recognising that it is neither private sector nor centralised. Clearly, a patient is not a customer in the same sense, yet any organisation with the scope and reach of the NHS requires strong leadership and management *at all levels and in all parts of the system*. Everything comes down to its people, both right now and in the future: so we must pay attention now if we are to expect results in 10, 15, 20 years. People are long-term.

The recommendations apply to the whole NHS, but they will not and cannot find universal support or answer all issues. However, a way needs to be found to implement them in what is essentially a federation. The development of people and sharing of best practice should not be left to chance. There is much good practice and good leadership out there. I urge the means to share it and to join it up so that best practice may be spread more rapidly.

The NHS is one of our society's proudest achievements, but the challenges it faces could hardly be more daunting. The NHS remains a comprehensive service, free at the point of delivery, regardless of the ability to pay, and funded from general taxation. However, rising demand and treatment costs; the need for improvement in certain kinds of care; and the state of the public finances means that "Simply doing things in the same way will no longer be affordable in the future."[6]

[6] *Government response to the NHS Future Forum report* (20 June 2011), Department of Health, www.gov.uk/government/publications/government-response-to-the-nhs-future-forum-report

The *Five Year Forward View* has a clear vision of what the future should look like; but not enough focus on leadership and skills that will be needed to implement it. I leave you with three questions related to my central themes:

- Leadership is the key to making changes stick. How is great leadership recognised across the NHS?
- How do we find and nurture the people that are needed to lead the NHS over the next 10 years?
- How do we help all NHS staff become the best versions of themselves at work?

This Review offers some answers to these questions.

Lord Rose

June 2015

Executive Summary and Recommendations

The NHS has most of the resources it needs to deal effectively with the issues identified in this review. The key strengths that the Review found include: the commitment of staff at all levels and in all parts of the NHS; the profound goodwill of its stakeholders, and the strong support of its funder, the Department of Health.

The quality of NHS clinical care, which is highly regarded, is not always matched by its ability to identify, assess, and manage its staff consistently. Some of the systems and procedures necessary for this do not exist, or where they do exist are only partially effective.

The level and pace of change in the NHS remains unsustainably high: this places significant, often competing demands on all levels of its leadership and management. The administrative, bureaucratic and regulatory burden is fast becoming insupportable. There are three areas of particular concern:

1. Vision: There is a lack of One NHS Vision and of a common ethos.
2. People: The NHS has committed to a vast range of changes however; there is insufficient management and leadership capability to deal effectively with the scale of challenges associated with these.
3. Performance: There is a need for proper overall direction of careers in management across the medical, administrative and nursing cadres.

Many of these problems are chronic and have been unaddressed over an extended period and by different Governments. Clearly, some of these recommendations are of a strategic nature; others tactical and operational. Several are interrelated and overlapping, as one would expect them to be in a complex organisation.

Recommendations:

There are two pre-conditions that must be met before any of these recommendations can be effected: These are simple and profound:

R1: Form a single service-wide communication strategy within the NHS to cascade and broadcast good (and sometimes less good) news and information as well as best practice to NHS staff, Trusts and Clinical Commissioning Groups.

and

R2: Create a short NHS handbook/ passport/ map summarising in short and/ or visual form the NHS core values, to be published, broadcast and implemented throughout the NHS.

Training:

R3: Charge Health Education England (HEE) to coordinate the content, progress and quality of all NHS training including responsibility for the

coordination and measurement of all management training in the NHS. At the core of this is a 90-day action cycle. HEE must promote cross-functional training in all disciplines and at all levels, coordinating the teaching of management basics such as appraisal, motivation, negotiation and leadership

R4: Move sponsorship of the NHS Leadership Academy from NHS England into HEE

R5: Include accredited/ nominated training establishments as part of a diverse training effort.

R6: Review, refresh and extend (x10) the NHS graduate scheme; establish career pathways, a greater variety of placements and a guaranteed job after three years' training (quality and assessment permitting).

R7: Refresh middle management by training and a more porous approach both from within the NHS and externally (recruitment from, and secondment to, other sectors).

R8: Require senior managers to attend accredited courses for a qualification to show that consistent levels of experience and training have been reached across the NHS. On completion of this course they will enter a senior management talent pool open to all Trusts.

Performance Management

R9: Set, teach and embed core management competencies and associated expected behaviours at each management level.

R10: Establish a mechanism for providing on-going career support for all those in a management role allowing individuals to increasingly take charge and identify their own development needs.

R11: Establish and embed an NHS system of simple, rational appraisal (a balanced scorecard for individuals) supported by a regular course in giving and receiving appraisals as part of the core provision of the single training body. At a senior level, these appraisals should be standardised across the NHS.

Bureaucracy

R12: Review the data demands of regulators and oversight bodies; these can then be rationalised and harmonised in order to produce consistent, clear and simple reporting that does not distract staff from patient care.

R13: Merge the oversight bodies, the Trust Development Agency (TDA) and Monitor.

R14: Spend time, on a regular basis, at all levels of the NHS to review the need for each data returns being requested and to feed any findings to the Executive and Non-Executive Teams to review.

R15: Establish and maintain a clearer system of simple rational appraisal (balanced scorecard for the organisation).

R16: Health and Social Care Information Centre (HSCIC) should develop an easily accessible Burden Impact Assessment template and protocol.

Management Support

R17: Create NHS wide comment boards. Website and supporting technology to be designed and implemented to share best practice.

R18: Set minimum term, centrally held, contracts for some very senior managers subject to assessment and appraisal.

R19: Formally review Non-Executive Director (NED) and CCG lay member activity (including, competence and remuneration); and establish a system of volunteer NEDs from other sectors.

Background to the Review

The NHS has recently undergone one of the largest and most radical changes in its 66-year history in the form of the 2012 Health and Social Care Act ("the 2012 Act")[7] and (two years earlier) *Liberating the NHS*[8]. The 2006 Act as amended by the 2012 Act is the legislation in force at the time of this Review.

This wave of change was designed in part to remove day-to-day management of the NHS from the centre of Government. GPs would commission services and the National Commissioning Board (now NHS England) would be given a mandate from Government that sets out the strategic direction in the form of objectives it must achieve; this would limit micromanagement of the NHS by the Department of Health and distance management of the NHS from Government.

The 2012 Act changed the landscape of the NHS fundamentally. Previously the Secretary of State for Health oversaw the NHS through 10 Strategic Health Authorities (SHAs) that in turn oversaw 151 Primary Care Trusts (PCTs). These PCTs commissioned services from hospitals, GPs and all others providing front-line NHS care. The 2012 Act increased the level of oversight by replacing SHAs and PCTs with a number of new bodies including NHS England which includes four regional commissioning offices, a number of Commissioning Support Units and 27 NHS England Area Teams which oversee Clinical Commissioning Groups (CCGs). Money flows from NHS

[7] Health and Social Care Act (2012), www.legislation.gov.uk/ukpga/2012/7/contents/enacted
[8] *Equity and Excellence: Liberating the NHS*, (12 July 2010), www.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf

England directly to the CCGs which then purchase care in hospitals, Mental Health and Community Services. Specialist services and primary care services are commissioned directly by NHS England, though this too is changing. Local Authorities can also commission some public health services. New levels of accountability were also created. Devolution of accountability away from the centre of government will take time to work.

Clinical Commissioning Groups (CCGs) are autonomous statutory bodies accountable to their members through a governing body. They work closely with other organisations such as local Health and Wellbeing Boards and NHS England. While CCGs are independent, there are a number of duties that they must fulfil which are set out in the [NHS Act 2006, as amended by the] Health and Social Care Act 2012. In late November 2014 some restructuring of NHS England took place with the 24 area teams outside London being replaced by 12 sub regions[9].

Background to the General Themes:

This is a time of extraordinary and rapid change, and this above all else shapes the evidence gathered here. A clear picture emerges of an organisation with many strengths and opportunities both to control the present and to plan for the future. But the picture also includes significant

[9] www.england.nhs.uk/2014/11/28/director-appointments/

shortcomings in the management of staff, and of a lack of local strategic oversight indicative of broader issues in the NHS.

This ought to be a time for great transformation *without structural reorganisation*: the NHS is facing both urgent and important issues. There is an urgent need for more efficiency savings, increased pressure on services from an aging population with multiple needs, and there are the unintended consequences of medical progress such as people living longer with multiple conditions. There are both risks and opportunities.

In funding, for example, the NHS has been rated by the US Commonwealth Fund as the most efficient health care system in the developed world: the NHS scores highest on quality, access and efficiency; it spends the second-lowest amount on healthcare among the 11 nations surveyed (£2,008 per head).[10] Yet the NHS is now being asked to make further massive savings of the order of those that Sir David Nicholson set out for 2011-2015[11]. There is estimated to be a potential deficit of £30bn by 2020-2021.[12] This is placing NHS staff under greater pressure.

The *Five Year Forward View*[13] is welcome and commonsense. It focuses on three things: *managing demand*, *improving efficiency* and *additional funding*. This thinking has helped to shape the context in which this Review made its

[10] *Mirror, Mirror on the wall, 2014 update: How the US health system compares internationally* (16 June 2014), The Commonwealth Fund, www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror
[11] www.stockport.nhs.uk/websitedocs/2010_11_25_Item_6.PDF page 2: *Department of Health Business plan 2011-2015*, (8 November 2010)
[12] *The NHS belongs to the people: A call to action*, (July 2013), NHS England, www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf
[13] *Five Year Forward View*, (October 2014), NHS England, www.england.nhs.uk/ourwork/futurenhs/5yfv-ch1/

findings. The *Five Year Forward View* brings a long overdue emphasis on prevention and a continuing and renewed commitment to patients being given more control of their own care. As many have pointed out, it is an "adapt or die" message.

The *Five Year Forward View*[14] recognises that there is a funding gap, a need to join up primary care, social care and acute care and show a practical route to making things more efficient. The vision set out will likely cost an extra £8bn, on top of the £22bn efficiency savings the NHS may be able to make on its own, to implement:

> "If the NHS achieves all the efficiencies identified in the plan – an extremely tall order in itself – leaders say that an extra £1.5bn a year above inflation will be needed, or around £8bn in total, to eradicate a £30bn deficit"[15].

The *Five Year Forward View* sets out the need to move away from the short-term answers into longer term more radical solutions. However, it does not dwell on the most important resource alongside money: people.

The story is the same in the 2012 Act. This put clinicians at the centre of commissioning, freed up providers, continued to empower patients, and brought the NHS, public health and adult social care together for the first time in Health

[14] *Five Year Forward View*, (October 2014), NHS England, www.england.nhs.uk/ourwork/futurenhs/5yfv-ch1/
[15] British Medical Journal (1 Nov 2014)

and Wellbeing Boards. The 2012 legislation created a number new structures, including CCGs, and enhanced roles for the Care Quality Commission; and removed others, including SHAs. The 2012 Act presaged radical change, and it is still too early to say if or how those changes will be successful. Yet wherever structures change, people need to be equipped to run them. Equally, the *Five Year Forward View* says little of the challenges for NHS staff from either the provider or commissioning side. A report from The King's Fund (December 2014) makes clear where some of these challenges currently sit:

> Talent management is key. The responsibility for developing future leaders needs to be taken seriously… It is important that a culture of development and support should pervade – one that allows senior leaders the time and space to try new things… one where they are free from the weight of scrutiny and blame that dominates today.[16]

It lists the well-established need to fill gaps in leadership training, to establish an NHS leadership strategy and development plan, and to remove the disincentives to innovate and take risks. The King's Fund report touches on many things noted in this Review: structural uncertainty, the regulatory burden, career development, talent management, and CEO tenure, all issues which have shaped the recommendations here.

[16] *Leadership Vacancies in the NHS: What can be done about them?* (2014), Ayesha Janjua, The Kings Fund,

Findings & Interpretations

There are seven **General Themes** that emerged; the Review grouped the general themes under the following headings:

1. **NHS vision & ethos (*one vision of the NHS*)**
2. **Leading constant change (*one vision of the NHS, its People*)**
3. **Training (*one vision of the NHS, its People*)**
4. **The management environment (*its People*)**
5. **Performance management (*its Performance*)**
6. **Bureaucracy (*its Performance*)**
7. **Trusts (*its Performance*)**

1 NHS Vision & Ethos

There is a huge opportunity here. The NHS has a great story to tell; but there is no focused vision given to the NHS workforce as a whole. The full-time workforce (1.38m) has grown by 160,000 since 2000[17]. There is an opportunity and need to instill an NHS-wide vision along the lines of "shared values – locally delivered".

[17] *Health and Social Care Information Centre, Annual Workforce Census, (2013*), www.hscic.gov.uk/catalogue/PUB13724/nhs-staf-2003-2013-over-rep.pdf

There have been many initiatives announced by successive Governments, most recently the *Five Year Forward View* (2014)[18] and the Dalton Review (2014). It is the aim of this Review to complement their work and to set out the necessary skills needed across the whole NHS workforce in order to make their visions a reality.

An agreed, shared, vision would give the NHS a united ethos and a consistent approach to getting things done. This would have a direct impact on what good leadership looks like, and on how it is recognised and felt. The NHS needs to focus all the more intently on a single ethos and vision to counteract its increasingly devolved structure. This is because the NHS is essentially a federation made up of individual organisations. Each varies by size and geography; and each has an identity shaped by practice and culture. However though there may be different organisations in the system, the leadership skills needed throughout are the same.

Unfortunately at no point has the time been taken to consider the skills and talent needed to drive the NHS system forward together.

The NHS, as a whole, lacks a clear, consistent, view of what 'good' or 'best' leadership look like. In 2013, Sir Robert Francis QC set out in his public inquiry report some of the criteria for what good leadership in healthcare might be, including visibility, listening, understanding, cross-boundary thinking, challenging, probity, openness and courage. Principal among these is "the

[18] *Five Year Forward View*, (October 2014), NHS England, www.england.nhs.uk/ourwork/futurenhs/5yfv-ch1/

ability to create and communicate vision and strategy."[19] This is a set of values that need to be broadcast more effectively within the NHS.

