge careers for people who are in positions like people who are women or BAME, who are often underrepresented at senior leadership positions. So, it is definitely something that I've become much more attuned to and hope that I've become a little bit more vocal on and support colleagues on, because I have to say I was very naive in the past about that not being at play. It is something that's very important and I definitely want to make sure that we have that at the forefront of our minds in work, and with the lens of COVID now, equality and equity is so important in terms of everything we do in terms of our patients and our staff.

Lara Mott (09:59)
Dom, what you said resonates with me personally, so much. I started my career in finance, which was a very male-dominated environment. I often got asked to make the tea in every meeting until one day, I just didn't do it. I also remember at one point in my career where they were doing a re-org and my job title came into question. I had quite a senior job title at the time and I was asked, 'well, actually, could you be an assistant instead'. Whilst that is a fantastic role, that was not my role. So, I really had to fight hard to sort of keep my title in that particular job. So, I share your passion in wanting to empower women to fulfil their potential in the workplace. I've personally worked with excellent female role models, and some not so excellent. And I think from what you say, improvements are being made - there are increasingly more women in non-exec and exec roles in the NHS. But is there anything more that organisations can do to show their support for encouraging women to progress into more senior roles across health and care?

Dominique Allwood (11:05)
So, I'm a member of a few women's networks that are running within my organisation that have been particularly vocal and active recently with the sad events of Sarah Everard. And also, I'm a member of the National Women's Network. And we had a really great event for International Women's Day recently, where we had lots of speakers talking at sessions where we were bringing an angle in of gender that really made people think, and actually start to understand that gender has an interplay in a lot of spaces and places that you wouldn't ordinarily think. I think it is about making these issues visible, it is about people having an opportunity to have a safe space to talk about them. It is about having peers who have similar experiences and bringing collective power to people to feel empowered, Lara I like the word that you used there. It is about empowerment, and it is about advocacy. And it's about changing the narrative. So, I found having opportunities to speak about issues and having some close solidarity with other women, and networks, and connections to see what people are doing in practice to really make a difference, has been really helpful to me.

Na'eem Ahmed (12:23)
The other big part, when we talk about inequality was the leadership, Dom, that you have provided, in terms of if we just set the context with COVID, and particularly the impact that COVID has had and the disproportionate impact unfortunately on communities, which you, Dom, have known about and written about and I have heard you speak about - the inequalities in society and how that impacts everything that we do and people's life chances etc. You speak about anchor institutions and we are hearing more and more about anchor institutions. I just wondered, given what we have been through and where we are going through with COVID, if you could just talk to us about anchor institutions and why you think they are so important.

Dominique Allwood (13:14)
Yeah, of course, and it is a pet subject and hobbyhorse - you've unleashed me now, so you'll have to rein me if I start getting too passionate! (laughter) Thank you, it's kind of you to say that it's been something I've been championing.

(13:27)
Part of the reason I was really passionate about going into public health as a specialty was this focus on equity and inequalities. It has been something that has driven my work and thinking for a long time and particularly that kind of connection with understanding what drives those gaps in health outcomes and access to health care etc. And understanding that people's context and what we call the social determinants of health - where people live, their education, their employment, their income, etc - are things that all impact on their lives and have contributions to make towards equity and equality. So those links have been very well known. And many people have spoken about them, including heroes of mine, like Professor Marmot and others.

(14:12)
I guess what has been really interesting for me to see is that those things often feel quite far removed from clinicians in their day-to-day practice. When they've seen sick patients in a clinic, they recognise those contexts going on for people but they don't always know what they can do to help influence them.

(14:28)
So, we talk a lot about the difference between biology and biography. So, the clinicians tend to focus on the biology of the patient and their illness and disease. And they take a social history about who do you live with, do you smoke, what's your job. But they don't fully understand the sort of biographic nature of people's lives and even if they did, they're looking more into the context of that person's illness and disease and potentially thinking, what can I do about this person who's got asthma and who's going back to a damp home every evening where that will just make those things worse.

(14:59)
I think what I found really interesting about the anchor institution notion is that this is a way in which organisations and individuals working in those organisations can really think about what role they play in improving people's health through the lens of social determinants of health and tackling inequality.

