Bromley Healthcare
better together

Clinical Directors Quarterly Report
Quarter 4 January – March 2015

Summary

The first 4 headings provided by the Kings Fund in *'What is staff engagement and why is it important?'* are:

1. Develop a compelling, shared strategic direction
2. Build collective and distributed leadership
3. Adopt supportive and inclusive leadership styles
4. Give staff the tools to lead service transformation

After discussing Bromley Healthcare's concordance with these principles, we have made a series of recommendations for the consideration of the Board. From these, we have considered which four in our view are likely to yield greatest clinical impact in the coming year; further to the recommendations in our Q3 report. These are:

- Engage in robust discussion with commissioners regarding (i) commissioning for quality rather than activity (ii) appropriate SMART KPIs for new services
- Review internal processes to weigh different targets and priorities and allow a clear direction of travel to be understood by all staff
- Invest further in leadership development and refuse to tolerate mediocrity moving forwards
- Review the particular issues of small services - and those with recruitment difficulties - who may need a refreshed leadership strategy

The development of a shared clinical record with primary care is also crucial, as a shared task with GPs and the CCG.

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Quarter 4 (January-March 2015)

Clinical leadership in action

Introduction

A recent Kings Fund report by Ben Collins has been published entitled:

'What is staff engagement and why is it important? Six building blocks for harnessing the creativity and enthusiasm of NHS staff'.

Our CEO Mr Lewis was one of the working party members. Thus it is no surprise that the areas identified are highly pertinent to the vision of a learning organisation that the clinical directors have sought to develop within Bromley Healthcare over the past 20 months. To recap, this vision is captured in our clinical governance strategy, published in 2013, and runs through our six clinical director board reports to date, the themes of which were:

2013-14

- Q2 Quality Team introduction- processes and quality metrics
- Q3 Quality Governance arrangements including Top 10 and Francis response
- Q4 Role and development of risk and training teams

2014-15

- Q1 Overview of quality strengths and weaknesses of current clinical services
- Q2 Innovation and excellence
- Q3 CQC readiness.

5 of our 8 key recommendations in our previous 'CQC readiness' report related to staffing:

1. Safe levels of staffing for all services.
2. Each member of staff adheres to Bromley Healthcare's Code of Conduct for Staff who provide care to service users, understanding their personal accountability for patient outcomes, taking appropriate actions to optimise this.
3. All services and teams to have monthly team/service meetings to ensure effective dissemination of learning throughout the organisation.
4. All clinicians to have a work plan that provides ring-fenced time for personal reflection, clinical supervision and continuous professional development.
5. All clinicians to have easy access to our information systems including our Intranet.

What is staff engagement and why is it important?

The headings provided by the Kings Fund in *'What is staff engagement and why is it important?'* are:

1. Develop a compelling, shared strategic direction
2. Build collective and distributed leadership
3. Adopt supportive and inclusive leadership styles
4. Give staff the tools to lead service transformation
5. Establish a culture based on integrity and trust
6. Place staff engagement firmly on the board agenda.

We have decided to utilise the first four headings to provide some recommendations for the Board around clinical leadership and clinical service development in our final joint report as clinical directors. Our recommendations do not extend to headings 5 and 6, not because we don't think they are important and relevant (they are), but because these are less specifically within the clinical director/quality team remit. We are however keen that the quality team should actively contribute to on-going Board discussion of these crucial areas.

Under each heading we have detailed some key explanatory information from the Kings Fund report in italics, along with the 'questions for Board members' suggested by the Kings Fund (in bold). We have followed this with our own commentary and recommendations, on behalf of the quality team.

1. Develop a compelling, shared strategic direction

Research from health care and other sectors shows that leaders who help their organisations to develop a clear vision and a compelling narrative about mission and priorities achieve higher levels of staff engagement. Staff are more enthusiastic about their work and collaborate more effectively, and this is reflected in better performance (MacLeod and Clarke 2009).