The lack of leadership based on values throughout the NHS has led to some of the most negative comments given to the Review, including; *there is a culture of fear*; *it's all too difficult*; *there is an obsession with targets* and *it is impossible to operate in the current climate of suspicion and change*. Or *What is its plan? What is its vision?*

A lack of good, clear, leadership in some areas is concerning. Some see the NHS, both internally and externally, as full of people making excuses for poor care, passing the buck and shrugging off responsibility. Some people remain afraid to raise concerns fearing that either nothing will happen or that if something does there will be a negative consequence to it. There is a lack of basic training for leaders and managers on how to listen to people and an increased feeling of unconscious pressure being brought to bear to achieve targets at the expense of staff who are willing to raise issues. Greater emphasis is needed now on the skills and development needed to support change and to assist in the delivery of the vision set out in the *Five Year Forward View*.

However, it is not just the lack of leadership that is creating problems. While individual hospitals and Trusts can usually (and rightly) articulate their own vision, for the NHS this seems to be lacking. When people were asked: *what*

[19] *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, Volume 3, Chapter 24- Leadership, page 1545, (6 February 2013),www.midstaffspublicinquiry.com/sites/default/files/report/Volume%203.pdf

does a good NHS look like, what would success be? shockingly there was no single answer. Despite what was set out in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, many had no answer at all.

Innovative care models depend on people to run them, on porters, receptionists, nurses, consultants, specialists, technicians, therapists, GPs, service commissioners and many others. These care models will never become a consistent and well-understood reality across the UK unless there is a single NHS vision effectively communicated and understood by all NHS staff.

This review also found that there was no consistant clear picture for CCGs of what 'good' commissioning performance looks like. CCGs are new bodies, understandably trying to find their feet; but without such a vision their leaders will find it difficult to secure services of a high standard and, over time, to recruit and retain high quality individuals.

2 Leading Constant Change

The *Five Year Forward View* rightly says: "we detect no appetite for a wholesale structural reorganisation.[20]" This puts it too mildly: there is widespread change fatigue and an irritation that new changes are not given sufficient time to bed in.

[20] *Five Year Forward View*, (October 2014), NHS England, www.england.nhs.uk/ourwork/futurenhs/5yfv-ch1/

A lack of stability is felt across the NHS, with a deep-rooted concern over the many and varied messages sent from the centre of Government. For a number of years there have been a range of initiatives and changes of emphasis: Patient safety and quality of care (Lord Darzi's *High Quality Care for All*[21]); Financial performance (derived from the Foundation Trusts reforms); and Performance efficiency (in light of current financial constraints). In other areas of the system we have seen shifts of emphasis between Local Authority commissioning, centralized commissioning through PCTs and more recently clinical commissioning, with a strong emphasis on a lead role for GPs.

None of these changes have been supported by the deliberate development of the skills needed to deliver them. That needs to be put right, with a greater focus on the whole NHS workforce and on developing the talent and skills of its future leaders: they need to be better prepared for the daily challenges of leading a Trust, a team, a ward, a clinical or specialist group or a CCG [over the long term].

This has implications for leadership (which provides the motivation and inspiration) and management (which provides the implementation). As the Dalton Review (2014) points out, "leadership is key to change" [22]. Strong and capable leadership is key to driving transformational change and often involves taking bold decisions. More support is needed for leaders to develop large-scale

[21] *High Quality Care for all: NHS Next Stage Review Final Report,* (June 2008), Department of Health
[22] *Dalton Review: options for providers of NHS care* (5 December 2014), Theme 5, www.gov.uk/government/publications/dalton-review-options-for-providers-of-nhs-care

change management, strategic and commercial skills and the ability to lead in a networked or group structure are becoming more important.

This is important throughout the NHS, and especially for the relatively new CCG Chairs and leaders, so they can fully implement the vision set out in the *Five Year Forward View*. The current level of support given to CCG Chairs and other senior individuals such as Accountable Officers and Chief Clinical Officers is woefully inadequate. There is no 'step up' for these individuals: either they have the necessary leadership skills or they don't. A systematic way to identify and develop this group is needed. Some CCGs do well planning for the future but instances of this are the exception rather than the rule.

Centrally and throughout the NHS there is concern that more structural change means a greater risk to services being delivered below standard. More generally, some argue that the time to take risks was when the NHS had money, and not now. However, this Review argues that the greater risk now lies in doing nothing.

It is widely accepted that the NHS requires transformation in places: most large scale organisations do. To make changes stick, more stable management is required. There will always be those that accept change in any organisation, and those who do not. The former are invariably in the minority. Leaders must ensure that the organisation understands the

necessity to change, and must find ways to bring their staff along with them. However, to do this, time and head-room are essential.

There are signs of growing frustration amongst those in CCG leadership roles at their inability to 'make a difference': some commented that with the publication of the *Five Year Forward View* they are looking to move from commissioning to provider roles. This frustration needs addressing. The models of care set out in the *Five Year Forward View* require strong leadership throughout the system to implement the vision and change needed.

3 Training

NHS management careers depend too much on chance. Training and development are often sporadic. There is limited investment in systematic leadership training for staff and as a consequence capability suffers which is ultimately poor for the patient.

There are several training institutions responsible for training NHS staff,[23] and no mandatory requirement to use them. A significant number of Trusts therefore develop their own training programmes with the help of external consultants. Many of these are of a high calibre but this plurality of provision results in a lack of consistency in the level of training and development received; both depend on the organisation, the area in which it is located and

[23] For instance the NHS Leadership Academy, Health Education England, the NHS Staff College

the individual ward or part of the hospital itself. This Review has found that all forms of initial training tend to lack a consistent, cross-disciplinary approach.

The NHS recruits high calibre graduate trainees, but the numbers are far too low (approx. 100 per year). Although these trainees receive excellent initial training, they are not subsequently managed, monitored and developed. While they are successfully retained, their potential could be better optimized. Some examples of how this could be achieved could be to develop specific roles for those recently graduated, or for there to be greater encouragement for secondments to a variety of NHS posts such as in a commissioning organisation or role. There does not appear to be the level of communication required between those who may have a need for a first year graduate, the graduates themselves and the NHS leadership academy. A number of organisations commented that they would welcome a first year graduate, particularly in the commissioning sector, but were unable to secure one.

Clinical students are not taught either early enough or in sufficient detail during their training about how the NHS works. Many reported that it took them a considerable amount of time to ascertain how the NHS worked as a whole. Neither is there a clear career development structure for clinicians wanting to take on management or leadership positions. The role of Clinical Director is a key role in a successful Trust and development for those clinicians who wish to take on this challenge must be supported and encouraged. While not all will wish to take on management responsibility, there is still a need for all to be able to show leadership skills.

The key leadership relationships within a Trust are between the Chief Executive, the Clinical Director and Chief Nurse, and between the Chief Executive and the Chair. A crucial relationship also exists between the Executive and the Non-Executive Team. There is a need for each group to undergo cross functional training (that is, training not specific to one area or organisation within the NHS) together to build their capability and resilience as well as their combined ability to lead.

The CCG Chair is the lynchpin of the system. Relationships between CCG Chairs in a geographical area, and between Chairs and their provider organisations, are key relationships. Cross-functional training for local Chairs, their top teams and local providers will build better communication between them.

The level of service integration envisaged in the *Five Year Forward View* highlights an opportunity to take joint training one step further. The creation of training programmes, open to all across the health and care sector would have a significant impact on leadership, in particular on the promotion of good practice and of positive collaboration throughout the system.

The NHS Leadership Academy (NHSLA) provides extensive training for large numbers of provider staff at all levels, but does not enjoy the following or

status necessary to make it the key provider for people development in the NHS. If it is to enjoy that status it needs to be bulked up and given the appropriate credibility and status to deliver. This might best be done under the aegis of another organisation such as Health Education England (HEE): at present the NHSLA is too light for heavy work and too heavy for light work. The NHS Staff College delivers similar leadership training to a diverse group of people including executive and ward teams. It too does not currently have the status or scale necessary for it to become the key provider for people development in the NHS.

Together the NHS Leadership Academy and the NHS Staff College working with other key leadership organisations (the NHS Staff College in particular already works with the British Military) should be able to develop and accredit a number of tailored courses, offered in a variety of lengths to suit the needs of the individual (such as a number of courses the NHS Leadership Academy currently provides) and/or organisation. All must be of a recognised and uniform standard.

Training across the NHS should be more mobile, flexible and agile. A variety of locations are needed with oversight from a single organisation. Training could be provided from other public facilities (eg military, education) already known to provide high quality leadership training.

Senior management development needs to be better served – both for the development of those from within the NHS and those recruited externally. Just

as graduate trainees need to be taught about how the NHS works early in their career, so too should those coming in at a more senior level so that they become effective quickly.

Whilst there should be more, and more consistent, promotion from within, there often appear to be barriers to recruiting externally. Reasons given to the Review were that the NHS is too complicated, the pay too low, or the media perception too negative. The current "fast track" scheme appears an expensive – and as yet unproven - way to develop/attract future top talent in sufficient numbers.

The NHS needs to be more porous, encouraging managers to join from other sectors, or leave to rejoin the NHS later; yet its main effort should be in developing its own. Retaining and developing existing staff will always be more cost effective than filling from outside. The Review found no systematic approach to developing managers and leaders (as there is for instance in the Department of Health or Civil Service more broadly)[24].

There is a lack of permeability or interchange of managers between providers and commissioners, yet the *Five Year Forward View* advocates greater integration. Moreover, CCG staff with a wider demographic view of health rather than an organisational one would be advantageous. Equally, a Trust employee moving to a commissioning organisation would provide the commissioner with a better understanding of the services it procures.

[24] *Civil Service high Potential Stream; A talent strategy for the Civil Service 2013/14 – 2016/17, https://civilservicelearning.civilservice.gov.uk/sites/default/files/corporate_talent_strategy_v0f.pdf*

Much more can be done to encourage those working in CCGs to take part in courses offered by the NHSLA and the NHS Staff College. This provision needs to be supplemented by a new training programme for the specific needs of those working in commissioning.

4 The Management Environment

There is a widespread and deep-rooted perception that management is "the dark side". Doctors and nurses can be seen and often position themselves in opposition to management. This is unhelpful.

Management itself is often far too tactical in its behaviour; there is not enough strategic thinking. Great commercial organisations tend to spend more time thinking about the future.[25] The short-termism of NHS management thinking derives from two things: the need for constant regulatory data, and the fear of not being able to change fast enough.

The management structures are various and complex. What became clear is that no one model fits all circumstances.[26] In a plural management environment, two things tend to happen: first, those leaders who are best able to read the rules and interpret the system will prosper (and this may be entirely serendipitous).

[25] *Tapping the strategic potential of boards,* (2014), Bhagat, Hirt & Kehoe, McKinsey and Company www.mckinsey.com/insights/strategy/tapping_the_strategic_potential_of_boards

[26] For example: service-level chain; multi-site trust; federation, joint venture; franchise; multi-service chain; integrated care organisation.

Second, in an uncertain environment, the quality of outcome depends all the more heavily on the quality of the people.

For example, many of the best leaders are successful despite the system; or they had found a way to work it to achieve what they needed. They knew there was no single or mandated way to get things done. For the better leaders, this presents an opportunity to solve or work around a problem; but for weaker and/or newer leaders in less well-resourced areas, this presents a real problem and erodes morale.

Risk taking within acceptable clinical and commercial parameters is not encouraged, recognised or rewarded. An avoidance of failure is often noticed more than drive for innovative success.

At executive level, Chief Executives in particular need a strong team around them for support. Once a solid executive team is formed in a Trust it will often move with them; this practice should be encouraged where appropriate and viable.

Discussions during the Review highlighted the churn of Trust Chief Executives and the unsettling effect this has on Trusts. 7% of all CEO positions were reported as unfilled[27]; and the average tenure was 700 days. There is little clarity on the accuracy of tenure; but these statistics paint a picture of frequent arrivals and departures of senior leadership, of unsettled leadership teams

[27] *Leadership vacancies in the NHS* (December 2014), The Kings Fund. The report states that 7% of all trusts were without a substantive CEO which increased to 17% for trusts in special measures

and of initiative fatigue as yet another Chief Executive brings in yet another fresh approach.

Trusts in special measures or which are poorly performing often have an experienced and well respected Chief Executive brought in to turn around the Trust. However, the reality is that the centre of government does not always give enough time for a new, experienced leader to analyze what is happening, to identify any issues and subsequently to bring in a new team to stabilise any problems found before being overrun with numerous, often unnecessary and, on occasion, heavy handed inspections. These inspections often come with the expectation of *immediate* improvement and when, unsurprisingly, an immediate, service-wide improvement has not been delivered, leaders and their teams are placed at fault. To identify, analyze, rectify and implement all take time; they are not a linear process, especially as poor practice comes to light. Changing embedded culture and increasing staff morale through mutual understanding and respect takes time to deliver. Whilst there are reasons behind the increasing number of inspections, balance is still lacking. Further work needs to be conducted on reflecting the need for the Care Quality Commission (CQC) in particular to continue to respond to concerns raised to them whilst recognising the time a new CEO may need to identify problems and issues and to begin turning round a failing Trust.

By treating leaders in this position impatiently, the NHS is missing a pool of experienced leaders who could be unwilling to put themselves and their careers under scrutiny without the assurance that they will receive the time

and space to consider and effect any necessary transformation. The addition of leadership as part of the CQC inspection under its "well-led" domain, while welcome has added additional pressure/scrutiny on staff.

In essence, since the beginnings of the professionalisation of general management in the 1980s as a result of the Griffiths Report[28], authority was given to the administrators whilst delivery remained with clinicians. An atmosphere of mutual distrust persists between clinicians and managers. It is particularly noticeable in Trusts which are not performing well rather than those that are; the latter tend to be a more cohesive team. There is no unifying ethos across all disciplines. Little has been done to rectify this. There is not enough management by walking about and listening. The NHS remains stubbornly tribal.

A number of CCG Chairs reported difficulties in balancing their role as Chair and their responsibilities as practicing GPs. More should be done to support these clinical leaders. Continuing in practice should be welcomed as it strengthens the authority and credibility of the individual. Without the necessary support and headroom a similar problem emerges where Chairs are managing rather than leading their CCG.