(15:17)
So, anchor institutions are institutions that are usually public sector bodies but not always - they have tended to be in the community for a long time. And by their very nature, they are often the very biggest employer of people locally, or they have a huge amount of assets in terms of their physical buildings, or they have huge purchasing and procurement power, and so by their nature they are anchored in that community. And this is about how do you leverage that type of activity to have more of a positive impact on the local community and people's lives, through who you might employ, how you might use the built environment and the physical space, what you do through your environmental activity, the organisations that you choose to partner with and how you work with your local community. I think that has been really powerful for many organisations to think, actually if we change or adapt the way in which we're employing people or target particular groups in the community, we can actually influence their health in a much greater way probably than we'll ever manage to by patching people up through our A&E etc.

(16:19)
There are individuals who work in those organisations who can do the very same thing through the lens of sustainability, or thinking in terms of when they're about to put out a contract for a good or service - what's the social value here. So people in their everyday roles can think about their responsibility to the social determinants of health and inequalities. But it shouldn't become a tick box exercise, people shouldn't just think, 'Oh well, if I do this employment scheme, or go and give these opportunities to medical students locally, then I've automatically ticked the box'. The consultant who gets the school that they used to go to and their friends and family in for work experience is not necessarily going to make a huge impact on tackling inequalities. But if we are purposeful about tackling the schools in which people who rarely go to university don't think of medicine or the health system as a career for them, have people whose English is not their first language, or people who have disabilities, or issues they might need to overcome that would prevent them often getting jobs and employment or training, that will be the way in which we really tackle inequality.

(17:24)
So, it is about understanding the issue, purposefully going and tackling a gap that you see, and then thinking about how you are going to try and close it, rather than just thinking these interventions will automatically impact on inequalities. And I think there is a really strong lesson in that for improvement for population health, or whatever you're doing you have to be purposeful and intentional about what you're doing. Otherwise, there is just this element of magical thinking, 'Oh, if we're an anchor, or we do an improvement project over there, it will automatically lead to these changes.' Unless we are being purposeful about inequalities, a bit like the conversation we just had before about women and ethnicity, you have got to be really purposeful and intentional about what you are targeting to actually narrow that gap and make a difference.

Na'eem Ahmed (18:09)
Are you optimistic? Because you have mentioned Marmot and we saw Marmot's 10 year report. I think there is a lot of pessimism about whether we can kind of make a dent on inequality. Where do you stand on it? Because this is a societal problem, right? Who's responsible? We can say everyone is responsible but by saying that then we know the reality is that no one's responsible. What's your sense of optimism around us making a dent on inequalities?

Dominique Allwood (18:37)
So, I guess maybe I am different to some of my colleagues. My public health colleagues who have a very good understanding of how we might influence inequalities might take a much more systemic view and think it's very complicated with politics at play, social factors, policy, all sorts of things that need to influence to really make a difference.

(19:02)
But I have grown up and trained very much in healthcare, and I'm very active-minded in terms of wanting to make things happen and think about what's in the sphere of my controlling influence. I work with clinicians on the ground and healthcare organisations and I feel really optimistic that people can play roles and make a difference even within that context of knowing that there are political and policy decisions that will ultimately influence a lot of that. I think COVID has brought a real watershed moment, we haven't had a time where we've talked about inequalities or seeing the stark reality that these inequalities have thrown up, more so than during COVID. So, I think we have got a real opportunity to galvanise on people's appetite, interest, desire and urgency to do this stuff differently and better and I think anchor institutions offer a potential way of being able to do that used in the right way.

(19:58)
So how do we work and co-produce with communities? What are the best types of interventions? And work with staff to do that. We have seen that people have really come together during COVID, particularly in communities, and how staff have looked after each other in ways that we wouldn't have expected. So, what have been the assets that people have drawn on? And how can we as organisations, and people, build on that to really help shape a future that we want to be a part of?

(20:24)
You are absolutely right, Marmot 10 years on is saying many stark things, as are people talking about climate, the climate emergency and other things. But if we don't think in a way that we can achieve stuff, I think we will end up getting paralysed with it or feeling too big and too complex and someone else's problem. So, I am all for what's within your sphere of influence - what can you change right now, here, today? And what can you do to influence that? So that might make me sound like a bit of a crusader. But I hope that makes people feel like they have a role to play and can do something personally because that is what I think it is about. What can we all do? And every little piece will add up.