In health care, there is evidence that developing a clear mission focused on high quality, compassionate care helps to bridge the fault lines between managers, clinicians and other groups (Bezrukova et al 2012). Achieving this is no easy feat and requires more than a well-crafted mission statement. In health care, leaders face a bewildering range of external expectations, which can lead to overlapping or disjointed goals (Dixon-Woods et al 2014).

The most successful organisations set explicit and challenging goals for achieving the vision and they measure progress in meeting them. The ultimate test of a vision has to be whether it transcends the mission statement and enters the organisation's bloodstream – the rites, rituals, cultural norms and stories about 'how we do things around here'.

Board members should ask the following questions

• Do senior leaders and staff agree that they are all working towards a clearly defined common direction?

• Do staff across the organisation understand the vision and how their roles contribute to it?

• Has the organisation set demanding goals for achieving the vision and is it monitoring progress in meeting them?

Bromley Healthcare has set a clear priority around quality of care and supported the creation of a quality team resourced to work alongside operations to facilitate this. Clinical leadership from the Head of Nursing and Head of Health and Care Professionals (with doctors and dentists relating to the clinical directors).
means all clinical groups can look to a peer clinical lead in the organisation for support to ensure quality is their overriding priority, as per our tenet 'Treat others as we would like to be treated'.

Embedding this philosophy in our organisation can be challenged by our commissioning mechanism, which is predominantly based on activity. This is not unexpected as identifying Key Performance Indicators that focus on quality is in it's infancy with Community Services.

Furthermore, it may not have always been explicit historically within the organisation how quality priorities should be weighed against financial ones. This has been rectified to some extent over recent years by ensuring that the budget-setting process incorporates a quality discussion. However the process needs to be strengthened by ensuring that the Quality team are as involved as the Finance team are in the planning of this process.

Within new and recommissioned services, the commissioners have generally set challenging key performance indicators (KPIs) which in themselves have created stress within services unfamiliar with such a performance environment. Bromley Healthcare has not always been able to mobilise new business with the speed and quality requested by commissioners. Much work has already taken place to tackle this issue, for example by setting stretch 'internal' KPIs to move services forward prior to recommissioning, and a strengthened governance process for clinical director sign off of new business prior to launch of new business.

In the NHS of the 21st century, strong performance management will remain crucial to the success of any organisation. As a community provider, modernisation of our services has been a huge task. Emphasis on productivity and efficiency has led many staff to question whether this focus has a negative knock-on effect on quality. Many traditional ways of working are not efficient and services have been tasked with making sure that their services are run efficiently without compromising on quality. The Quality team have worked closely with Operations towards achieving this goal. Our approach seeks to ensure that grass-root staff lead and take ownership of this change guided by senior management e.g. Top 10 Quality Metrics. Concerted effort needs to continue to be made to communicate to all staff our vision and plan to ensure continual improvement of patient outcomes and experience.

Recommendations from clinical directors:

- Engage in robust discussion with commissioners regarding (i) commissioning for quality rather than activity (ii) appropriate KPIs for new services
- Ensure adequate resources are costed into new business proposals to ensure that rollout can meet commissioner expectations

- Review internal processes (including via budget setting process) to weigh different targets and priorities and allow a clear direction of travel to be understood by all staff.

2. Build collective and distributed leadership

The most successful health care providers – like high performers in other sectors – are reducing reliance on top-down leadership in favour of collective and distributed leadership, where all staff are supported to play leadership roles.

According to Paul Plsek, Chair of Innovation at the Virginia Mason Center in the United States, 'a learning organisation seeks to develop skills in the process of leadership at all levels of the organisation, and seeks to flatten hierarchy and eliminate rigid policies' (Plsek 2013). However, we cannot underestimate the challenges of developing a collective leadership culture within many NHS organisations, given the legacy of rigid hierarchies and 'command-and-control'.

