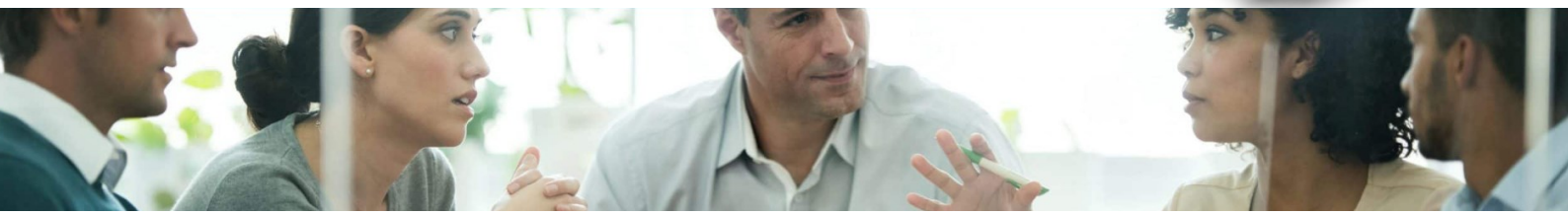
Insight

December 2021



Another extraordinary year

As 2021 draws to a close it has been another year that will be remembered. We can hope it will be remembered for the good points and the achievements. There has been no bigger achievement than the successful COVID-19 vaccination programme which was largely led by primary care. At the same time business as usual was maintained by primary care services, who always see the majority of patients, with general practice delivering over 300 million consultations per year, versus 23 million A&E visits, and that's just general practice. Dental, optometry and community pharmacy see many more.

Services have been criticised for the change in culture, a shift away from face to face to on -line consultations, while these won't suit everyone they have played a major role in keeping health care teams safe during the pandemic and many now prefer to access services in this way. This has been a major cultural change and one that some patients and the public have found difficult to come to terms with. As in any change, it takes time for peoples core values, or basic assumptions to change, and their behaviour at times has illustrated their attitudes and beliefs that they should be able to access care face to face, which has always been

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possible, but the front door became digital for many. Accessing care differently is a change that requires a cultural shift that will take time to embed and the journey has started. Transparency that there is a range of options available will support the next phase of change. Supporting inclusion, especially digital inclusion is important to allow this change to embed successfully.

The successes of the year have been driven by front line health care professionals – delivering care, managing innovation and change to deliver vaccination programmes and to maintain services while keeping themselves as safe as is possible. 2022 will bring more change, but we hope building on the innovation and change to date, embedding the collaboration that we have seen, empowering local leaders and enabling them a voice as integrated care systems develop to shape resilient and sustainable services for the future.

PCC has been honoured to support the NHS during the pandemic, we are proud to have worked with over 7500 delegates attending our virtual workshops and events during the past year and supporting many organisations with additional capacity and capability when it has been needed.

We hope all across the NHS have a peaceful Christmas and we look forward to working with you in 2022.

Author
Helen Northall
Chief Executive, PCC

The establishment of ICBs – where does primary care fit?

An interview with Sheena Cumiskey

In the second of our interviews with those working to set up integrated care boards (ICBs), we spoke to Sheena Cumiskey. Sheena is Chief Executive of Cheshire and Wirral Partnership NHS Foundation Trust (CWP) and joined the Cheshire and Merseyside Health and Care Partnership in September on an interim basis for three months, as chief officer.

Sheena is a well-respected and highly experienced leader, known for her commitment to co-production and putting people – staff, service users and stakeholders - at the heart of decision making. She has had a significant and positive impact on the Cheshire and Merseyside Health and Care Partnership in the short time she has been at the helm.

A new, substantive appointment has now been made and Graham Urwin, designate chief executive of the Cheshire and Merseyside ICB will start on 1 December.

What does your current role entail?

I'm in an interim role, to provide the bridge until the substantive chief officer for the integrated care system (ICS) is appointed. It's a great privilege albeit for a limited period of time, and my main objective is to ensure the ICB is able to fulfil its statutory role from the 1st of April, subject to the Health Act being passed, and also, provide an oversight to the NHS system in Cheshire and Merseyside.

By integrating health and care the aim is to improve outcomes for the population and to really start to tackle health inequalities. The integrated care system is about creating the scaffolding to enable this to happen, with our communities at the heart of everything we do.