There remains tension between CCGs and provider organisations. In part this is due to the fragmented nature of commissioning (a single hospital for example will have multiple commissioners of the same service). More should

[28] The Griffiths Report, (October 1983), http://www.sochealth.co.uk/resources/national-health-service/griffiths-report-october-1983/

be done to encourage greater collaboration and integration of working between CCGs and providers. A good example of this is in East London where a strategic programme brings together providers of acute and mental health care with the local authorities, the three local CCGs, NHS England and the TDA. The publication of the *Five Year Forward* View creates an opportunity to rethink management structures and back office services. Co-location of different area management teams would be one way to achieve this, although for reasons of geography or historic credibility it may not be possible for all.

5 Performance Management

There is little differentiation between the good, the bad and the ugly. All Trust Chief Executives are paid similarly, although those in Foundation Trusts are likely to be paid more than those in NHS Trusts (executive salary tends to increase in larger NHS organisations). The NHS is unable to clearly state and identify in specific areas what they do well and what they could do even better; and this it seems makes the job of leaders even harder. For CCGs the differentiation is even harder to see.

In terms of remuneration CCG Chairs were able to negotiate their own salaries. Without the means to understand what areas are doing well and not so well there is no way to help share best practice, to drive up performance, or to understand if a salary is appropriate for an individual in a specific area.

The Review heard that a CCG scorecard is currently under development and this is to be welcomed.

Performance management of individuals is haphazard and weak. It is too often a form-filling exercise; staff are not held to account, praised and developed in equal measure. Done well, this is a good way to improve organisational performance or quality. There is work ongoing but it does not go far enough and is not embedded throughout the NHS. The 2013 NHS staff survey results stated that 84% of staff had received an appraisal while only 38% said that their appraisal had been well structured. This resonates with what this Review heard.

Performance management means thinking about how best to train, equip and assign the right people to the right roles; it should help managers and others plan their own careers and acquire the necessary professional skills. However, throughout the NHS the phrase 'performance management' when applied to individuals is synonymous with something negative; when it should mean a communication process that occurs throughout the year between manager and employee to support both the employee's and the organisation's objectives, it can equally be considered as a regular conversation on an individual's career development.

As a whole the performance management culture within the NHS is lacking: objective setting, reviewing, and clear lines of responsibility and accountability are absent. Agenda for Change should have addressed this but more work is

still required to embed this within local management structures. Moreover, due to the infancy of a thorough performance management system in the NHS there appears to be a lack of a transparent 360 degree feedback system.

There is suspicion throughout the NHS, quite understandably, that as performance management is not consistently applied, it becomes a case of *why to me and not to them*? How often individual managers, units, wards request feedback for their staff from patients is unclear.

Closely related to performance management is talent management. There is no central talent pool or NHS-wide structured talent management scheme in place. This is the case for general management, for clinicians and for both Trusts and CCGs. The creation of a talent pool on a national scale has been attempted by the NHS on a number of occasions; clearly one size cannot fit all NHS organisations; but there must be a rational attempt to improve what there is now. While there is currently greater emphasis being placed on developing and 'spotting' talent in Trusts this report has less concern in this area than in the commissioning sector where there is not such a large pool of individuals to draw upon. There is no lack of talent here, rather there is no longer a joined up approach to both talent and succession planning. Encouraging greater flow of individuals between provider and commissioner organisations would utilise this untapped talent.

Talent cannot be managed without a single competency framework for all NHS staff. There isn't one. This absence, combined with the lack of a systematic appraisal, makes development and deployment of key talent almost impossible. Consistent use of competency frameworks and appraisals help set standards. Throughout the NHS there appears to be a marked lack of holding people to account for their performance. The NHS is still seen to routinely move staff upwards or sideways, not out, even when they're not performing. This must stop.

Clinicians contributing to this Review felt they were treated differently from general managers in that they find themselves under greater and more stringent scrutiny. Moving a poorly performing manager essentially rewards incompetence or semi-competence; although it is extremely difficult to sanction or remove a clinician, the stakes are high for that individual (he or she can be struck off the medical register). There is a need here to level the playing field.

At Board level, performance management is also vital. The quality of Non-Executive Directors (NEDs) on Trust boards appears highly variable as do lay members of CCGs. NHS Trust NEDs receive comparatively poor pay and are required to commit significant time to the role particularly in comparison to those working in a Foundation Trust. For NHS Trusts the current rate for NEDs is £6,157 and for Chairs between £18,621 and £23,600 depending on turnover. These rates can be increased by the Secretary of State for Health on an exceptional basis. Foundation Trusts are able to set their own levels of

remuneration necessary to successfully fill their posts. This means that though many NEDs are of a high calibre and are dedicated to their role, the NHS is mostly limiting itself to those with time to devote to the task; these people are often retired and sometimes lack currency in day-to-day management. This is particularly pronounced in NHS Trusts and CCGs, where there is a real need to make these roles more attractive.

There is a lack of clarity about the value NEDs bring. The key question is: *are they holding Trusts to account*? Many seem diligent; but how can their expertise be better shared across the system? How can it be amplified? NEDs need to see beyond their own institutions. This is difficult given the commitment to an individual institution and the fragmented structure of the NHS. The story is similar for lay members in CCGs.

The lack of performance management and talent management has three severe consequences for the NHS.

- First, management cannot improve without the means to do so. Yet there appears to be an embedded reluctance in asking for help; support is viewed as a weakness. There are instances of bullying in this area. There are few role models (particularly in medical management) and not enough shared leadership practices (for example, some of the best leaders leave around 30% of their time

unscheduled so that they can walk around, listen and know and understand what they are driving).

- Second, there is a chronic shortage of good leaders in the NHS. Leadership can be taught and learned. Bringing into the NHS people at higher levels is not the whole answer. Rather the NHS needs greater *diversity* by bringing people into leadership at all levels.

- Third, management standards are not recognised or applied across the organisation. For example, there are obvious inconsistencies in simple practices, systems and communication across wards and hospitals. For instance, there is a wide difference in the quality of notice, patient and ward communication boards, patient documentation, IT systems and nurse staff uniform colours.

Performance management should relate to an organisation's values. But for the NHS, there are many competing values: the NHS is stuck in a circle of *finance - quality - safety - efficiency* as operational priorities. All should be classed as an NHS priority equally. Performance must be managed throughout by means of a more balanced scorecard.

6 Bureaucracy

In 2013 *The regulation and oversight of NHS Trusts and NHS Foundation*

Trusts promised:

> "In [the] future, this division of roles will be simpler and clearer: the Care Quality Commission will focus on assessing and reporting on quality and Monitor and the NHS Trust Development Authority will be responsible for using their enforcement power to address quality problems[29]".

However, the NHS is drowning in bureaucracy. This is evident at all levels. There are two reasons for this: first, the NHS is too vertically structured; and second there are too many regulatory organisations making too many reporting requests.

The number of oversight bodies has grown as the NHS has become more fragmented and more distant from Government. Each of the bodies responsible for monitoring and compliance (eg CQC / Monitor / TDA) has its own mandate; each issues its own demands for data as well as requests directly from CCGs. This has spawned an industry of data collecting. Requests for data are often made regardless of whether the data has been collected in a different format elsewhere and irrespective of the impact on daily business. Regulators appear to be in overdrive and whilst some of this is understandable there needs to be a renewed focus on the sharing of information between regulators and for their perspective to change to consider outcomes rather than inputs.

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[29] *The regulation and oversight of NHS Trusts and NHS Foundation Trusts (May 2013), www.gov.uk/government/uploads/system/uploads/attachment_data/file/200446/regulation-oversight-NHS-trusts.pdf*

Requests to Trusts from CCGs are often the product of a central (DH/NHS England) demand. Requests made in this manner put needless strain on all areas of the system from Trusts, CCGs and indeed NHS England area teams.

It is a commonly held belief that there are one too many oversight bodies and the findings of this Review support that view. This was also the view of the Francis Report and the thrust of one of its recommendations. Since then CQC, Monitor and NHS TDA have built closer working relationships, but there is still some way to go[30].

Monitor's role as a health service oversight body is to ensure NHS Foundation Trusts are well-led and that essential services are provided should a Foundation Trust get into difficulties, it also has a wider remit as the sector regulator. The NHS Trust Development Authority provides a similar role to NHS Trusts, overseeing their performance and governance, as well as progress toward NHS Foundation Trust status. These two bodies operating as a single oversight body would significantly clarify the NHS regulatory and accountability structure.

The Review notes that the influence of targets, regulators and inspectors is seen as ubiquitous and wearing. Bureaucratic reporting has made both individual Trusts' and the NHS' views short-term. And if short-termism also

[30] *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry,* (6 February 2013), www.midstaffspublicinquiry.com/sites/default/files/report/Volume%203.pdf Recommendation 19 – There should be a single regulator dealing with both corporate governance, financial competence, viability and compliance with patient safety and quality standards for all trusts

means the lack of a long view, it is an unintended consequence of the lack of a strategic intermediary; the disappearance of the Strategic Health Authorities means there is no one to lead any region in a collaborative reconfiguration over the longer term.

Although it has been suggested that CCGs should undertake this important role, it would be unreasonable to expect that most of these relatively new organisations have capacity or authority to do so – at least for now. This means that a significant gap in regional leadership remains; many continue to mourn the loss of SHAs.

Too much is being done by numbers. Within the NHS, everyone is managing upwards by means of complying with data requests; for good leadership to flourish, they should be delegating downwards. People need to be and to feel trusted beyond compliance.

7 Balkanization of Trusts & Silo Working

There are currently 211 CCGs, 158 Acute Trusts, 10 Ambulance Trusts, 51 Mental Health Trusts and 31 Health and Care Trusts as part of the NHS federation as well as a myriad of other providers of care. The landscape of this federation has become fragmented in terms of both the numbers and activities of Trusts; within many Trusts silo working is endemic. This means that any activity within a Trust is horizontally separated from the same activity in other Trusts and vertically separated from other activities in its home Trust.

The same is true for CCGs, where there is a need for greater local and regional collaboration. Yet collaboration is more difficult in an environment that has been designed to create competition. Better communication between Trusts and CCGs would help reduce fragmentation of the landscape. There are too many "city-states" and not enough cooperation between them.

The current Trust system is inimical to collaboration; it is not a proper open market as Trusts cannot share with each other commercial information such as price with their suppliers. While their suppliers have a complete picture of the commercial territory. All recent reforms have been about devolving the system. Now there is no one system leader; so all are vying for territory. The loss of the Strategic Health Authorities, for example, means there is no mandate for system leadership, and no eye on what is happening across the system.

The Review heard that the system is creaking and that competition is causing harm, even that there has been too much competition. It is notably absent from the *Five Year Forward View*. Foundation Trusts have been a good development, but left to their own devices and without a framework for competition and cooperation, they are part of a system that is dangerously centrifugal. There is a need for a new balance between competition and cooperation to be considered for the good of the patient and for good practice to be more widely shared.

There are two classes of Trust. The rich have got richer and the poor poorer.

Big has become beautiful and bigger Trusts are becoming richer and therefore more successful with few exceptions. There is no predisposition to close that gap.

Given that Trusts tend to work in isolation from each other, Chief Executives reported the difficulty in being given the room to make decisions that benefit their *regional* health economy but are against the Foundation Trusts' (in particular) best interest. In some cases, the best decision in local health terms has exposed the Foundation Trust to scrutiny from Monitor.

Trusts are resolutely separatist, silo organisations; often they think tactically rather than strategically. They are therefore not keen to lend out staff, and consequently both the individual and the organisation feel unable to grow (this is a particular problem at middle management level). Chief Executives expressed concern over the challenge of taking on the more difficult Trusts: they saw them as isolated outposts with no central protection.

There are a number of notable collaborations[31] within the commissioning landscape in particular in and around London. The NHS must consider these, and other, areas of best practice and look to share and disseminate lessons learnt. There is no place in the vision outlined by the *Five Year Forward View* for individualistic, separatist Trusts and CCGs.

[31] For instance http://www.swlccgs.nhs.uk/ and http://integration.healthiernorthwestlondon.nhs.uk/,

In summary

First, change in the NHS is constant, at times radical, unwelcome and uncertain. Second, over time the NHS has become more devolved, more market-like, more local, more distant from the Department of Health, and hence more fragmented. Third, patients have a greater voice, as do regulators like the CQC and Monitor; each with their own priorities and demands.

These three clear observations place huge demands on NHS staff, on doctors, nurses and administrators alike. None are fully trained or equipped for the extra uncertainty brought about by constant change, the extra complexity brought about by the proliferation of NHS Foundation Trusts, the introduction of CCGs and the increased demands for data and performance metrics brought about by a regulated approach.

This has produced a critical leadership tipping point in the NHS. This point has coincided with a set of internal and external challenges. The answer is not more management but better leadership; not more attention to resources but more focus on how to handle change and uncertainty. The NHS is operating with unprecedented levels of demand, and with limited funding, and its people are under pressure not previously felt. There is an undeniable and urgent need for all NHS leaders to be more visible and to be seen as embodying the culture and values of the NHS. A value-based leadership culture is noticeably absent.

There is a feeling of too many undoable jobs; of over-stretching targets given the available resources; of no time or space ("bandwidth") to think; of limited available mentoring and support; and of the intense scrutiny (top-down command and control, even comments of bullying) that is stopping staff (all types: nurses, general managers, doctors, specialists) wanting to take on extra responsibility and leadership roles.

Managing and leading in the NHS is now harder than ever; the capacity for managers to think through strategic changes and embed them is limited. There is constant fire-fighting in a data-hungry environment closely governed by targets set and monitored by regulators and inspectors. This has led to a high degree of bureaucracy and upward management which is time-consuming and often distracts leaders from focusing on patients.

The complexity and requirement for continuous reporting has caused distraction from delivering the big picture. There is a preoccupation with targets. Data collection in acute Trusts is not always appropriately managed, and there is little Board oversight. Furthermore the NHS has moved from a space of too much 'underlap' pre-Francis where one regulator assumes another is dealing with the data, to a place where there is too much overlap and duplication.