For many top-performing providers, it requires huge commitment to develop a new leadership philosophy. It takes time and effort to redesign decision-making structures and equip staff at different levels to play different roles, alongside concerted programmes to deliver the necessary cultural change. In the early 2000s, University College London Hospitals NHS Foundation Trust stripped out layers of management and gave clinicians joint managerial and clinical responsibility for the performance of their divisions, with the role of ensuring both quality of care and financial sustainability.

Alongside these types of changes, staff at every level must be given explicit authority to identify opportunities for improvement or to raise concerns, and – just as importantly – opportunities for these contributions to be considered fairly and acted on.

Board members should ask the following questions
• Do we have a leadership strategy and a leadership development plan?
• Do we have a clear understanding of our current leadership culture and the leadership culture we are trying to create?
• What approaches have we developed to empower staff throughout the organisation to play leadership roles?
• Are we absolutely sure that staff can speak up when they have concerns and that their concerns are considered fairly?

This report is from the clinical directors so focusses primarily on clinical leadership. Bromley Healthcare's clinical leadership strategy relies heavily on the service lead to provide strong, robust and creative leadership for their team. The approach varies widely between teams. There are many examples of excellence and others of weaker practice.

The clinical directors have been working closely with the Head of Nursing (Amanda Mayo) and Head of Health and Care Professionals (Jo Walls) to support the development of clinical leadership via the quarterly review 'challenge' process with service leads (this meeting includes the operations managers) and other mentoring opportunities. Leadership training has also been made available. A competency tool was recently developed by the executive team to assist operations managers in

appraising service leads against a set of defined 'success' criteria. The dynamics between the quality and operations teams create triangulation of analysis which helps ensure that critical thinking is maintained.

Leadership innovation is occurring such as the Buurtzorg model being adopted in two of the community teams, which flattens the leadership hierarchy in exactly the way described by this Kings Fund paper. This has been popular with staff and appears to be successfully allowing more junior staff to appropriately gain confidence as the scheme supports them to increase their decision-making and accountability on a day to day basis.

The clinical forum has spent a lot of time in the past 20 months discussing clinical leadership and innovation and also the importance of speaking up with concerns. This was also a hot topic at the last two Adult Safeguarding strategy groups and is an area of increasing discussion in the safeguarding context. Emphasis has been placed on learning about other services and sharing experiences e.g. best practice, incidents, complaints, audits, service developments. Annual Survey of the membership has been done to ensure that the forum is effective and relevant. These forums needs to be maintained and strengthened, and those service leads not currently engaged in them need to be persuaded to participate.

Bromley Healthcare now regularly raises quality alerts to the commissioner about other providers. A whistleblowing policy is in place to support raising internal concerns and it has been utilised on several occasions in the past 2 years. In each case a full investigation has taken place with a process to address the issues raised, usually involving either the commissioner or some other independent party to ensure a robust approach.

Recommendations from clinical directors:

- Support operations managers to develop clinical leads, including robustly addressing any competency gaps identified in service leads
- Evaluate the Buurtzorg programme and roll out any successful practices across the organisation, where clinically appropriate
- Strengthen the clinical and safeguarding forums and engage non-engaged teams/leads
- Continue to support staff to speak up with concerns and ensure they are considered fairly.

3. Adopt supportive and inclusive leadership styles

Research shows that leaders and managers who adopt supportive and inclusive leadership styles have more engaged staff. The most successful leaders deploy a range of leadership styles depending on the circumstances, but with greatest reliance on inclusive styles, such promoting collaboration, involving staff in decisions, encouraging and coaching staff, and supporting staff in overcoming organisational challenges.

Yet despite this evidence, studies suggest that NHS leaders and managers continue to rely first and foremost on directive leadership styles such as leading from the front, setting the

pace or laying down demanding targets – precisely those styles that run the greatest risk of disempowering and alienating staff.