Our people are key to this. Our workforce has been through an awful lot in the last 18 months, and we need to support them, protect their resilience and make sure that we all have a clear common purpose. We need our people to be in the best place that

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they can be personally so we can create that scaffolding and improve outcomes for the populations we serve.

I realise it's very easy for me to say all these things, but it is much harder to do. At the heart of it all is primary care, because primary care is the cornerstone of being able to come alongside people in their communities, where they live their lives and work together with our communities.

How do you see primary care being commissioned in the future? Is it going to be ICB level at place level or somewhere else?

Primary care is key partner in place-based partnerships and in Cheshire Merseyside these are aligned with the nine local authorities or boroughs at place level so they will be fully involved in the work of these places. We're still working with regional NHS England and NHS Improvement colleagues to understand what, if any, of the functions and responsibilities regarding primary care would transfer to the ICS. Until this work is complete, it's difficult to fully answer the question about how primary care is commissioned in the future.

Where will the planning of primary care take place?

A population health approach focusses on where people live their lives so the real planning must start at place and in primary care networks. Co-production by health and care professionals together with the local population, will help us to understand what we need to do and design different ways of meeting people's needs. Inevitably, there will have to be some aggregation at a system level because some things have to be done at scale to make sense, both from a clinical perspective and also to get better value. So, the unit planning will be very much done at place around primary care networks, but then some work will need to be done at a system level.

How can primary care teams get involved at ICS level?

Recognizing different members of the primary care teams and involving them will be key. They've got to be centre stage alongside people who access care and communities. So they will be involved, at place and at care community level and will be a key partner at place. But they also need to be connected to system working, as this is where the transformational change programs will be happening; where people are thinking

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about what can be designed differently and then delivered differently.

It is also important for primary care to be involved in provider collaboratives where they will get together with acute, mental health, community service, voluntary and faith sector providers to determine and develop pathways of care together.

In the Cheshire and Merseyside Integrated Care system we have a primary care forum, where we engage with our primary care network leads and other primary care health professionals including optometrists, dentists and pharmacists. This is an effective way for us to engage with and involve primary care at an integrated care system level.

"We're also developing a framework for clinical care professional leadership"

We're also developing a framework for clinical care professional leadership. This will outline how primary care can be involved at all levels of decision making across the ICS and in all parts of the integrated care system.

How can the ICB support the various stakeholders to get to know one another?

We already have a Partnership Assembly and a range of other stakeholder events but the development of the clinical care framework will be important in enabling people to get involved, get to know each other and to listen to others. Part of this is about co-design, so engaging with people and asking them how they want to get involved is important. We recognise that people have limited time, different interests and want different levels of involvement and actually listening to people will help us to meet people's needs in the way that they want them to be met.

What do you think the biggest challenge in all that is going to be in terms of taking hospital outside care out of hospitals and moving it into primary care?

One is how you ensure that you enable teams to work together in the right conditions to be able to focus on integrated, connected care. I think the way to meet that challenge is by working together with primary care teams and co-producing the solutions.

Another challenge we have is workforce capacity and people availability. There are a limited number of people and we need to make sure that we support them, enabling them to be the best they can be and to work effectively so they have the time to care, to

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work together and to transform.

In addition, having the right information or business intelligence to give us an understanding what works well at the moment, what can we do differently and better, and how do we understand our population health needs is essential.

The final challenge is our financial resources and getting the best value. When it comes to these finite resources, traditionally the NHS has looked at pounds and pennies rather than value and outcomes. First and foremost, we should look at value in terms of the outcomes that we deliver, including the social value to our communities. We know that good health and reducing health inequalities provides huge amounts of social value and contributes to economic regeneration, which in turn affects people's health. Talking about resources in terms of value is much more engaging for both the people who provide care and the people that access care. Talking about a cost reduction program doesn't motivate people who come to work to provide great care, great outcomes, and reduce inequalities and that's about the value of what we're doing, not the cost although clearly we do need to ensure we work within the resources available.

"Another challenge we have is workforce capacity and people availability"

What do you think are the leadership qualities are needed to make ICS/Place work effectively?