Unfortunately this is compounded by the three prominent staff groups "the triumvirate" of disciplines (Nurses, Doctors and General Managers) who often

do not understand each other's priorities. Despite the importance of clinical leadership a gulf remains between clinicians and managers; it can be hard to get clinicians to sit around a table and be accountable for the organisation as a whole.

Imagine an organisation where everyone understands and values the role of others, however seemingly small; where the main effort is clear; where local variations can apply without bureaucratic censure; where people trust each other and seek to be trusted; where delegation, training and personal and professional growth are seen as aspects of the same thing. This is what an organisation with effective leadership looks like. It is an organisation equipped both for long-term planning and also for the immediate uncertainties and complexities required of any group of people (especially a large one) that seeks to provide the full range of health care to a large and changing population.

A lack of cohesive leadership will produce an organisation where relations between staff and patients are merely transactional, doggedly contractual, obsessed with data and lacking in innovation and inspiration.

There is no less capability or capacity in the NHS than in the private sector; this Review addresses the question of how to harness them so people can give their best. The NHS has all that is needed to be an extraordinary organisation in which values produce the leadership qualities and behaviours necessary for it to thrive in the future.

Recommendations

The Review's findings shaped its seven main themes. These strategic elements are common to any organisation that seeks to achieve anything remarkable; there must be a shared vision; attention must be paid to people, and those people must be helped, guided and assessed in their performance. These themes flow through everything that is recommended here, and have a bearing on the success of all the recommendations. Most importantly, two conditions (R1 and R2) are a necessary prelude to all the recommendations. These are simple yet profound, and they set the scene for success.

1. First, *the NHS needs a collective vision.* A federation as large and plural as the NHS cannot afford to be disjointed. It must think collectively and act locally. The NHS is full of very good people, but it must do more to communicate and share good practice, celebrate success and foster a united ethos. There should be a concentrated effort to create a communications strategy in order to do this. Focusing on the positives within the NHS will bring up and drive out the negatives (it tends to be counter-productive to focus too much on negative behaviour). A collective effort depends on a collective understanding.

R1: Form a single service-wide communication strategy within the NHS to cascade and broadcast good (and sometimes less good) news and information as well as best practice to NHS staff, Trusts and CCGs.

2. *The second prerequisite condition is cultural. The NHS needs to create a values-based culture*. A large and complex organisation can be made more effective if all of its people behave in ways that are ethically consistent, and in ways that show they share the same values and base what they do on those values. There is already the ground work for this: the NHS Constitution includes a Staff Handbook, and Trusts communicate the NHS values contained within it in a variety of ways. But there needs to be a consistency in approach. Values must be easily and quickly understood across the NHS. Great leadership must be understood and fostered in staff at every level; the three military services are good examples of how this can be achieved across an organisation. A new and more visual format will promote this.

R2: Create a short NHS handbook/ passport/ map summarising in short and/ or visual form the NHS core values to be published, broadcast and implemented throughout the NHS.

The Review's further recommendations fall into four practical areas. **Training (R3-R8), Performance Management (R9-R11), Bureaucracy (R12-R16), and Management Support (R17-R19)**. In practical terms, the Review recommends what can and must be done. These areas are inter-related: the first two focus on providing what is not yet there, and the last two on removing barriers to great performance and effective, satisfying work.

Every one of these recommendations is aimed at supporting staff and patients of the NHS. They are practical, realistic and sometimes pragmatic: in a word,

commonsense. They have to work for all concerned, and are designed to make people's jobs easier, to release potential, and to optimize performance.

There is some overlap between them but this is only in terms of impact; something to be expected in a complex organisation such as the NHS. Some of these recommendations are strategic, others are tactical and operational. There is no recommendation to do nothing: in fact, the risks of inaction (although this can be a proper decision in some circumstances) are considerable. The Review urges that 2015 must not be yet another year when these much needed changes are left undone.

Training (R3–R8)

3. *The NHS needs a central body to coordinate its training effort and resources*. The NHS is a federal organisation. The performance of its management depends on its capacity and ability to set and maintain standards in management, to set and support the right kinds of behaviour, and to share across the organisation those things that it does best. Performance management of individuals must link to core competencies, values and objectives with time set aside to discuss and central oversight of this. Support and training needs to be given at all levels to do this. There are a number of places that these universal competencies could be taken from including the CQC 'well led' competencies or the NHS Leadership Academy's Clinical Leadership Competency Framework. Other organisations that achieve this do so by concerted training overseen by a centre that can

coordinate what things are taught, why they are taught, and where and how they are taught. Without such a body and the clarity it must be charged with bringing, the NHS is at extreme risk of wasting management effort and resources. In order to make training consistent, replicable and responsive across the organisation, such a body would be responsible for a consistent training regime across clinical, administrative and nursing / ancillary disciplines. Moreover, such a training body should be set up to be alert and sensitive to changing needs, and should have at its core a 90-day cycle of training requirement set by a body of more junior or middle-ranking staff: their body informs the core what their staff training needs are, and in 90 days the core reports back; in a further 90 days, the training must be in place.

R3: Charge HEE to coordinate the content, progress and quality of all NHS training including responsibility for the coordination and measurement of all management training in the NHS. At the core of this is a 90-day action cycle. HEE must promote cross-functional training in all disciplines and at all levels, coordinating the teaching of management basics such as appraisal, motivation, negotiation and leadership.

4 *People must be equipped for the changes the NHS has asked them to make.* There has been enormous change in the NHS in the last two years. This has come at a time when catalytic change has been the only constant. Yet little has been done to equip people either personally or professionally to manage change and to make themselves properly able to do what is asked of them. The NHS must help its people manage their performance by moving

towards a single competency framework – with one locus (not necessarily a central establishment) of delivery. There needs to be a single training hub to co-ordinate all aspects of training for all individuals across the NHS. There are valuable examples across the military (much could be learned from the Joint Services Command & Staff College, for example). Training must take the form of competencies across all disciplines: leadership, project management, finance, negotiation, motivation, and HR etc. To work, it must be consistent. There must therefore be a single body responsible for the coordination of all training levels, including management training in the NHS.

R4: Move sponsorship of the NHS Leadership Academy from NHS England into HEE.

5. *It is important to maintain quality, pluralism and innovation in training courses,* These should be available in various locations across the country. Training courses should have status, appeal and impact for those staff taking them; they should also be substantial enough to allow people time to reflect on what they have learned, and to form cohorts with their peers. For the NHS these courses should be diverse, accredited, and flexible. This form of collective and action learning is invaluable in developing both individual and organisational competence.

There should be greater diversity of training programmes, some directed at specific organisational needs, such as those working in the acute sector or in the commissioning sector. Others should be directed at increasing collaboration across the sectors bringing together leaders from a variety of

sectors such as local government, Public Health, acute, commissioning and primary care.

R5: Include accredited/ nominated training establishments as part of a diverse training effort.

6. *The graduate scheme is woefully small and under-powered.* The scheme needs to be reviewed, refreshed and extended tenfold with larger numbers of individuals joining each year. To produce managers who see the bigger picture across the NHS, a wider range of postings should be undertaken (NHS acute, mental health, ALBs, CCGs) with an assessment necessary at the end of the tenure to ensure consistency of standards; this approach might better support a flexible and innovative programme of graduate recruitment.

R6: Review, refresh and extend (x10) the NHS graduate scheme; establish career pathways, a greater variety of placements and a guaranteed job after three years' training (quality and assessment permitting).

7. *As managers progress, they must be supported by being exposed to the learning they need in order to do their job*; this learning must of course be current, but equally it should be maintained, such that there is little "skill fade" or stagnation. Exposure to other forms of management and leadership, in other sectors, would be of great benefit.

R7: Refresh middle management by training and a more porous approach both from within the NHS and externally (recruitment from, and secondment to, other sectors).

8. As management is identified and nurtured from within the NHS, and encouraged from outside the NHS, *standards must be maintained and benchmarked against internal and external data*. This is not a call for new measurement or burdensome reporting, but an answer to the need for consistency in performance across all Trusts. One way of achieving this is by an accredited qualification. This has two benefits: external talent can measure itself by qualifying for entry into the NHS management cadre; internal talent can, by registering for and passing this checkpoint, begin to form a *talent pool* on which the entire organisation can draw.

R8: Require senior managers to attend accredited courses for a qualification to show consistent levels of experience and training have been reached across the NHS. On completion of this course they enter a senior management talent pool open to all Trusts.

Performance Management (R9-R11)

9. *It is crucial for the future of the NHS that it creates and supports a cadre of capable, trained and current managers from all disciplines and increases its level of cultural diversity to better reflect its staff.* In order that its training effort can be rational and effective, the NHS must identify and

broadcast core management skills and competencies across the organisation and expectations for delivery at clearly structured management levels. The NHS must begin cross-disciplinary (doctor, nurse and administrative) leadership and management training earlier in individuals careers.

R9: Set, teach and embed core management competencies and associated expected behaviours at each management level.

10. As a consequence of a more highly trained and self-aware management cadre in the NHS, with recognised and developed competencies, *there will be a need for some form of through-career support* to guide individuals as they progress. Individuals should be encouraged to increase their personal accountability for their training needs. Existing talent must therefore be identified and nurtured: More resource should be applied to the development of all management careers in the NHS. Training gates / experience points should be established as part of career progression. A widespread HR programme of talent-spotting, mentoring, networking and inside/outside secondment should be established.

R10: Establish a mechanism for providing on-going career support for all those in a management role allowing individuals to increasingly take charge and identify their own developmental needs.

11. In step with a more rational training programme, better career handling, and recognised leadership and management competencies, *the ways in which people give and receive praise or encouragement or advice need to be codified and made more uniform*. The Review noted that there is little

consistency in how appraisals are conducted, and this must be addressed urgently; this is in part to support the one vision of the NHS (inculcating NHS values into the training and appraisal environment), and in part so that everyone can reasonably expect the same from their appraisal, process wherever they work[32]. The best leaders give *feedback that is both constructive and thought- provoking*. Both positive and negative feedback should be descriptive – given with openness, transparency and candour. This should be built into any new framework.

R11: Establish and embed an NHS system of simple, rational appraisal (a balanced scorecard for individuals) supported by a regular course in giving and receiving appraisals as part of the core provision of the single training body. At a senior level, these appraisals should be standardised across the NHS.

Bureaucracy (R12-R16)

12. *There is an unnecessary burden of bureaucracy*: the NHS is justified in its complaints that there are too many organisations asking for similar returns of data for compliance and monitoring purposes. Reviews have looked into this before (the latest by HSCIC) but they need to go further. There is a need to move from a system where information is *pushed to the centre* to a system where information is *pulled from the centre.*

[32] *NHS Staff Management and Health Service Quality* , Michael West and Jeremy Dawson www.gov.uk/government/uploads/system/uploads/attachment_data/file/215454/dh_129658.pdf , Shows that a good appraisal correlates to lower levels of patient mortality and increases staff engagement

R12: Review the data demands of regulators and oversight bodies; these can then be rationalised and harmonised in order to produce consistent, clear and simple reporting that does not distract staff from patient care.

13. *Clarity is needed within the NHS's accountability and regulatory structure*: bringing together the two current oversight bodies the NHS TDA and Monitor would significantly contribute to this. While any further structural reform needs to be fully justified, the publication of the *Five Year Forward View* provides a stimulus to consider the future oversight model for the NHS. Furthermore, a review of the TDA is now due, as when originally established it was agreed that there would be a review into its continued existence within three years[33]. In the past there may have been good reasons for viewing Foundation Trusts and NHS Trusts differently. However, given that both sets of organisations now display a wide range of performance, it makes sense if support is provided by a single body which has the necessary breadth of experience, staff and contacts.

R13: Merge oversight bodies, the NHS Trust Development Authority and Monitor.

14. *There is an urgent need to improve the management environment by cutting bureaucracy*. As part of an initiative to make the NHS less bureaucratic, and to clean out its attic, the whole organisation needs to undertake an effectiveness review to simplify, standardise and share best

[33] http://www.legislation.gov.uk/uksi/2012/901/memorandum/contents

practice. Further, there is a need for a 'good housekeeping' review of necessary / unnecessary data returns to be taken periodically and an effectiveness review to take place to simplify, standardise and share best practice in data management. Committee work and administrative burden must be lessened. Non-Executive Directors in Acute Trusts would be well placed to consider the level of reporting requested and to communicate concerns around feasibility of requests to the organisation concerned. They could also be instrumental in considering the level of data needed to discharge their duty in holding the Trust to account.

R14: Spend time on a regular basis at all levels of the NHS to review the need for each data return being requested and to feed any findings to the Executive and Non-Executive Teams to review.

15. *The NHS must know how to recognise the good, the bad and the ugly*: this can be achieved by annual appraisals and merit awards, all matched against a single vision and ethos. The NHS requires a *consistent balanced scorecard* in which each critical area is given equal prominence. Through enhanced performance management at all levels and in all disciplines, the NHS should be able to identify both the good and poor performers and be able to seek new ways of working together to accomplish strategic goals.

R15: Establish and maintain a clearer system of simple rational appraisal (balanced scorecard for the organisation).

16. This Review has commented on the specific level of data burden felt by Trusts from data requests from CCGs. Many of these requests are driven

directly by NHS England and the Department of Health (DH). A greater level of independence and power should be given to CCGs by means of an accountable SRO (at either Director of Commissioning, Chief Information Officer or Caldicott Guardian level) for ensuring that data requests are not creating additional burden on the system and are necessary and proportionate. It would be their responsibility to ensure that for each data request a Burden Impact Assessment had been produced by the initial requestor (NHS England or DH) and to share it on demand from a Trust Board when discharging their duty to review all requests.

R16: Health and Social Care Information Centre (HSCIC) to develop an easily accessible Burden Impact Assessment template and protocol.

Management Support (R17-R19)

17. *The NHS must simplify, standardise, and share best practice*. The NHS can and must make use of its diversity and scale by sharing experience and best practice. People must be able to talk between Trusts, organisations and across distance. This will break down barriers between organisations, inform managers, doctors and nurses, and above all benefit patients by bringing the collected wisdom of the organisation to bear on their treatment. This will make the spread of best practice more consistent, more urgent, and more speedy. Individual NHS organisational identities should not shirk sharing

between one another, and between sites; nor should they be a barrier to asking for help.