A small number of high-performing NHS organisations have made concerted efforts to develop more inclusive and supportive leadership styles. For example, Oxleas NHS Foundation Trust made substantial investment to convince sceptical leaders and managers of the need to change, before helping them to 'unlearn' ingrained behaviours and develop a broader set of leadership skills. In 2013, Oxleas was the mental health trust with the highest levels of staff satisfaction in the quality of their work and in the patient care being delivered (NHS Staff Survey 2013).

Board members should ask the following questions

• What do we think are the most prevalent leadership styles throughout our organisations?

• What do our staff think are the most prevalent leadership styles? Do they think leaders and managers are inclusive and supportive?

• What investment have we made to develop the leadership styles that support high levels of staff engagement?

As described above, Bromley Healthcare has a range of leadership approaches amongst service leads. In a strongly led team, the quality targets are evolved by consensus and any resulting work (audit, service development, Emis development etc.) done across the entire team. Some of our teams have already achieved this, for example community paediatricians and bladder and bowel team. We know several other services do not yet manage to adopt this approach. For example, it is evident from a recent detailed review one of our services service that key messages and developments are not always 'filtering down' via the service lead and that the quality targets generated were done without the consensus of the team, with the result of staff feeling disempowered and underperforming when audited.

Developing strong service leads able to lead collaboratively and to drive collective innovation and development is vital to Bromley Healthcare's on-going success. This point cannot be sufficiently overstated, in our view. It is however a challenge, particular in smaller teams or teams where it is hard to recruit. The NHS pension has gone some way to improve Bromley Healthcare's ability to recruit high quality clinical leaders but further consideration needs to be given to how to optimise leadership in those smaller services where leadership is currently weak, moving forward.

For many staff groups of NHS background, tackling underperformance is an area of challenge. It may seem easier to 'work around' an underperforming team member than confront their issues- this having been the traditional NHS approach historically, in many instances. This is an important area of cultural change required by Bromley Healthcare moving forward and creates its own challenges in that it may appear to contradict the desire to be 'supportive'. Leaders need specific guidance and backup (for example, from HR) to address such conflicts in a positive way and without disengaging other team members, who may feel they should 'side' with the member of staff being performance managed. In the case of performance managing the service lead themselves, this can create particular difficulties, especially if the area of

weakness is clinical and there is no peer clinician within the organisation able to assess performance. External expertise may be required and this can be costly.

Recommendations from clinical directors:

- Invest further in leadership development and refuse to tolerate mediocrity moving forwards
- Review the particular issues of small services - and those with recruitment difficulties - who may need a refreshed leadership strategy
- Provide robust support for leaders and teams involved in performance management
- Invest in external expertise if needed to performance manage senior clinicians where there is no suitable internal peer to manage the process
- Avoid drift.

4. Give staff the tools to lead service transformation

The most successful health care providers – just like cutting-edge organisations in manufacturing, transport and other sectors – are giving their staff the tools and resources to lead transformation from the front line. Rather than calling in external experts to redesign services, they are using these resources to help frontline staff master modern methods of quality improvement.

By investing in and empowering their staff, these organisations are unleashing their employees' enthusiasm and creativity to improve how they do their work, creating a constituency of leaders of change, rather than stubborn opponents to change.

In doing so, they are creating 'learning organisations' where staff at all levels participate in continuous, daily improvements in care – rather than one-off flurries of activity when an organisation or service hits the buffers.

Board members should ask the following questions
• Do we have a strategy to support continuous learning, innovation and improvement?
• Have we invested resources in building the capacity needed to help staff innovate and improve services?
• How much senior leadership time is dedicated to supporting frontline staff in trialling innovations and delivering improvements?

Within Bromley Healthcare, a positive example of clinical transformation is the Emis programme which has given staff an excellent opportunity to review and standardise their clinical processes and in the main this has been enthusiastically embraced. It has however created pressures around lack of protected time and backfill of clinical work. Our Q3 report has already made recommendations around the importance of protected time as recapped in the introduction above.