Leadership and clinical leadership is absolutely vital to all of this because if we're going to achieve all the ambitions and the way of working that I've described, clinical leadership is going to be really important. I think the essence of that is enabling our leaders to coalesce around a common purpose, and ensuring they can take a population approach, to see and understand how people live their lives so they can come alongside to work in coproduction. Leaders also need to support people to solve problems in collaboration and be able to take difficult decisions as I know clinicians do daily.

First and foremost, the leadership skills that people need will facilitate collaborative working and coproduction so we can work together with our stakeholders to identify problems and issues; design suitable solutions; then deliver those solutions effectively. However, we need to recognise that not everybody has to be able to work in each of these three domains. Good leaders should know their people well enough to know

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where their skills are best placed. They should also be able to create the conditions that enable all this to feel real, and worthwhile to people.

I think the golden thread is people and equity, recognizing that everybody has a unique contribution to make, and everybody's life is valued.

What will a successful ICB look like for those living in Cheshire and Merseyside?

Success will be where we have created the right conditions and set up that scaffolding so the ICB can enable all the things that I've described to continue to grow; where our places and communities will see different ways of working; where we achieve better outcomes; and see a reduction in inequalities.

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

Cheshire and Merseyside
Health and Care Partnership

PCN service and estate planning toolkit

During mid-November we saw the launch of the latest toolkit to support primary care. This time for PCNs to support with their estate planning and development of estates strategies.

The toolkit has been developed jointly by Community Health Partnerships (CHP) and National Association of Primary Care (NAPC). It has been developed to provide a national framework that will support primary care networks (PCNs) and integrated care systems (ICSs) to identify their primary care estate change and investment requirements, whilst facilitating consistency and supporting service development strategies across the wider health economy.

It builds on the guidance publication Primary Care Networks: Critical thinking in developing an estate strategy which was published in March 2020.

The toolkit has two objectives:

- To enable each PCN to identify and prioritise their estate optimisation, disinvestment, and subsequent capital investment requirements to address population health priorities and future service needs.
- To support the production of capital investment plans for PCNs and places and help ICSs to aggregate and prioritise local primary care investment requirements against other system demands for capital.

So, what does it contain and how do we use this?

The first thing to say it that is not mandatory. PCNs are not obliged to use the template, so if work has already started in your local area, you don't have to start again. However, the toolkit has been designed to utilise data and analysis already gathered via the primary care data gathering programme (PCDG) and live local datasets held on the SHAPE PCDG Atlas. Each PCN will be able to request a pre-populated version of the templates with their local SHAPE data embedded, to provide a good starting point.

The toolkit contains a PowerPoint template which contains all the sheets to populate and

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links to external excel templates (that can be pre-populated at PCN level based on the data available) and then developed and updated. Each section has a supporting guidance document to help understand what to think about and how to populate. It also suggests running some workshops and gives you the topics to be covered etc. The outcome at the end of the process is a robust, evidence based PCN service and estate investment plan, supported by a population health led clinical vision and based on current PCN estates information.

Fig 1: The contents of the toolkit

The toolkit will help each PCN to fully assess its existing estate against its local clinical vision, service strategy and forecasted demand. It is envisaged that every building will be able to be placed into one of the following three categories:

- **CORE -** Buildings that will remain in operation delivering primary care services for at least the next 10 years
- **FLEX -** Buildings that will be providing primary care services for at least the next five years but may not be needed longer-term as the clinical model evolves
- **TAIL -** Buildings that are likely to be disposed of within the next five years.

In addition, following the processes set out in the toolkit will enable PCNs and local healthsystems to identify how much investment is required, with each building placed into

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one of the following classifications:

- **Category F1 -** Building is surplus to requirements and will be disposed of within the next two years
- **Category F2 -** Building is in urgent need of a minor improvement grant (MIG) within the next two years for it to meet all Care Quality Commission (CQC) and statutory legal requirements. This is an investment that must be made for building compliance reasons irrespective of the clinical model if the building is to remain operational.
- **Category F3 -** Building is likely to be surplus to requirements and can be disposed of within five years, if appropriate investment is secured for alternative and replacement facilities
- **Category F4 -** Building will continue to be core operational estate and will require only a small amount of investment of less than £250,000 between years 3-5. Buildings in this category are likely to be candidates for future MIGs
- **Category F5 -** Building will continue to be core operational estate over the next five to ten years but will need significant investment (£250,000-£1m) to meet demand growth and/or changes to clinical strategy. This could be a building extension or a significant refurbishment/ reconfiguration
- **Category F6 -** These are options where new facilities are likely to be required over the next five to ten years. These may be new buildings but could also be re-purposing of existing buildings such as retail units or include moving into existing NHS estate such as community hospitals or CHP LIFT/NHS Property Services buildings.