Lara Mott (21:04)
Yeah, it is an inspiring way to look at it, for sure.

Na'eem Ahmed (21:09)
We hear about people saying, 'it's not a national sickness service, we need a National Health Service, we need people to start thinking about population health and those important concepts that you have discussed'. So, what do you think is really next for our health service? And the way that we're thinking about health, what do you think are the next three big challenges, I guess, or the three big opportunities? So we mentioned to anchor institutions as one, what's in the top of your mind as being some risks and opportunities you think within the health service?

Dominique Allwood (21:42)
So, I think during COVID it was really interesting. It was one of the first times that I saw healthcare be able to adapt and respond to the context in which it faced. So generally, we understand healthcare to be supply-driven - by that, I mean we have a certain number of resources and we expect the 'demand', which is the patients and their needs, to fit in with what we can offer. But when we look at COVID, we saw ICU beds surging and we saw mutual aid happening across London where people were moving resources around to respond to the needs of the population. I think that that really shone a light onto the health service to think we can be more responsive to the context in which we face, and there is some learning about how do we better understand the needs of our communities, the public, before they even become patients, and then once they are patients, their needs and what demands they make on healthcare? And then how do we be more agile in the way that we supply that healthcare? That might be the way in which it is delivered virtually through technology, or the way in which we might be able to flex roles and people and spaces in order to live our healthcare in a different way. I think I am really optimistic about that. So becoming much more of a need-led healthcare system would be great. I think starting with the population is really important. How do we understand what their health needs are and their context? What does that mean then for their health and disease progress in future? And where are they best place to get that care and support?

(23:18)
The second thing I would predictably say, which is what you would hear many people say, is that integration is going to be really important. We are seeing them move much more towards that, particularly in England. But that has been the case in the devolved nations for a longer time, where health and social care are coming together and different types of health care across a defined population to say, what do people need? And how are we going to deliver best on their needs.

(23:45)
A final thing for me is this intersection of methods and thinking and approaches. So, I think change is really important. We have learnt a lot through improvement using a healthcare lens around safety, patient experience and staff experience. And I think we've got a lot to think about how we bring some of those quality improvement methods now out to thinking about improving health and the social determinants of health and tackling inequalities.

Na'eem Ahmed (24:10)
One of the key components of that which you have demonstrated in the Nightingale is the use of technology. And where do you see that as part of that package in terms of its need and use?

Dominique Allwood (24:22)
So, I think technology is really important but it has to be attenuated with understanding what the benefits are of human interaction. Technology is not just used in isolation, it needs to be integrated into social systems about how we understand how technology is used in its multiple different formats, and how we interpret the things that it is telling us and what we do as a result of that. And that is a classic sort of learning system. The two main things of the learning system really are kind of noticing and responding - and tech can really enable that. So, things like apps can help you gather and collect data either actively or passively. Technology can be used for data analysis and it can be used for all sorts of things. So, I am optimistic about the use of technology. But I am cautious and anxious when I see people trying to hold it up as a bit of a panacea, because actually healthcare and the system we work is a social thing. And care is about caring and we can't replace that. But what we are thinking about is how do we use technology to help enable that and make things easier for staff, patients, communities, carers, etc.

Na'eem Ahmed (25:27)
You have spoken about the community. What about the workforce in terms of improvements and challenges and opportunities for the workforce, do you have any thoughts on that?

Dominique Allwood (25:39)
Yeah, we have seen the workforce be such an important and integral part of the COVID response. And there's been huge amounts of public support for key workers, which is absolutely right. But we have to recognise the tone in which COVID has played on many people - the psychological impacts will be felt for a long time, especially by the staff that were on those wards with that volume of people who were very sick, dying and unwell. And we need to think carefully about how we are going to support our best resource going forwards. Often staff have not felt invested in and have felt that they are doing a very difficult job. So, things that are symbolic of how you care and provide a culture of compassion and be a good employer. Things like the staff canteen or rest spaces and things, have been eroded, often for good reason - as space is short, people are starting to move into shift patterns and resources aren't always there to do that. But I think what COVID has really shown is that we absolutely need to prioritise staff welfare, physical, mental, etc. So, that is one thing that I think is really important.