The Emis templates being developed utilise Read coding to create substantial innovative intellectual property for Bromley Healthcare which will massively facilitate both analysis/development of internal quality and also demonstrating quality and innovation when tendering.

The quality team has worked hard in the past two years to get alongside teams to foster quality improvement from the grassroots up. Alongside direct mentoring, a range of training opportunities has been provided around areas such as change management and customer service; however they have not always been taken up by teams. A large component of the reason identified is lack of protected time in job plans for personal/professional development.

A robust approach to internal innovation and development goes a long way to pre-empt the challenges of service recommissioning, since it is often possible to largely predict the likely refreshed model/targets (based on best practice elsewhere) and ensure processes are put in place proactively to achieve them.

Recommendations from clinical directors:

- Continue to support the development of Emis
- Consider which other specific resources would build innovation capacity and allow services to proactively identify and build likely future commissioning intentions/models
- Support job planning including protected time for personal/professional development and innovation/improvement.

5. Establish a culture based on integrity and trust

Research shows that staff are more engaged in their work and committed to their organisations if they believe that their leaders act with integrity and if they have confidence in the fairness of their organisation and its procedures. Staff are also more engaged if they feel valued by leaders and operate within a supportive community (Maslach et al 2001).

Board members should ask the following questions
• Do we have a clear sense of the values and behaviours that we want to promote in the organisation?
• What are we doing to promote those values and to address behaviour that is inconsistent with them?
• What actions have we taken recently to tackle bullying and harassment in the organisation?

The code of conduct has clearly identified the values and behaviours we wish to promote as an organisation. Many but not all staff have signed it. As stated in our Q3 report, this is a key priority.

The above code is an important facet of our partnership working, for example was a specific part of the 'stage 1' agreement around Emis data-sharing with GPs. A shared complete clinical record with primary care will massively facilitate joined up patient care as well as hugely consolidating Bromley Healthcare's position in the Bromley marketplace by integrating and interweaving our care with that of general practice. Strengthening GP confidence in the integrity of the values and behaviours of our staff- evidenced by the code of conduct being signed- is a key driver to the rollout of this record-sharing.

Policies and procedures are in place around bullying and harassment; they are not within the specific remit of the clinical directors so are not commented on further here.

6. Place staff engagement firmly on the board agenda

Boards of NHS organisations need to dedicate greater time and attention to staff engagement, not as a passing fad, but as a subject demanding regular discussion and reflection.
For example, the board of Bromley Healthcare discusses staff engagement at each of its board meetings, as a standing item alongside quality of care.

Board members should ask the following questions
• How often does the board discuss levels of staff engagement and how they could be improved?
• Are we making best use of the NHS Staff Survey and do we need other data to assess levels of engagement in different teams?
• What steps have we taken to increase levels of staff engagement in the past year?

It is great news that the Kings Fund has sited Bromley Healthcare in its report as an example of excellence. The latest staff survey shows some deterioration in engagement - no doubt the Board will be discussing this actively.

Conclusion- Clinical Director top 4 recommendations

We have made a series of recommendations for the consideration of the Board. From these, we have considered which in our view are likely to yield greatest clinical impact in the coming year.

Further to the recommendations in our Q3 report, we now make four further main recommendations for Bromley Healthcare based on the above observations:

- Engage in robust discussion with commissioners regarding (i) commissioning for quality rather than activity (ii) appropriate SMART KPIs for new services
- Review internal processes to weigh different targets and priorities and allow a clear direction of travel to be understood by all staff
- Invest further in leadership development and refuse to tolerate mediocrity moving forwards
- Review the particular issues of small services - and those with recruitment difficulties - who may need a refreshed leadership strategy

The development of a shared clinical record with primary care is also crucial, as a shared task with GPs and the CCG.