Access to the toolkit is freely available via a simple registration process which enables the download of the generic templates and guidance notes from https://shapeatlas.net/pcntoolkit/ Access to pre-populated templates for a specific PCN requires the applicant to confirm consent that the GPs within that PCN are happy to share the data. For support and queries, please contact PCNToolkit@communityhealthpartnerships.co.uk

If you are looking for support to develop your estate strategy, our team of premises advisers are able to assist. Contact enquiries@pcc-cic.org.uk to see how we can help.

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Practice support - successful service change

Working with Aneurin Bevan University Health Board (part of NHS Wales) PCC advisers with expertise in planning for and leading change, communicating with patients, and the wider community delivered a series of workshops for individual practices to help them get to grips with the transformation agenda.

These workshops were attended by representatives from each of the practice teams, and each session was designed in response to conversations with practice staff including GP's, nursing and other clinical staff, the practice manager and the reception and admin teams.

The workshops covered:

GIG CYMRU NHS WALES
Bwrdd Iechyd Aneurin Bevan Health Board

- Discussing and agreeing a practice vision that would enable them to transform the service provision in a planned and effective way. During this workshop staff had the chance to understand the changing context for primary care in Wales and to explore what this meant for both staff and patients

- Planning for future changes including for example new practice roles such as paramedics and MSK practitioners and to really think about what does different feel like and look like and how to get there

- Planning for change and understanding how to manage and implement change

- Empowering the reception team in each practice to have more effective influencing skills when dealing with patients about as part of the implementation of the practice vision

- Working with a specialist communications expert to develop a realistic and achievable communications plan that informs and keeps up to date both patients and the wider community about the service transformation happening at the practice.

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What staff said:

> Good to involve the whole team in the process, empowered everyone and made them feel valued. It's been difficult to hear and accept the 'let it go' – we're still in the midst of challenging times – realise it is necessary to move forward however – THANK YOU.

> Thanks for yesterday Karen, it was a great success and just what the practice needs to help us move forward

> Polly's facilitation was excellent in identifying areas to improve patient experiences and satisfaction.

> Great to have someone to help the team facilitate and articulate how they feel, and they want to improve. Only thing that concerns me is ensuring all our wonderful actions plans are followed though – but that's on us.

Practice support - impact of COVID-19

PCC recently supported a Sheffield practice to identify and understand the impact that COVID-19 had on all aspects of its work, helping the practice to proactively capitalise on, and embed the changes and service adaptions that had been made.

We did this by providing an assessment tool to each team within the practice, so they were able to consider and then assess all the changes and adjustments the team and the practice had made.

The tool helped them to explore what was working well for staff and patients, which changes they could continue with, what changes could be made to work well with some modifications and what changes hadn't delivered results and should be discontinued.

Based on their responses PCC produced a summary report that was taken to a practice meeting. A PCC adviser also joined this online meeting and facilitated a conversation that gave everyone time to share their views and reflect on the findings.

The conversation resulted in an action plan (looking at short, medium and long-term actions) that the whole practice understood and supported and which they are now working together to implement.

Contact enquiries@pcc-cic.org.uk to discuss how we can support your practices

Coaching works

As part of PCCs growing leadership development programme, we have delivered coaching and mentoring support to a number of senior leaders in the NHS. Coaching and mentoring support is delivered by our ILM 7 executive coaches who take part in regular supervision meetings which helps them to explore how they operate as coaches, and is a reflective space for planning, discussing feedback and learning from each other.

Why have coaching?