R17: Create NHS wide comment boards. Websites and supporting technology to be designed and implemented to share best practice.

18. Some senior managers and senior leaders will be attracted to turning around poor Trusts. *The NHS needs a team of turnaround specialists ready to apply their expertise to failing Trusts – an elite cadre of known and trusted individuals* implicitly trusted by the regulators, and paid centrally. In order to do so, they need time to assess the situation, assemble their team, and execute their strategy. In order to give good leaders the headroom and protection needed to take on the more challenging Trusts the TDA and Monitor should consider creating a shared resource of individuals willing to be on two year fixed term contracts able to work in an agile manner, deployed to a variety of Trusts.

R18: Set minimum term centrally held contracts for some very senior managers subject to assessment and appraisal.

19. *Trust boards, their Non-Executive Directors and CCG lay members must be better trained.* Research by McKinsey & Co across 770 companies in commercial and not-for-profit sectors showed that better performing boards spent over twice the amount of time than poorly performing boards when it came to talent management, performance management and strategy[34].Trust Executive and Non-Executive Teams require a training programme to allow

[34]McKinsey Quarterly (2014, Number 2), McKinsey and Company, www.mckinsey.com/~/media/mckinsey/dotcom/insights/sustainability/mckinsey%20quarterly%202014%20number%202%20issue%20overview/mckinsey%20quarterly_2014_number%202.ashx.Page 14

them to develop as a cohesive group of leaders. Consideration must be given to increasing the base level of remuneration as standard across NHS Trusts in order to increase the number of potential candidates. This is the same for CCG lay members. The time commitment of Non-Executive Directors and lay members can be extensive, and there is a need to review the expectations of a NED, or the way in which they are brought into the organisation. For instance a single NED job could be shared between two people, shorter terms of employment could be examined or a system of volunteer NEDs from other parts of the health service or other sectors could be considered. There is a role for Boards in Leadership Development and this should be fully explored. A talent pool of potential NEDs and lay members should be considered for the future.

R19: Formally review NED and CCG lay member activity (including, competence and remuneration) in line with the CQC Well Led initiative; and establish a system of volunteer NEDs from other sectors.

Acknowledgements / References

Acknowledgements

The questions asked of me by the Rt Hon Jeremy Hunt MP

- What more could be done to attract top talent from within and outside the health sector into leading positions in NHS hospital Trusts, and;
- How strong leadership in hospital Trusts can be used as a force for good to transform organisational culture

were by necessity wide ranging and focused on acute Trusts. However during the course of my review I found that leadership challenges in the NHS are not confined to these areas alone. I therefore welcomed the request to consider the whole system, following the publication of the NHS's Five Year Forward View.

I hope that my recommendations can be taken as a blueprint going forward for the NHS as a whole, whatever part of the system.

Over the course of the Review, I have had the opportunity of visiting many health care organisations across the length and breadth of the country, including Foundation Trusts, NHS Trusts, Mental Health Trusts and CCGs.

In each location I met with many enthusiastic, dedicated and passionate people, administrative, medical and nursing staff at all levels. These people work incredibly hard and through difficult times, yet were prepared to find the time to meet with me and openly share their thoughts and views on leadership across the NHS. They have helped shape this review and their contributions have been invaluable.

I have met with a number of health sector experts, too many to name here but I would like to thank them all, including those from the Kings Fund and the Nuffield Trust, for giving their considered opinions.

I would like to thank the Care Quality Commission, Monitor, Health Education England, NHS Leadership Academy, Trust Development Agency, NHS England, NHS Confederation and the Foundation Trust Network.

I must also acknowledge Sir David Dalton (Salford Hospital), Sir Robert Francis QC and those individuals from the Shelford group. The wealth of experience and understanding that they shared with me has been instrumental in delivering this review and they each have provided me a valuable insight into the intricacies of the NHS.

Andrew St George (Aberwyswyth University and Cass Business School) has been my source of broader knowledge and information on leadership challenges and has been key in bringing together this report; my thanks go to him.

Lastly thanks must be given to officials at the Department of Health who have been a great source of support, guidance and knowledge to me during this process, to David Thorpe and especially Joanna Edwards who was a tireless source of help and coordinated the many moving parts of this report.

Thank you to each and every individual from the organisations below and their patients who gave their time so generously to speak to me individually and in roundtables. Your insights were invaluable.

Airedale NHS Foundation Trust
Hampshire NHS Foundation Trust, Basingstoke Hospital
King's College Hospital NHS Foundation Trust
Medway NHS Foundation Trust
Sherwood Forest NHS Foundation Trust
Buckingham NHS Trust, Amersham Hospital

Birmingham Children's Hospital NHS Foundation Trust
Calderdale and Huddersfield NHS Trust
North Cumbria Hospital visit
Hertfordshire Partnership University NHS Foundation Trust
Camden CCG
Waltham Forest CCG

Dr Charles Alessi (NHSCC)
David Behan (CEO, Care Quality Commission)
David Bennett (CEO Monitor)
Ian Cummings (CEO, HEE)
Sir David Dalton (Chief Executive Salford Hospital, author of the Dalton Report)
Giles Denham (DH Director, Leadership)
Dr Michael Dixon (Chairman NHS Alliance)
Nigel Edwards (Chief Executive, Nuffield Trust)
David Flory (CEO, TDA)
Sir Robert Francis QC (Author of the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry)
Sir Malcom Grant (Chairman, NHS England)
Dame Barbara Hakin (COO & Deputy CEO, NHS England)
Professor Aidan Halligan (NHS Staff College)
Professor Chris Ham (CEO, Kings Fund)
Chris Hopson (CEO, FTN)
Professor Sir Bruce Keogh (Medical Director, NHS England)
Sir Alan Langlands (Vice-Chancellor University of Leeds)
Clare Marx (President, Royal College of Surgeons)
Dr Keith McNeil (CEO, Cambridge University Hospitals)
Dame Gill Morgan (Chair, NHS Providers)
Sir Robert Naylor (CEO, University College London Hospitals NHS Foundation Trust)
Sir David Nicholson
Una O'Brien CB (DH Permanent Secretary)
Professor Sir Mike Richards (Chief Inspector of Hospitals, CQC)
Ed Smith (Deputy Chairman, NHS England)
Dr Julia Smith (NHS England)
Jan Sobieraj (Managing Director, NHS Leadership Academy)
Simon Stevens (CEO NHS England)
Rob Webster (CEO, NHS Confederation)

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The King's Fund Ideas that change health and care

Mr Shane Devlin
Mrs Vivienne Toal
Dr Maria O'Kane

22nd February 2021

From the Chief Executive

The King's Fund
11-13 Cavendish Square
London W1G 0AN

Tel 020 7307 2400
www.kingsfund.org.uk

Dear Shane

Re: Support for the senior management team/board

Thank you very much for your time over the past fortnight; it was a pleasure to meet you all. I am now writing to provide a summary of what we jointly proposed and to set out our terms. These are enclosed.

If you are content with the proposal and terms, I would be grateful if you could email me to confirm that you wish to proceed on this basis.

Kind regards,

Sally Hulks
Senior Consultant, The King's Fund

The King's Fund: Proposal for Southern Health and Social Care Trust, Senior Management Team/Board support

Your requirements

The King's Fund last worked with the Board of the Southern Health and Social Care trust in November 2018. Since then the trust has experienced an extraordinarily challenging time, largely as a result of the extreme pressures of the pandemic, but also with other serious clinical issues, which in turn generate high levels of scrutiny, plus ongoing changes in senior personnel.

The pressure of leading through Covid-19 is ongoing and unlikely to subside fully for some time. Nevertheless, the new Chair has taken up her role recently and, whilst there will be further Executives retiring shortly, it seems important now to pause, give time to taking stock as a leadership team, to reconnect with each other, in order to lead the organisation forward. There is a need to explore collectively your approach to leading the wider team into the next phase, how best to continue to drive a culture which focuses on safety and quality in the current context.

You have suggested the work starts with two pieces of support:

Commented [WS1]: Is there potential for phase 3 which might be the 3 elements below

1. The provision of 1:1 coaching for Directors who would like to take up the offer;
2. 3-4 half-day or full day-workshops for the Senior Management Team (SMT) and the full Board;

The focus of the workshops will be informed by initial 1:1 inquiry conversations with each member of the Board.

Anticipated Outcomes

As an output of the proposed engagement it is envisaged that the Board members will be in a position to commence developing plans to strengthen leadership within the Trust to support and drive an culture of safety and quality that will include:

- Strengthening service-level thinking for improvement including developing integrated collective leadership structures
- Regaining the ability to refocus on medium and long-term goals that are strategically clear and develop meaningful frameworks for decision-making
- Developing internal structures that can proactively develop longer term initiatives in response to the changing health and social care environment, including the ability to review and adapt these plans and strategies to make sure they remain relevant and achievable.

Our approach

Coaching provision

The King's Fund has a team of qualified executive coaches on our permanent faculty and within our associate network. Below I have listed the bios of coaching colleagues who would be delighted to work with your Directors; we ensure everyone has choice in who they work with. Our costs per coaching session are set out in the Fees section below. We suggest a set of 4 sessions, each 1.5 hours via Zoom, as the initial commitment.

Inquiry interviews

We recommend a core team of two King's Fund faculty to lead the work with the SMT and the Board: i) George Binney, who has a wealth of experience working at senior levels across health and care sector; and ii) Tricia Boyle, who worked with you previously and can act as the golden thread to look back/forwards and retains a sound understanding of your specific challenges. Their bios are listed in the section below.

Given the pandemic has forced the senior team to work relentlessly on operational delivery issues within their own areas of responsibility, at the expense of time spent working together, we suggest the work starts with 1:1 telephone interviews with each member of the Senior Management Team, plus other Board members, as appropriate, in order to hear each person's perspective on priorities and energy for the work. The interviews would be conducted by George and Tricia via telephone/Zoom and take 45 minutes per person.

Workshops with SMT and full Board

The inquiry, facilitated by George and Tricia, would inform the focus for an initial 3-4 half-day or full-day workshops, taking place bi-monthly, perhaps starting with the SMT, if helpful, and then extending to the full Board. In the Fees section below, we have costed one full-day workshop by way of example.

You want the process to provide space to reflect carefully on the past year, to understand how each of you feels, given the demands that have been made of you, to explore what it takes now to lead the Trust forward. Your aim is to reconnect with the Trust's purpose, values and behaviours that have been stretched under recent pressures, to ensure you can go forward collectively to reengage the wider leadership and lead in ways which create a psychologically safe environment for all, to explicitly support a culture of continuous safety and quality improvement.

Logistics

- Platform – Our preferred platform for delivering virtual group sessions is Zoom because of the enhanced functionality it offers over MS Teams. Your team members would need to be able to access Zoom from a suitable device in a quiet location.

- Administration – We will provide Zoom links ahead of each session and technical support during the sessions, as appropriate.

The team

The core Faculty team

George Binney, MA, MBA, Barrister

George is an experienced coach and a long term, confidential adviser to a number of senior people in business, the voluntary sector and the Department of Health and Social Care. He specialises in working with powerful women who are in senior leadership roles.

He started his career in business, working as a finance manager and director in GEC and Courtaulds and a consultant for McKinsey & Co. In the last 20 years he has focused on helping senior professionals – doctors, scientists and lawyers – become more effective leaders. Between 2008 and 2018 he was the Ashridge Director of the National Institute for Health Research's Leadership Programme. He also led Ashridge's leadership development and research strategy work with the World Health Organisation. George is an Associate of The King's Fund.

He has:

- Worked with an NHS Trust chief executive and her executive team to help develop the sense of common purpose
- Supported the chief executive of a Government agency by acting as a mediator and resolving tensions between board directors.
- Helped many doctors and scientists to make the transition from "expert" to "expert and leader"
- Supported the development of common cause among a dozen senior individuals leading development, internationally, across a number of health organisations.
- Has advised a number of chief executives on succession planning.
- Coached participants in the Health Foundation's 'Generation Q' Programme to develop leaders of service and quality improvement in the Health Service.
- Has also done extensive individual and group development work in leading international law firms and in commercial companies like Anglo American, Nokia and Reuters.

George is an accredited coach with Ashridge/Hult. He has an MA in history and law from Cambridge University, an MBA with distinction from INSEAD and is a barrister.

Publications

George has researched and written extensively on the realities of leading in large organisations. His books include *Leaning Into The Future*, *Changing the Way People Change Organisations,* Nicholas Brealey, 1995; *Living Leadership - A Practical Guide for Ordinary Heroes,* FT Publishing, 2012 and *Breaking Free of Bonkers - How to Lead in Today's Crazy World of Organisations,* Hachette 2017.

Patricia Boyle

Tricia is an experienced consultant and coach. She has 20 years' experience of external consultancy work in government departments, local authorities, voluntary and private sector organisations and 10 years' experience leading an internal consultancy team of organisational development specialists in a Scottish health board. She has worked extensively at board and senior management levels and with teams in difficulty, with start-ups, restructures and mergers. She has also delivered development in business-school environments to tailored and open, mixed organisation groups.

Tricia's work at The King's Fund includes directing the 'Leadership for Consultants' programme and the 'Care homes, housing, health and social care learning network' and Leading Breakthrough conversations programme. Current and recent consulting work includes the Blood Transfusion services the UK and Ireland, Kettering General Hospital, Manchester University Hospital FT, University Hospital Southampton, Surrey Heartlands CCG, Humberside, Leeds and Wakefield Primary Care systems.

Tricia's experience inside the NHS is extensive, working within and across acute, community and corporate divisions on service breakdowns and turnarounds, improvements and transformations, restructures and closures, new hospital building projects and service moves. She has worked in several Scottish boards by invitation of their senior teams to work on particularly challenging issues and geographies using dialogue methodologies to encourage constructive conversations for organisational change, turning around difficulties where there has previously been a chronic lack of progress.