(26:50)
But I guess it's important to not think of staff as a homogenous group - there's 360 odd careers in the NHS. So, those people have very different needs from a careers perspective, but also from a personal perspective - people's lives outside of work, their set up, the things that drive them and motivate them are exactly the same as our patients. Staff are our biggest community. We need to think very much about their needs and be responsive to them. So, there have been many staff who have quite rightly had a lot of attention on them - staff and clinical staff working in the ICU etc. But there have been cleaners and porters who earn small wages for the work that they do, who have been on a very sharp trajectory through COVID bearing the brunt of that work, and also doing it on a very low income and very challenging circumstances about their employment. So, understanding what someone like that needs on a contract is very different to understanding what somebody in a clinical role might need.

(27:49)
So, I think that piece about who is your community; who is your population; what are you trying to do with them and co-produce solutions that really work for them; and that lens of inequalities comes back again and understanding some of those people who are often invisible - their voice is not heard. It is interesting stuff – a survey came out recently from the NHS – but we have very little ability to be able to drill down to understand the experience of people in different parts of the health system and the roles in which they provide. So, looking forward, I think we need to get better at gathering insight and nuance.

(28:23)
We have talked a lot in the past about learning how systems are being able to gather stuff and insights about improvement. But that is not just about improving patient care, that’s in fact about improving their own working environment. And tools like ImproveWell are so integral and important to be able to do that to empower people to say, what it is that isn't working for them and what could be better. So, I think when we're thinking about improvement, it's about our staff as well as our patients and people are very much moving in that direction now - but we've got a long way to go still.

Na’eem Ahmed (28:55)
Certainly as someone still working clinically, what you have said really resonates. And you're right. It's really those staff members that haven't had much of a voice but like you said, are not just impacted because of the jobs they have, but likely, as we've seen due to COVID, their communities have been affected, their living areas have been affected, and we need to take some action quite quickly on them.

(29:25)
Dominique, it has been brilliant to chat. The amount of information that you have given us has been amazing. How we can distil your fantastic career in this short space of time, and we probably need to do a whole series just dedicated to you.

(29:44)
We have a part of our podcast where we talk about a Small but Mighty idea - I don't know Lara, if you have that - something that we think is a small action, could make a massive difference.

Lara Mott (30:02)
From the perspective of a patient interacting with frontline staff wearing personal protective equipment, or PPE, it is a very different experience to what we are used to. It can feel daunting, it makes it harder to establish that human connection with those who are caring for you, particularly if you can't see their facial expression, for example. So, we have seen lots of simple ideas where staff have pinned a photo of themselves smiling to their uniform, or people have used masks with a clear mouthpiece, which has also helped patients with hearing impediments, or they have used things like digital flashcards to assist with communication. So, we would like to highlight these Small but Mighty ideas that are all aimed to ease stress and anxiety for people at an already difficult time.

Dominique Allwood (30:48)
Thank you both. Well, what an important Small but Mighty problem to think about. I guess it is a really nice thread that has pulled together lots of things that we have been talking about - thinking about people who have different needs and being very cognizant of those. And I think understanding staff and patients with disabilities that impact the way in which they are able to undertake their roles is so important to be able to support them. I think that suggestion is really important and it is very pertinent at resonating with me across my roles. So I think, thinking about the different ways in which the PPE can work to help support people to be able to interact in ways that are meaningful, and help include everyone is really important. And I think not just through PPE, but you know, people who have been living in social isolation, who have had to distance from people - in terms of physical distancing - all of those things have been really excluding for people. So, it is a really important thing to be highlighted.

Lara Mott (31:51)
That’s a perfect way for us to wrap up! Dom, thank you so much! We will be watching your career developments with interest and hope to speak to you again in season two of The Improver, to see how many more hats you have added to the collection!

Dominique Allwood (32:07)
Delighted to come back anytime and thanks to you guys for being such good partners in the work that we have been doing to try and improve things for patients and stuff, particularly through COVID. It has been amazing to work with you all.

Na’eem Ahmed (32:19)
Thank you.

Lara Mott (32:21)
Thanks Dom, it has been an absolute pleasure!

Ending
The Improver is a production of ImproveWell Ltd. Thank you to today's guest Dr Dominique Allwood. To find out more about the ImproveWell solution, visit improvewell.com. Subscribe to The Improver at Apple Podcasts, Spotify or wherever you are listening.