Coaching is effective. The Institute of Coaching found:

- Over 70% of individuals who receive coaching benefited from improved work performance, relationships and more effective communication skills.
- 86% of companies felt they recouped the investment they made into coaching, plus more on top

How does coaching work:

- Learner controls how and what they learn
- Focus on skills, behaviours or personal transformation
- Supports personal experimentation and reflection
- Can build motivation to learn and learn competence
- Coaching is timely and of immediate relevance and applicable to current work situation

Why PCC:

Effective coaching is a complex and challenging skill. Our coaches work with clinical and non-clinical leaders in the NHS. Some of these individuals are new to their leadership role and can feel overwhelmed with the magnitude of their role. Some bring other issues such as personal development or challenging relationships for discussion. Our coaches have many years of experience in supporting individuals to meet their goals.

Our coaching support is getting excellent feedback, which we review and learn

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from so we can be flexible in the support we provide. Feedback received includes:

How did having a coach benefit your work/life?

- Safe space to let off steam, unravel beliefs, discover new approaches and ideas.
- Barbara took the time to get to know me, my approach to life/personality type and current set of issues.
- Helped me prioritise and together we tackled a few key problems together. Helped me view these using different lenses and analyse the issues before helping me create a list of actions.
- It makes me feel more in control of my work life balance
- Having a coach to talk things through with at regular intervals helped me gain reassurance that I was capable and was delivering rather than floundering.

What particular support or strengths do our coaches bring to the coaching

- Being non-judgemental at ease
- Wonderful listening skills and open attitude. I felt incredibly comfortable talking about both work and personal issues without fear of judgement
- Ability to be realistic and managing my expectations on myself, which I don't always do well.

Additional feedback:

- Helen is a very calm kind person with whom you feel safe to open up
- Am thoroughly enjoying the sessions and can't wait till the next one!
- Really appreciate the consideration and approach. The choice of 'tools' to assist focus and structure was beneficial.
- The focus of the coaching relationship and sessions provide the opportunity to reflect and consider which is not generally available
- I want to thank you for your help and support over the past 12 months. You

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have helped me through a turbulent time in my career. Settling into a new role has been more challenging that I had anticipated and having a professional and independent person to talk to has been an asset to me. It resulted in me having greater confidence been more challenging that I had anticipated and having a professional and independent person to talk to has been an asset to me. It resulted in me having greater confidence.

Find out more

Our new offer is for individuals to receive six sessions, which last up to two hours, over a twelve-month period.

We believe it's important to match individuals with the right coach. If you're interested in coaching, one of our coaches would arrange a brief call with them to go through what to expect and to discuss the reasons for wanting coaching. This helps us determine the best coach for that individual.

We would love to have the opportunity to talk to you about coaching for you or your teams, please contact enquiries@pcc-cic.org.uk

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Head of development, PCC

Author
Barbara Dingley
Director of operations, PCC

Mental health starts with you

We coach more than our fair share of primary care professionals here – and they're often slow to reach out. Our experience suggests there are two reasons for this. Firstly, personal coaching can seem a little self-indulgent when everyone else in the practice is just so desperately busy. Secondly, the training many doctors receive suggests they're supposed to know all the answers anyway – saying "I simply don't know where to go from here" is rarely considered acceptable.

Sadly, we pick up many of our clients way too far down the road… by now they are desperate, burned-out, shells of their former selves, and – quite apart from the misery they (and their families) endure – they have become a grievous waste of expensive human resource.

It is our belief that we all deserve to be the very best possible version of ourselves – it is in this way that we achieve ultimate fulfilment and make the best contribution to the communities we would aspire to serve. ***Often the person we have got used to being is not necessarily the person we really are.***

> "problems can't be solved using the same thinking that created them."

As we begin to help our most damaged clients reverse out of the cul-de-sac which has become the metaphor for their prevailing experience, we typically ask them what they ***really*** want and need from their lives. And it used to surprise us that so few people knew that – but no longer! It seems that many of us begin a journey "which seemed the right thing to do" or because the biggest influencers on our careers thought they knew best. As life unfolds, as the environment and our personal needs change, it is very difficult to objectively reassess our position on the map of the world because, as Einstein is credited with saying, "problems can't be solved using the same thinking that created them."

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So – what are our 'needs'?