Tricia's coaching work is focused on supporting leaders involved in change projects, assisting them to see themselves and the system as clearly as possible so that they can make proactive interventions and achieve successful service developments. She has coached chairs, chief executives and senior leaders in private and voluntary sector organisations involved in health and social care integration and in NHS and local authority organisations.
Tricia is an accredited Ashridge/Hult coach has a Masters degree in Organisational Consulting and is registered with the British Psychological Society in the use of psychometric instruments and is accredited in dialogue with the Kantor Institute

The coaching team

We also offer the bionotes of some of our team of Executive coaches.

Deborah Homa

Deborah is part of the leadership and organisational development team and has more than 25 years' experience in the health care sector. For the past 15 years, she has worked as a consultant and strategic adviser to NHS organisations and boards, most recently as a partner in an international consulting practice. She began her career as an NHS management trainee and has held director posts acute, commissioning and mental health organisations.

Deborah is passionate about supporting organisations to develop compassionate cultures that deliver high-quality care. Her interests include using occupational psychology and evidence-based approaches to develop leadership, OD strategy and OD interventions that make a demonstrable difference for staff and patients. She is experienced in team development and facilitation, and leadership and organisational development working with groups ranging in size from small teams to whole organisations.

Lindsey Masson MSC, BSc, DPM

Lindsey has been a coach and consultant for 25 years, working with a wide range of private and public sector clients. Lindsey previously led Ashridge Business School's Custom & Consulting business, and held a range of roles at Ashridge including Director of Executive Coaching. She particularly works in the areas of strategy development, change, leadership and one-to-one and team coaching. She has also been a tutor on Ashridge's Coaching for Organisation Consultants programme and Consulting and Change in Organisation programme. Lindsey coaches chief executives, directors, senior managers and high potentials across a wide range of sectors and on an international basis. She focuses on providing practical support that compliments both the individual and the organisation within which they find themselves working. Lindsey often finds herself coaching other female leaders, supporting them as they transition and helping them find their authentic voice in the organisation.

She is an Ashridge accredited coach and previously has been an Ashridge accreditor of coaches, as well as a developer and accreditor of coaches for BBC, British Airways and ADIA (Abu Dhabi Investment Authority).To support her practice, Lindsey has monthly supervision, she is Level 2 BPS qualified and uses psychometric instruments in her work as and when appropriate.

David Birch BA, PGCE, MSc, PG Cert Supervision

David is an executive and team coach, facilitator and supervisor who brings over 30 years' experience to helping individuals, groups and organisations make a difference to the world.

David's practice is founded on the understanding that change occurs within and through relationships. He combines expert coaching skills, psychological insight and creative embodied methods to help his clients explore the most pressing issues, however tricky and awkward they may be. His business background and professional training means that he is alert to the political and psychological dimensions of the work, enabling his clients to gain insight into their assumptions, motivations and impact on others. Over time, this builds the self-awareness and resilience needed to respond positively in what are often complex, emotive scenarios. He is comfortable working in a range of settings including retail, engineering, tech, creative, finance, healthcare, professional services, public sector and not-for-profit organisations.

He will sometimes accompany his clients in their workplace, or interview colleagues and other stakeholders to gather rich qualitative feedback.

Examples of recent coaching assignments include:

- The executive team at a UK university
- The partners at a private equity firm
- The executive team at an NHS Trust
- The CEO and founder of a technology business
- The COO of a challenger bank
- General Counsel at a government organisation

David holds postgraduate degrees in organisation consulting, integrative psychotherapy and coaching supervision and is accredited as a mediator by the Law Society. He is a trainer, supervisor and accreditor of executive coaches to Masters level at Ashridge and is sought after as an author and conference speaker on the subject of coaching and coaching supervision. He holds British Psychological Society Level A and B certificates of competence in psychometric testing.

Ben Fuchs

Ben is a Senior Consultant in leadership and organisational development at The King's Fund. He has been a practicing psychologist for nearly 30 years, developing people, teams and organisations. He works with healthcare leaders and leadership teams who are facing strategic and cultural challenges, often within a pressured environment of complexity and uncertainty. He has also worked in community development, leading conflict resolution projects with former adversaries in Nicaragua, Mexico and Northern Ireland.

Areas of Expertise:

- Leadership Coaching: Works with leaders at their 'growing edge,' to build confidence, explore implicit assumptions and to navigate the complexity of power and cultural dynamics in organisations and systems.
- Leadership Development: Facilitates experiential learning of practical skills and tools to close the gaps between leaders' intentions, their actions and their results.
- Leadership Team Development: Develops teams to increase psychologically safety, address difficult issues, and to work collaborate.
- Conflict Management: Helps to resolve tensions, promote mutual understanding and find win /win solutions.
- Culture Change: Helps to identify and shift the mind-sets, patterns of communication and behaviours that impact both the staff and service user experiences.
- Stakeholder Engagement: Brings together diverse perspectives, creates generative dialogue and develops common ground for effective action.
- Equality, diversity and inclusion: Helps leaders and organisations address the drivers of inequalities and develop proactive approached to increased equity.

Ben holds an MA counselling psychology and has undertaken professional training in Coaching, Group Dynamics, Conflict Resolution, Appreciative Inquiry, Harvard Negotiation, Process-Oriented Psychology and MBTI. He is also a qualified supervisor of coaches and consultants.

Fees and expenses

The costs below will give you an indication of our price structure. We will be happy to give a more specific price once you decide on numbers for each aspect of the possible activities. We are happy to do the work in stages, co designing the shape and style of the work with you, based on the findings of the initial data gathering interviews.

Coaching	Units	Unit cost	Total cost
Coaching per person 1:1 coaching, 4 x 1.5 hours via Zoom	1	Commercially Sensitive Information redacted by the USI	
TOTAL COST per person			

Board Development	Units	Unit cost	Total cost
Inquiry 1:1 inquiry interviews with SMT/Board members 2 consultants, 1 day each (6 interviews per day each)	2	Commercially Sensitive Information redacted by the USI	
TOTAL COST inquiry			

Delivery per full-day workshop 2 consultants		Commercially Sensitive Information redacted by the USI	
0.5 day each co-design with yourselves	1		
1 day each delivery	2		
Administrative/technical support	1		
TOTAL COST per workshop			

Payment details

Please provide the details below of who and where the invoice should be sent to. The invoice (including fee and expenses) will be issued after the event.
Name and job title:
Invoice address:
Work email:
Phone:
Generic accounts payable email address:

Purchase order number (if applicable):

Service agreement – terms and conditions

Cancellations:

All cancellations should be confirmed in writing before the event.

In the event of the customer cancelling or postponing confirmed delivery dates, any costs and expenses already incurred by The King's Fund prior to cancellation or rescheduling will be chargeable regardless of when cancellation takes place.

In the event of a last-minute cancellation (5 to 1 working days prior to the programme/ event date), The King's Fund reserves the right to charge 100% of fee and expenses already incurred.

Intellectual property:

In performing their obligations under this agreement, the parties shall not knowingly infringe the Intellectual Property Rights of any third party. Where there are known to be prior rights or rights of third parties in any customer property or other material to be supplied to the Fund by the customer, the customer shall obtain prior written consents before passing the customer property to the Fund for the purposes of performing the Services.

Any Intellectual Property Rights and know-how generated or developed by the Fund in the course of the provision of the Services including in the deliverables whether vested, contingent or future shall belong to the Fund and shall not be assigned to the customer unless expressly agreed in writing and detailed as an annex to this Agreement.

The provisions of this Condition shall apply during the continuance of this Agreement and after its termination howsoever arising, without limitation of time.

The King's Fund

Stinson, Emma M

From: Best, David <[redacted]>
Sent: 18 December 2020 09:21
To: OKane, Maria
Cc: Johnston, Julian; Wallace, Stephen
Subject: RE: Indepdendent Medical Examiner

Maria

Excellent news. Over the Christmas period we have decided to pause reviews and we will recommence in the first week of January. The IMEs are meeting on 4 January and we will consider how best to include the Southern Trust and from which date.

As a first step, could you confirm a lead doctor for both Craigavon and Daisy Hill. We will then liaise with them around the practicalities of what is required. We have developed an information sheet for dissemination to medical staff and essentially, we just need that to be distributed and for doctors to be aware that the process is starting. We will confirm a start date, following our meeting with the IMEs on 4 January.

Thanks

Davy

From: OKane, Maria [mailto:[redacted]]
Sent: 18 December 2020 00:12
To: Best, David <[redacted]>; Johnston, Julian <[redacted]>
Cc: Wallace, Stephen <[redacted]>
Subject: FW: Indepdendent Medical Examiner

Dear Julian / Davy,

Further to the meeting held with the Stephen and Damian last week regarding the newly established regional Independent Medical Examiner role the Southern Trust would be pleased to participate in the next phase of the project.

Can you advise what steps we need to take to commence this?

Regards
Maria

Dr Maria O'Kane
Medical Director

Southern Health & Social Care Trust archive all Email (sent & received)
for the purpose of ensuring compliance with the Trust 'IT Security Policy',
Corporate Governance and to facilitate FOI requests.

Southern Health & Social Care Trust IT Department [redacted] Irrelevant redacted by the USI

Cervical Cytology Service – Position paper - Feb 2021

Background

The Trust's Cervical Cytology Service is delivered through Craigavon Area Hospital (CAH) Cellular Pathology Laboratory. The service typically supports primary screening for 24,000 smears per year. 6000 of these smears also require further verification by a senior Biomedical Scientists (BMS) in the lab.

In the last three years, the service required additional sessions to keep up with demand, supported by waiting list funding from Health & Social Care Board. In recent months the service has lost three WTE BMS to other Trusts and backlogs are now accruing. In addition to the imbalance between service demand and capacity, additional NI Cervical Cancer Audit Framework requirements have been introduced which are putting additional pressure on the service.The current position is not sustainable and this position paper sets out a proposed more viable way forward for the service in the context of Pathology modernisation.

Pathology Modernisation

The Pathology Modernisation program is progressing through the regional Pathology Network chaired by Jennifer Welsh (Chief Executive – Northern Trust). It is recognised that in future there will be some changes to how laboratory services are delivered across Northern Ireland as a region. Whilst most cellular pathology services will remain unchanged and continue to be delivered on their current locations, a small number of service areas will be delivered by either one or two laboratories. Cervical Cytology Screening is one of those service areas.

Primary HPV testing will eventually replace Cervical Cytology screening as a primary screening tool and this policy change will consequently mean a smaller number of locations are needed to deliver the future service. The Southern Trust Laboratory Team accepts that change is inevitable and that Cervical Cytology will not be delivered here in the future. Therefore we are seeking to proactively manage this change whilst supporting staff through the process and focusing on a robust and sustainable SHSCT Cellular Pathology service model.

Target areas for CAH Cellular Pathology service development include:

- Support and expand Radiology in Rapid Onsite Evaluation Diagnostics.
- Increase capacity in biopsy reporting for elective and unscheduled care.
- Digital Pathology and Advanced Roles for Biomedical Scientists to support Consultant workforce shortages.
- Develop and deliver training programme for advanced BMS roles.

Primary HPV Testing

NI is the only region of the UK not to have rolled out primary HPV testing within cervical screening. Primary HPV testing is more sensitive than cytology which means it is less likely to miss pre-cancer compared to cytology. Cytology is a suboptimal test relative to what is available and a policy decision to move to primary HPV testing has been awaited in the region for several years.

As we deliver the screening programme by cytology rather than HPV testing, Quality Assuring the service is difficult as no national benchmarking will be available in the future. There is added risk at present and until a policy decision is made to introduce primary HPV testing this risk continues. To mitigate this risk co-testing could be considered and adopted (where all smears have both cytology and HPV testing done) however, the PHA does not currently support this move. Co-testing would mean little change to patient pathways as the colposcopy referral rate in SHSCT is high already. There would be a small additional financial cost of a HPV test.

Demand and Capacity

There is currently insufficient capacity available in the cellular pathology service to meet demand. Despite a significant amount of additional screening having been done, backlogs can accrue thus introducing clinical risk. The current staffing model for Cervical Screening is as follows:

Table 1:

Staffing	Sessions / WTE	Role
Consultant Sessions	3	Consultant Pathologist reporting / MDT
Band 8A BMS	0.5	CSPL
Band 7 BMS	2.5	Primary screening and checking
Band 7 BMS	0.5	Primary screening

This current staffing model in **Table 1** provides capacity for 12000 smears to be screened and reported by the Cervical Cytology Service at SHSCT. The demand currently however is, based on 2019 cervical cytology workload, around 24,000. The additional numbers were supported at financial risk through overtime.

The current deficit in capacity is resulting in backlogs and delays in reporting resulting in reduced turnaround times. Currently the training of cervical screeners is paused and recruitment of staff to support our service here is not an option. As a short to medium term solution, through the regional cellular pathology escalation process, it is proposed that 12,000 cervical cytology specimens are sent to Cellular Pathology in the WHSCT for primary screening and reporting through an SLA / contract. This proposal will ensure the safe delivery of the Cervical Cytology Service at the proposed reduction of the current workload. The WHSCT are agreeable to this proposal.

Cervical Cancer Audit Review

New Framework

The Northern Ireland Framework for the Audit of Invasive Cervical Cancers and Disclosure of Findings was published in 2019 and applies to all new cervical cancer diagnoses from the start of 2019 onwards.

This requires the Trust to carry out a review of the cervical screening history in all women diagnosed with cervical cancer. This involves a review of any previous screening test (cervical cytology), diagnostic test (biopsy) and any clinical treatment or management (colposcopy).

In most cases there is either no adverse review finding or minor review findings within the limitations of screening, classified as Category 1 and 2 outcomes respectively. In all these cases the patient is written to and advised that the audit review is complete and the outcome disclosed to patients where they require this, including invitations to meet with the Trust to discuss if necessary.

However, sometimes a more serious error is found (Category 3 outcome) and if such an error is found it is usually within the screening test, where a patient has received a false negative result – this is when the test result says you don't have a condition, but you actually do.

In the specific circumstances of this audit review of cervical cancer patients we will identify some women who were previously told they had a negative or normal smear test when in fact pre-cancer changes were present. These changes could have been treated and prevented cancer from developing.