The way we typically position this is to imagine – from the moment we step out of bed in the mornings – that we are driven through our day by ***nine internal engines*** (think 'airliner', with its multiple engines). Our research suggests that we each have the same engines, but they vary hugely in their relative power. We have named these needs: Meaningful Work, Creativity, Status, Expertise, Power and Influence, Autonomy, are amongst them. These engines drive us through the day, and it is vital that we have our ***needs*** met – they are far more important than just 'wants'.

As we start to explore the lives of our most challenging clients it is almost invariably the case – there are very few exceptions – that they have not understood, and certainly not been meeting, their most important needs for an extended period. Provided our mental health is in good shape, we can all accommodate temporary deficiencies – that's a situation perceived as 'frustration'. But over the long term the consequences of this slowly become evident both to ourselves and others. Breakdown is the eventual result.

We encourage all the professionals we work with to regularly appraise their Key Internal Drivers, as we call them – since they typically change dramatically as we transition through key life events. This review becomes a personal compass – decisions become easy: take the option which is going to best support your key internal drivers… because much of good mental health depends upon it.

For more details contact enquiries@pcc-cic.org.uk

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Director of Professional Development at Developing Professionals International, and a PCC Associate of many years.

How to create health - Building Back Together following COVID-19

During the pandemic, many health professionals witnessed first-hand what communities are capable of; people's desire to help during the lockdown periods; the deft way that communities organised to keep everyone connected, fed, occupied and receiving the health management and medicines they needed; and the willing volunteers staffing testing sites and vaccination centres.

Practices and PCNs have worked together with community groups and voluntary organisations to deliver huge programmes of care and relationships have been forged in the heat of an emergency. How do we hold on to and build on those effective relationships now as we look to transform healthcare and tackle the health inequalities that have been highlighted for all to see?

Shifting the focus from 'making people better' to creating the conditions for everyone in communities to be 'well' is one way of thinking about the change that needs to happen across the system. There is now widespread acknowledgement that both individuals and communities need to become active participants in their health (and not just passive recipients of services) and Health Creation provides a framework and practical resources for making that shift.

Health Creation involves working with people and communities; connecting with and supporting local partners who already have credibility with local people; and enabling the health workforce to embed and mainstream new ways of working so that Health Creation becomes business as usual.

In the wake of the COVID-19 pandemic, our Call to Action is to 'Build Back Together' because experience tells us that when the people who live in a place and the people who work in a place are working together, on equal terms, and playing to everyone's strengths, these are the optimal conditions for lasting Health Creation to take place. Our 10 key messages associated with this call to action align well with the 10 principles for working with people and communities recently published by NHS England and NHS Improvement as part of the ICS Implementation Guidance (see below).

More fundamentally, the five features of health creating practices, which reflect people's and communities' lived experience on the ground, provides a very effective and concise

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steer when you are working out how to redesign your services to be more health creating.

The five are:

1. **Listening and responding**: Effective, genuine listening to the reality of people's and communities' lives is essential, followed by responsive action, acting differently and not just reverting to the established systems. Listening can also help to build trust that enables truth-telling if people feel safe to open up about matters that concern them.

2. **Truth-telling**: When people and practitioners identify and acknowledge what holds them back from creating health, rather than focusing on treating symptoms, they can start to get to the root causes of problems and find solutions. This can be a challenge at first but the benefits are life-changing.

3. **Strengths-focus:** Health creation happens when attention is paid to what people can do for themselves or others. Enabling people to recognise their strengths, and finding opportunities for them to use them, unlocks their potential and builds confidence for creating health.

4. **Self-organising:** Helping people to connect meaningfully with others makes it possible for them to find solutions and take actions together. They are more likely to find purpose in their lives and this drives wellness. Over time, people become less reliant on health and care services.

5. **Power-shifting:** People are conditioned to depend upon the NHS and practitioners are accustomed to give direction and advice. It will take time to blur those edges and the introduction of shared decision-making is a big step in that direction. Helping people feel confident to take control of their self-care, digital solutions and personalised care roles working in communities will all help to shift the power balance and give people more autonomy over their own wellbeing.

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Whatever your role within the wider health system, you can play your part. You can maintain and build on the community contacts and relationships you made during the pandemic. You can introduce your colleagues to the five features of health creating practices and discuss how you will implement them in your workplace. And you can challenge your system when it reverts to more traditional ways of working.