The Framework asks for a specific standard to be applied when defining the audit outcome – *'Did staff carrying out the screening or diagnostic test do so to a standard that most staff could be expected to achieve?'* Applying this means for the Southern Trust around 3 women per year diagnosed with cervical cancer will have a previous false negative result. These are then required to be investigated as a SAI.

Every year in which cytology has been used as the primary screening test will have this outcome. Since it usually takes around 10 years for cervical cancer to develop the Trust will have to continue to undertake this audit until at least 2030 adding an additional year for each year that passes where HPV is not introduced to replace cytology as the primary test.

SHSCT New Framework outcomes 2019 and 2020

The Trust has completed the new framework approach for the 2019 patient cohort. There are three category 3 outcomes for 2019 and these are being investigated as Level I SAI. The review team has been established and the process to engage with patients has begun. This new framework approach has a significant additional administrative time commitment, acknowledged in other Trusts also, which is unfunded. So far there are no Category 3 outcomes for 2020.

Cervical Cancer patients 2009 – 2018

Prior to the Framework above Trusts had been asked to carry out a review of the cervical screening history in all women diagnosed with cervical cancer. The Medical Director of the Public Health Agency wrote to Trust Chief Executives to ask that this be done for all cases diagnosed from 2009 onwards and that the NHS cervical Screening Programme guidance (*'Disclosure of Audit results in Cancer Screening, Advice on Best Practice')* was to be followed. In 2014 a laboratory specific protocol was introduced but largely resulted in little change to the audit review.

Whilst this audit review has been done in the Southern Trust 2009 – 2018 but there is no evidence of patients having been told it was happening and subsequently very few instances of disclosure of outcomes.

This issue has been put to the Directorate of Legal Services (DLS) as questions below:

Questions to DLS

1. Considering the *'Disclosure of Audit results in Cancer Screening, Advice on Best Practice'* guidance drawn to the attention of Trusts in 2009:

Between 2009 and 2014 did the Trust have a duty of care or any obligation to patients in respect of this audit of invasive cervical cancers?

(a) To ensure patients knew the audit was being undertaken *and*

(b) To disclose the results of audit reviews for those who asked to know the outcome?

2. Considering the *'NI Protocol'* Trusts was asked to follow in December 2014:

From then onwards did the Trust have a duty of care or any obligation to patients in respect of this audit of invasive cervical cancers?

(a) To ensure patients knew the audit was being undertaken *and*

(b) To disclose the results of audit reviews for those who asked to know the outcome?

3. Does the Trust have a duty of care or obligation to now retrospectively disclose the results of all audit reviews were a patient consents to know the outcome?

Response from DLS:

The Trust owes a duty to the patients from 2009 onwards to advise that an audit of their screenings has taken place and disclose same where the patient consents.

Governance and Patient Safety

The current service model for cellular pathology is not sustainable and will inevitably change as the pathology modernisation work progresses. The new NI Cervical Cancer Audit Framework will add pressure to the team, which they are not currently able to deliver. It is in this context that now is the time to change the service model – committing to cellular pathology activity that is deliverable and safe, as well as refocussing on the development of different parts of the service in the context of the pathology modernisation programme.

In conclusion

We need a sustainable service model for Cellular Pathology which takes cognisance of regional pathology modernisation and focuses on the parts of the service that will be delivered from SHSCT Cellular Pathology Laboratory.

It is acknowledged that cervical cytology as a service area will not be delivered from the SHSCT in the long term. We are seeking to proactively manage this change whilst supporting staff through the process and focusing on the development of development of other services in the context of pathology modernisation.

In the short to medium term it is proposed that the following actions are progressed to address the issues / risks highlight in this report:

- **An SLA is established with the WHSCT to support delivery of the SHSCT cervical cytology service** pending regional progress on a policy decision. Our current staffing model provides the capacity for 12000 cervical cytology specimens to be reported by the SHSCT cellular pathology laboratory. We propose sending 12000 cervical cytology specimens to the WHSCT for screening and reporting through the establishment of an SLA. This SLA would also free up time to allow us to deliver the Cervical Cancer Audit Review Framework. *The cost of this arrangement will be c£115K*. The SLA can commence on 15 March 2021.Previously this need would have been met through a combination of additionality, support from other Trusts or through high cost locums screeners, therefore this plan would be broadly in line with costs from previous years.

- Primary HPV testing is a more sensitive test and will eventually replace cervical cytology as a primary screening tool. NI is the only region of the UK not to have rolled out primary HPV testing. It will be difficult to quality assure our service as no national benchmarking will be available. We acknowledge the false negative risk of a cytology based test screening programme and that NI is currently at variance with UK and ROI. **Until a policy decision is made to introduce primary HPV testing in Northern Ireland It is proposed that we commence co-testing from 15 March 2021. The cost of this arrangement per year is estimated to be up to £100K**

- **The team are requesting that the Trust formally raises the issue of disclosure for the patients during the period 2009-2018 with the PHA** - this could equate to approximately 30 patients. The Trust should indicate to the PHA that we plan to make contact with these patients; however it would be preferable if this was coordinated regionally.

Phase	Action
Phase 1	• Patient Safety Data and Improvement Manager, Band 8a **Being Recruited** • Senior Manager Risk & Learning, Band 8b **Complete** • Datix Manager Band 6 **Being Recruited** • Patient Safety Strategy Manager, Band 7 **Being Recruited** • Project Manager Band 7 **Being Recruited**
Phase 2	• Corporate Clinical Audit Manager, Band 7 • CSCG Training Officer Band 7 • Morbidity and Mortality Manager Band 6 • Directorate Clinical audit and patient safety posts Band 5
Phase 3	• Datix Admin, Band 4 • Risk and Learning Admin Support Band 4 • Training admin Support Band 4 • Business Partner posts Band 5

Belfast Health and Social Care Trust

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JOB DESCRIPTION

POST: Patient Experience Officer

LOCATION: Belfast Trust (multiple sites)

BAND: 4

REPORTS TO: Patient Experience Manager

RESPONSIBLE TO: Co-Director Risk and Governance

Job Summary / Main Purpose

The Belfast Trust vision is to be one of the safest, most effective and compassionate health and social care organisations and the Trust aims to be in the top 20% of high performing care providers in the UK by 2020. To help to achieve this aim, one of the key improvement objectives for the Trust is that we will provide real time feedback to teams from our patients and service users.

The postholder will work as part of Real Time Patient and Service User Feedback Team that are responsible for capturing the experience of patients and service users that are inpatients in our care. Information is collected from patients and service users using a questionnaire whilst also documenting any comments regarding their experience whilst in our care. Patient feedback is very beneficial to individuals and teams to highlight the excellent care they provide and also for suggestions of how we can improve. There are 25 questions based around 10 domains in the patient experience questionnaire.

The postholder will also collect key safety information and information relating to the medication that patients and service users are receiving. This information, taken from patient notes, will provide assurance on the safety and quality of care we provide and also highlighting areas for improvement. This data will be uploaded to the NHS Classic and Medication Safety Thermometers so the Trust can benchmark against other NHS organisations.

https://www.safetythermometer.nhs.uk/

The information collected both on the patient experience and the safety information is returned to the ward or unit in a report within 24 hours.

Main Duties / Responsibilities

For each of the following, the postholder will;

Service Delivery

- Be responsible for the collection of patient experience data relating to the various elements of the patient experience real time feedback programme, completion of all questions and gathering free text comments.
- Be required to use high level communication skills to elicit as detailed information as possible from patients and service users. For example, using communication skills to tease out their views on any particular issue. It is essential that feedback is complete and accurately conveys the views of the service user and is not a partial answer which would be then difficult for the team to act upon.
- Be required to use their communication skills to prompt service users to provide feedback in the free text comments relating to any of the domains where the postholder has judged that more detailed information would be valuable for the ward/unit.
- Be required to use their communication skills to prompt service users to provide feedback in the free text comments that summarises and emphasises the key themes of the feedback they provided, e.g. to highlight and name individuals or to emphasise the areas where they feel improvement is needed.
- Be responsible for the collation of information to complete the NHS Medication Safety Thermometer and the NHS Classic Safety Thermometer audits. This will involve searching patient notes and medication documentation to complete the different audits.
- Be responsible for the upload of audit data to the NHS Improvement website in relation to the NHS Medication Safety Thermometer and the NHS Classic Safety Thermometer. This is done direct from an app or by uploading the audit results to the website from excel.
- Be responsible for the extraction of analysis reports and provision to the wards from the NHS Safety Thermometer website.
- Be responsible for the development of real time patient feedback reports following patient interviews. The postholder will collate the feedback into a report format and provide to the ward/unit. This includes collation of patient comments.
- Use judgement and analytical skills to determine if there is an important safety issue or an issue concerning the patient's well-being that needs to be raised immediately with ward staff.
- Contribute to the development of a patient experience improvement plan as required on a ward.
- Upon request meet with the ward/unit team to provide overall feedback on any issues raised by patients and service users and to give more detail or answer any queries the team have.
- Support the ward/unit teams in the development of improvement plans linked to the feedback received from patients and service users.
- Provide advice, guidance and practical support in eliciting the views of patients, service users, carers and the public.
- Support staff to involve patients, service users, carers and the public in their patient experience activity.
- Produce information regarding the quality of care delivered in the Trust.
- Submit patient and service user feedback and data collected in a timely fashion each day.
- Be responsible for the collection of patient safety data on wards to enable submission to the NHS Classic Safety Thermometer.

- Be responsible for the collection of patient medication data on wards to enable submission to the NHS Medication Safety Thermometer.
- Contribute to the development of guidelines and policies to support the collection of patient and service user feedback and safety data.
- Constantly seek to improve the real time patient and service user feedback programme.

Collaborative Working

- Liaise with clinical and non-clinical staff regarding the patient experience real time feedback programme.
- Raise any clinical safety concerns to the ward sister or relevant manager.
- Use negotiation and persuasive skills when discussing patient experience issues with a range of professionals to achieve improvements to patient outcomes.
- Build relationships with the various wards and units assigned to the postholder to work collaboratively to improve the patient experience.
- Communicate effectively any patient experience issues with all grades and disciplines of staff including senior and clinical staff in a ward or unit.
- Act as a mentor for new employees into the team.

General Responsibilities

Employees of the Trust are required to promote and support the mission and vision of the service for which they are responsible and:

- At all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.
- Demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- Comply with the Trust's Smoke Free Policy.
- Carry out their duties and responsibilities in compliance with the Health and Safety Policies and Statutory Regulations.
- Adhere to Equality and Good Relations duties throughout the course of their employment.
- Ensure the ongoing confidence of the public in-service provision.
- Maintain high standards of personal accountability.
- Comply with the HPSS Code of Conduct.

Information Governance

All employees of Belfast Health & Social Care Trust are legally responsible for all records held, created or used as part of their business within the Belfast Health and Social Care Trust, including patient/client, corporate and administrative records whether paper based or electronic and also including e-mails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000, the Environment Regulations 2004, the General Data Protection Regulation (GDPR) and the Data Protection Act 2018. Employees are required to be conversant and to comply with the Belfast Health and Social Care Trust policies on Information Governance including for example the ICT Security Policy, Data Protection Policy and Records Management Policy and to seek advice if in doubt.

For further information on how we use your personal data within HR, please refer to the Privacy Notice available on the HUB or Your HR

Environmental Cleaning Strategy

The Trusts Environmental Cleaning Strategy recognizes the key principle that "Cleanliness matters is everyone's responsibility, not just the cleaners" Whilst there are staff employed who are responsible for cleaning services, all Trust staff have a responsibility to ensure a clean, comfortable, safe environment for patients, clients, residents, visitors, staff and members of the general public.

Infection Prevention and Control

The Belfast Trust is committed to reducing Healthcare associated infections (HCAIs) and all staff have a part to play in making this happen. Staff must comply with all policies in relation to Infection Prevention and Control and with ongoing reduction strategies. Standard Infection Prevention and Control Precautions must be used at all times to ensure the safety of patients and staff.

This includes:-

- Cleaning hands either with soap and water or a hand sanitiser at the appropriate times (WHO '5 moments');
- Using the correct '7 step' hand hygiene technique;
- Being 'bare below the elbows' when in a clinical environment;
- Following Trust policies and the Regional Infection Control Manual (found on intranet);
- Wearing the correct Personal Protective Equipment (PPE);
- Ensuring correct handling and disposal of waste (including sharps) and laundry;
- Ensuring all medical devices (equipment) are decontaminated appropriately i.e. cleaned, disinfected and/or sterilised;
- Ensuring compliance with High Impact Interventions.

Personal Public Involvement

Staff members are expected to involve patients, clients, carers and the wider community were relevant, in developing, planning and delivering our services in a meaningful and effective way, as part of the Trust's ongoing commitment to Personal Public Involvement (PPI).

Please use the link below to access the PPI standards leaflet for further information.

http://www.publichealth.hscni.net/sites/default/files/PPI_leaflet.pdf

Clause: ***This job description is not meant to be definitive and may be amended to meet the changing needs of the Belfast Health and Social Care Trust.***

Belfast Health and Social Care Trust

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PERSONNEL SPECIFICATION

JOB TITLE / BAND: Patient Experience Officer / Band 4

DEPT / DIRECTORATE: Medical Director's Office

Notes to applicants:

1. *You must clearly demonstrate on your application form under each question, how you meet the required criteria as failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Shortlisting will be carried out on the basis of the essential criteria set out below, using the information provided by you on your application form. Please note the Trust reserves the right to use any desirable criteria outlined below at shortlisting. You must clearly demonstrate on your application form how you meet the desirable criteria.*
3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

ESSENTIAL CRITERIA

The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage.

You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.

Factor	Criteria	Method of Assessment
Experience **Qualifications** **Registration**	• NVQ Level 4 or equivalent and 1 years' experience at Band 3 level or equivalent in the HPSS. **OR** 3 years' experience at Band 3 level in the HPSS. • English Language GCSE O Level (Grade A-C / 9-4). • Sound knowledge of Microsoft Office Suite packages.	Shortlisting by Application Form
Knowledge **Skills** **Abilities**	• Excellent planning and organisational skills, including a high level of accuracy and the ability to work to tight deadlines.	Interview

	• Excellent communication skills to fully capture the patient and service user experience and relay important information to teams. • Ability to work as part of a team and on own initiative. • Ability to develop good working relationships with officers of various grade and professions. • The flexibility to work in a changing environment. • Ability to identify problems and recommend appropriate solutions.	

DESIRABLE CRITERIA		
Desirable criteria will **ONLY** be used where it is necessary to introduce additional job related criteria to ensure files are manageable. You should therefore make it clear on your application form how you meet these. Failure to do so may result in you not being shortlisted.		
Factor	**Criteria**	**Method of Assessment**
Experience Qualifications Registration	• Experience of undertaking audits.	Shortlisting by Application Form
Other (e.g. Knowledge Skills Abilities)	• A knowledge of the NHS Classic Safety Thermometer and Medications Safety Thermometer.	Shortlisting by Application Form / Interview

NOTE:
Where educational/professional qualifications form part of the criteria you will be required, if shortlisted for interview, to produce original certificates *and* one photocopy of same issued by the appropriate authority. Only those certificates relevant to the shortlisting criteria should be produced. If educational certificates are not available an original letter *and* photocopy of same detailing examination results from your school or college will be accepted as an alternative.

If successful you will be required to produce documentary evidence that you are legally entitled to live and work in the United Kingdom. This documentation can be a P45, Payslip, National Insurance Card or a Birth Certificate confirming birth in the United Kingdom or the Republic of Ireland. *Failure to produce evidence will result in a non-appointment*.

Where a post involves working in regulated activity with vulnerable groups, post holders will be required to register with the Independent Safeguarding Authority.

HSC Values

Whilst employees will be expected to portray all the values, particular attention is drawn to the following values for this role

What does this mean?	What does this look like in practice?
Working together We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibilty of all.	• I work with others and value everyone's contribution • I treat people with respect and dignity • I work as part of a team looking for opportunities to support and help people in both my own and other teams • I actively engage people on issues that affect them • I look for feedback and examples of good practice, aiming to improve where possible.
Excellence We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high quality, compassionate care and support.	• I put the people I care for and support at the centre of all I do to make a difference • I take responsibility for my decisions and actions • I commit to best practice and sharing learning, while continually learning and developing • I try to improve by asking 'could we do this better?'
Openness & Honesty We are open and honest with each other and act with integrity and candour.	• I am open and honest in order to develop trusting relationships • I ask someone to help when needed • I speak up if I have concerns • I challenge inappropriate or unacceptable behaviour and practice.
Compassion We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.	• I am sensitive to the different needs and feelings of others and treat people with kindness • I learn from others by listening carefully to them • I look after my own health and wellbeing so that I can care and support others.

University College London Hospitals
NHS Foundation Trust

Job Description

Job title:	Patient Advice and Liaison Service Officer
Division:	Corporate Nursing
Board/corporate function:	Chief Nurse Division
Salary band:	Band 5
Responsible to:	Head of Patient affairs
Accountable to:	Deputy Chief Nurse
Hours per week:	37.5
Location:	Trust wide, UCH, NHHN sites

University College London Hospitals NHS Foundation Trust

University College London Hospitals NHS Foundation Trust (UCLH) is one of the most complex NHS trusts in the UK, serving a large and diverse population.

We provide academically-led acute and specialist services, to people from the local area, from throughout the United Kingdom and overseas.

Our vision is to deliver top-quality patient care, excellent education and world-class research. We provide first-class acute and specialist services across eight sites:

- University College Hospital (incorporating the Elizabeth Garrett Anderson Wing)
- National Hospital for Neurology and Neurosurgery
- Royal National Throat, Nose and Ear Hospital
- Eastman Dental Hospital
- Royal London Hospital for Integrated Medicine
- University College Hospital Macmillan Cancer Centre
- The Hospital for Tropical Diseases
- University College Hospitals at Westmoreland Street

We are dedicated to the diagnosis and treatment of many complex illnesses. UCLH specialises in women's health and the treatment of cancer, infection, neurological, gastrointestinal and oral disease. It has world class support services including critical care, imaging, nuclear medicine and pathology.

Job Purpose

The Patient Advice and Liaison Services have been established in every Trust to deal impartially with patient and public concerns on the spot and to try and resolve issues before they become more serious. PALs also provides information on Trust services to assist with the flow of contacting the NHS and acts as an entry point for people wishing to participate in patient and

public involvement. PALs acts as a catalyst for change within the NHS and uses the information from its work to effect service change and improvement.

To provide a point of contact for patients, carers and relatives in order to provide information to resolve problems and make referrals to other services in a timely way.

The PALs facilitation team consists of 4.6 PALs officers and a Lead who also has responsibility for other services as indicated. The facilitation team operates across all sites of the Trust and liaises on a day to day basis with both patients and staff at all levels in the organisation.

Key Working Relationships

Nursing corporate. Complaints team. Patient experience. All wards and departments.
Identify the reporting arrangements and job titles of the posts directly reporting to the post holder; indicate whether there is a full line management, or supervisory responsibility.
Specify other major working relationships and liaison with any other departments or external agencies.

Key Results Areas

The primary responsibilities of the post holder. The focus should be on results rather than activities. There should be between 3 and 6 key result areas or perhaps more if the job is very senior.

Main Duties and Responsibilities

- To facilitate efficiently the concerns of patients who contact PALs, by providing a professional and empathic service in accordance with agreed PALs procedures.
- To ensure patients/public receive appropriate and accurate information and assistance in respect of internal/external services, by handling enquiries in accordance with agreed PALs procedures.
- To enable the active involvement of patients/public, by identifying projects/groups which may be appropriate to their expertise, and to identify potential PALs link patients who may be willing to assist in the work of the PALs service.
- To increase patient satisfaction/ resolve problems by handling a portfolio of casework at varying levels without supervision, working collaboratively as a member of the facilitation team.
- To have a high degree of awareness and judgement to balance the requirements of client confidentiality and the need to escalate issues relating to safeguarding etc.

Communication

- To achieve resolution of patient problems brought to the service by negotiating with Trust medical, nursing, administration staff at all levels, and assisting to broker a solution.
- To ensure that staff across the Trust are aware of PALs and how patients can access the service, and that they feel supported by the service with patient issues. This is achieved by building and maintaining good working relationships with clinical and non clinical staff across directorates and their boards.
- To assist patients in a manner appropriate to their needs by analysing their problem, assessing their individual requirements and action their requests in an appropriate manner in accordance with PALs procedures.
- To ensure that those PALs contacts that request and/or need it are referred to specialist advocacy by utilising accredited and appropriate agencies in line with PALs procedures.
- To provide support for patients wishing to make a complaint about Trust services by providing information about the complaints procedures.
- To ensure that PALs link patients and Trust staff and are appropriately supported and their feedback recorded by maintaining regular contact with them. The frequency of such contact is to be patient led.
- To deliver ward and departmental surgeries so that patients/relatives/carers and Trust staff can more readily access PALs.
- To prepare and deliver presentations about PALs to Trust staff and outside agencies.

Quality

- To deal with PALs contacts in line with the agreed PALs time scales to ensure compliance with PALs standards
- To be responsible for recording all contacts in line with agreed time scales and in the agreed manner, enabling PALs to report in a timely fashion on contacts within the service.
- To maintain up to date knowledge of Trust policies, procedures, guidelines and services.
- To maintain knowledge of the role of the PALs service in the Trust majax procedure. To ensure that no person who contacts PALs will receive less favourable treatment from PALs on the grounds of their sex, marital status, race, colour, creed, religion, physical disability, mental health status, learning difficulty, age or sexual orientation.
- To receive regular supervision and appraisal with designated senior PALs officer, to increase self-awareness, ensure alignment of objectives with Trust values and goals, and towards professional and service development.

Administration

- To enable the PALs service to correctly identify possible improvements by maintain accurate, complete and timely records of PALs contacts using Datix Web database.

Planning and Organisational skills

- To assist the senior PALs officers with clinical board reports and contribute to meetings as required, to highlight issues of patient concern, working with them to develop and implement action plans to improve services.
- To assist colleagues in feeding back issues and suggestions for improvement to divisions.

Most difficult aspects of the job

- Providing an effective and consistent service to all individuals who contact PALs given that the quality and complexity of the caseload handled by each officer will vary from day to day.
- To be responsible for analysing situations and be able to negotiate/mediate successfully and impartially between staff at all levels and individuals who may be volatile/distressed/aggrieved.
- Balancing the needs/requirements of individual patients with the capacity/capability of the Trust and achieving positive outcomes.

Other

The job description is not intended to be exhaustive and it is likely that duties may be altered from time to time in the light of changing circumstances and after consultation with the post holder.

You will be expected to actively participate in annual appraisals and set objectives in conjunction with your manager. Performance will be monitored against set objectives.

Our Vision and Values

The Trust is committed to delivering top quality patient care, excellent education and world-class research.

We deliver our vision through values to describe how we serve patients, their families and how we are with colleagues in the Trust and beyond.

We put your safety and wellbeing above everything

Deliver the best outcomes	Keep people safe	Reassuringly professional	Take personal responsibility

We offer you the kindness we would want for a loved one

Respect individuals	Friendly and courteous	Attentive and helpful	Protect your dignity

We achieve through teamwork

Listen and hear	Explain and involve	Work in partnership	Respect everyone's time

We strive to keep improving

Courage to give and receive feedback	Efficient and simplified	Develop through learning	Innovate and research

Person Specification

Essential defines the minimum criteria needed to carry out the job and the job cannot be done without these

Desirable refers to criteria not essential and which successful applicants would be expected to acquire during their time in post. The desirable requirements are not taken into consideration in a job evaluation panel.

Requirements	Essential	Desirable	Assessment Criteria			
			A	I	R	T/P
Knowledge and Qualifications • Educated to degree level, or equivalent medical / nursing qualification/ experience. • Knowledge of Independent advocacy, data protection, complaints process, safeguarding, freedom of information, equal opportunities, disability discrimination, majax procedures, informed consent.	E E		A	I i		
Experience • Significant experience of dealing with public face to face in a variety of situations • • Experience of working in health care settings. • Experience of dealing with difficult or volatile situations.	E E E		A A A	I I		

• • In depth experience of workings of NHS/ Social care including funding streams and patient flow. • Substantial experience of handling case work.		D D	A A			
Requirements	**Essential**	**Desirable**	**Assessment Criteria**			
			A	**I**	**R**	**T/P**
Skills and Abilities • Communication and customer care • Ability to assimiliate and analyse and precis complex information and make sound judgements • Ability to balance patient expectations and Trust capacity/ capability and achieve resolution • Personal and People Development • Advanced conflict resolution skills including mediation and negotiation • Ability to liaise and work effectively with staff and public at all levels. • Ability to motivate and influence at all levels. • Ability to think laterally and find innovative solutions acceptable to all parties. **Quality and service improvement** • Ability to prepare data and presentations for a range of audiences. • Demonstrate commitment to patient	**E** **E** **E** **E** **E** **E** **E** **E** **E**	**D**	**A**	**I** **I** **I** **I** **I** **I**	**R** **R**	

care • Attention to detail • Demonstrate commitment to Trust Values and objectives linked to these in practice, and through appraisal and supervision. **Information processing/ IT skills** • Well developed computer skills and use of WP packages • Working knowledge of Datix web client rich database. • Ability to interrogate databases	E E					
Personal qualities • Excellent team working with ability to work unsupervised and to escalate concerns to senior PALs officer for advice when needed. • Ability to investigate and solve problems. And queries using own initiative. • Ability to plan and organise own workload effectively to meet deadlines in the short and long term. • Ability to deal tactfully and discretely with confidential and sensitive matters.	E E E E	A A		I I I	R R	
Specific Requirements Able and flexible to work at different Trust sites according to service need and requirements.	E			i		

A= Application I= Interview R= References T/P = Test/Presentation

REPORT SUMMARY SHEET

Meeting: Date:	Senior Management Team 9th March 21
Title:	Clinical and Social Care Governance Report
Lead Director:	Dr Maria O'Kane, Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	Information

Overview:

Provide SMT with an Oversight of Weekly Activity in relation to Clinical & Social Care Governance

Key Issues / Risks for SMT Consideration:

- 88 Ongoing SAI's – 29 Acute, 44 MHD, 11 CYP, 4 OPPC
- 2 New SAI Notifications

Reference Personal Information HSCB Ref: Personal Information redacted by the USI patient transfer issues re CAH and -RVH Patient in CAH for renal biopsy. Patient bled post procedure, requiring extensive resuscitation. The patient allegedly transferred to RVH without an agreed specialty bed to go to. Patient was transferred and experienced an acute deterioration. Patient remains in critical care unit in RVH.Review will consider learning in relation to transfer process to Regional Centres and review of criteria of what support is provided during transfer to Regional Centre.

Reference Personal Information redacted by the USI Patient to Patient assault-aggressor has been detained and receiving psychiatric inpatient support. Review to establish learning in relation on how to identify high risk/aggressive patient potential and placement of this cohort as well as learning re local response and management.

- Meeting arranged to Discuss EGR's at St Andrews Hospital who has provided care to SHSCT patients in the recent past-(UK based centre which has had recent poor performance against CQC standards.)
- 1 New Negligence Claim re alleged delay in diagnosis
- 6 Preliminary Hearings Scheduled in March 2 re self-harm, 2 re unexpected death and 1 re fail/delay in treatment
- 3 Medication Incidents
- 8 Responses sent to HSCB for Safety and Quality Reminders

Outcome of SMT Discussion:

Summary of Weekly Governance Activity 22.02.2021 - 28.02.2021

	DIRECTORATE				
	ACUTE Number	MHLD Number	CYP Number	OPPC Number	TOTAL Number
New SAI's Notification's	2	0	0	0	2
SAI Reports submitted to HSCB	0	0	0	0	0
Ongoing SAI's	29	44	11	4	88
High Risk Complaints	0	0	0	0	0
NIPSO Case Accepted for Investigation	0	0	0	0	0
NIPSO Draft Reports Received	0	0	0	0	0
Early Alerts	0	0	0	0	0

Grading of Formal Complaints Received 22.02.2021 - 28.02.2021