Let's stop looking to government for all the answers and work together, with our communities and local partners, to move beyond delivering services to a model that is principally focused on how the NHS, communities and other local partners create health together.

[1] Framework for Health Creation Health Creation | The Health Creation Alliance

The ten key messages can be found here: Building Back Together: 10 Key Messages. They are drawn from the following The Health Creation Alliance reports:

1. Health Creation: How can Primary Care Networks succeed in reducing health inequalities?
2. Primary Care Networks and place-based working: addressing health inequalities in a COVID-19 world. A partners' perspective
3. Learning from the community response to COVID-19; how the NHS can support communities to keep people well
4. Digging Deeper, Going Further: creating health in communities. What works in community development?

For more information and how to join the Movement for Health Creation: Members | The Health Creation Alliance

The Health Creation Alliance

Author
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Chief Executive,
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Upcoming PCC Events

An introduction to primary care - dental, eye-care, medical and pharmaceutical services

Tuesday 14 December 2021 (13.00-16.00)

Online training session

https://www.pccevents.co.uk/2607

Facing the future with confidence

Wednesday 19 January 2022 (13.00-16.00)

Online training session

https://www.pccevents.co.uk/2634

Understanding pensions for sessional GPs

Thursday 20 January 2021 (10.00-12.00)

Online training session

https://www.pccevents.co.uk/2630

SocialPrescriberPlus Programme

Wednesday 26 January, Thursday 27 January and Thursday 10 February 2022 - all sessions 09.30 - 12.30

Online training session

https://www.pccevents.co.uk/2637

Full events calendar https://www.pccevents.co.uk/calendar

A day in the life of an account manager (events) – Sophie Dixon

Hello, my name is Sophie and I work on the event team at PCC. I have worked at PCC for over seven years, first starting off as an event assistant and now working as an account manager where I schedule, lead, and plan a programme of events and workshops for clients. Part of my role which I enjoy the most is meeting and working with so many different people on a day-to-day basis whether that's the PCC team, our associates, speakers, or customers.

At PCC we continually deliver a programme of events, webinars, surgeries and programmes nationally for our customers, these might be personal and team development sessions, or more technical subject matter. I regularly keep up to date on current topics and trends to ensure the events I schedule are relevant and of interest. Take a look at our events calendar for all of our upcoming sessions.

Within the last 18 months there has been some significant changes within the event industry globally given the pandemic. Prior to March 2019 most of our events were face to face, we could meet our delegates at the registration desk as they arrived and check in with them throughout the day over coffee. When the pandemic hit, very quickly we had to change how we delivered events and convert to online delivery and although this is very different than having everyone in the same room, there have been some real benefits. Our audience are exceptionally busy and whereas before they might not have had the time to take a train to London for the day, we find that logging onto a session for a couple of hours is more manageable and have opened ourselves up to a new audience and their pets!

Alongside our national programme of events, I also work with clients to plan their own events, this includes all pre-event, on the day and post event support. Within the last couple of years, I have worked with clients including Cheshire Local Medical Committee, NHS 111, The Office of the Chief Scientific Officer, The National School of Healthcare Science and The National Police Chiefs Council (NPCC), to name a few. These Continued...

range from a one-day conference for a couple of hundred people, to a four-day residential conference and exhibition for thousands of people.

Although our main audience is health care the client side of event management means we can work with organisations outside of healthcare (as you may have spotted above). I really enjoy working with different clients and adapting my working style to suit their needs. It is also really rewarding to work for months on a project and getting to see the final outcome.

Within PCC I am also the event lead for the South region in England. I work alongside our adviser team sending regular updates to our clients in the South and ensuring the successful delivery of workshops and events.

Given the number of clients I work with and different types of events we run, day to day my role is very varied, and I manage a number of different projects at the same time. In one day, I could be attending a planning meeting with a client, managing a budget, liaising with a venue, speaking with an audio visual/ staging team, or managing delegate queries, for a number of different events I am working on. No one event, client or day is the same. It certainly keeps me on my toes!

In the near future I am really looking forward to being onsite again and hopefully seeing more of you in person. In the meantime, I hope you enjoy our events virtually from your home or office.

PCC welcomes your news for future editions of PCC Insight—if you have something to share or would like to contribute an article please let us know enquiries@pcc-cic.org.uk

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