
# NHS WORKFORCE: Respect and challenge

## Key questions for the board

Written by Dr John Bullivant
FCQI, Chairman, Good Governance Institute

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HERE TO HELP LEADERSHIP NETWORK

# Dr John Bullivant

## FCQI, Chairman, Good Governance Institute

Two-thirds of trust chairs and chief executives believe the workforce is the most pressing challenge to delivering high-quality healthcare at their trust. (NHS providers 2018 [1]). Industry agrees with many commentators observing that succession challenges and the ability to attract top talent is now firmly established as a top ten risk [2].

In 2018, Allocate continued its leadership network forum bringing together a group of health service practitioners to explore the challenge of the workforce: how we recruit, train, retain, respect, motivate and deploy our skilled staff.

**Speakers included:**

- Mike Wright RN, Chief Nurse, Hull and East Yorkshire Hospitals NHS Trust
- Dr. Andy Haynes, Medical Director, Sherwood Forest Hospitals NHS Foundation Trust
- Chris Goulding, South West London Collaborative
- Dr. Nadeem Moghal, Senior Clinical Fellow, The Nuffield Trust
- Liz Jones, Director of Marketing, Allocate

A mix of clinicians and managers heard from senior medical and nurse directors disgussing the challenges and successes of employing directly, in England alone, over a million staff together with another 400,000 agency and contracted staff providing NHS services.

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**Key solutions included:**

- developing team-based job plans
- clarifying the role of the MD
- marketing rostering data up to the board
- monitoring clinical engagement
- improving data quality
- involving clinicians in financial turnaround
- how bank collaboratives solve not only staffing issues but create a forum for partnership working.

**Respect**

Holders of public office must respect fellow members of their public body and employees of the body and the role they play, treating them with courtesy at all times.

Our colleagues in Scotland have added respect for staff to their Nolan principles [3]. England should do the same. In South Africa the King IV report [4] is based on principle rather than compliance. Regulators in the UK fail to recognise the burden of their role seemingly misunderstanding that assurance of safety, value for money and joined up services comes from within the organisation itself. However, the focus is now moving to system or place based teams and services which creates new challenges for public reporting, governance, audit and delivery.

The report that follows includes a series of challenging questions for Boards together with great and not so great answers, produced jointly by Allocate and the Good Governance Institute.

Thanks to Allocate for a great day of discussion, commitment and sharing. The next session will be held at Chandos House - home of The Royal Society of Medicine in London 2nd April… I can't wait.

John Bullivant, Chair, Good Governance Institute.


Ref 1: https://nhsproviders.org/a-better-future-for-the-nhs-workforce/the-workforce-supply-challenge
Ref 2: https://riskonnect.com/blog/top-business-risks-2018/
Ref 3: King IV: https://www.good-governance.org.uk/wp-content/uploads/2018/11/GGI-King-IV-for-Health-and-Social-Care-Paper.pdf
Ref 4: Respect: https://www.qmu.ac.uk/media/5425/appendix-08-the-nine-principles-of-public-life-in-scotland.pdf

Other refs
https://blogs.deloitte.co.uk/health/2018/02/time-to-care-securing-a-future-for-the-hospital-workforce-in-the-uk.html
Guidance for providers on good governance in local health economy working
Draft for stakeholder engagement , NHS I 2018
https://improvement.nhs.uk/documents/115/Guidance_on_good_governance_in_a_LHE_context_final.pdf


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# Questions for the board

| Question | Poor answer | Good answer |
|---|---|---|
| 1. Have we identified the risk appetite of our partners, suppliers etc. ? | That's a matter for them. | We have identified the strategic objectives that can be compromised by others and sought to understand their plans, priorities and risk appetite. Where these are misaligned to our plans we have sought to engage. |
| 2. Have we considered King IV corporate governance model based on principles especially when involved in well led KLOE reviews? | King IV is not official policy in UK. We have enough to do with central requirements. | Board has had a session on King IV and integrated public reporting. We have cross referenced to Well-led KLOE and CIPFA International Governance principles and use as a principles-based guide to our governance practice. |
| 3. Have the board discussed the 4 lines of defence and undertaken an assurance mapping exercise to ensure all areas are effectively covered? | Our managers, sub committees and auditors provide us with assurance that all is working. Ultimately regulators protect the public from service going awry. | We have carried out an assurance mapping exercise to clarify the strength of assurance at all four levels of defence on delivery against strategic objectives and major service areas. |
| 4. Have we developed an etiquette for working with partners etc across place-based activity: STP/ACS etc. ? | We have good working arrangements with all our partners. | We have a formal etiquette agreement with local authorities and are developing a similar model with partners and suppliers across the STP area. |
| 5. How much time are key staff spending on regulatory enquiries? | We treat compliance for information from regulator as a high priority however much time it takes. | We see the level of regulatory demands as an onerous burden and have streamlined our evidence into a single system which feeds all enquiries with current and quality data. We work with our trade associations to lobby for reduced appropriate levels of compliance whilst we develop relevant operational metrics. |

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| 6. Have we a system in place to measure medical engagement? Is it improving?<br><br>7. Have we developed this to cover all clinicians? | We carry out regular staff surveys. | Our initial medical engagement methodology shows improvement and we have now extended to a comprehensive clinical and managerial engagement process. Board receives updates and analysis. |
| 8. Have we defined the role of medical director? How well does our MD perform in this role? | MD is very experienced and respected. He provides a means of senior staff to lobby the board and is helpful in explaining technical medical matters. | MD has a JD reflecting his/her strategic role and our renumeration committee carries out regular reviews of all executive staff grades. |
| 9. Does the board know the top 3 risks facing the organisation? | Our BAF provides an update on key risks. | Yes, we have defined our SMART strategic objectives and the principal risks which compromise future delivery. We also carry out a future risk exercise to identify new risks for both our organisation and our partners and suppliers. |
| 10. If workforce is not on that list can we explain? | Workforce is a key issue but has not been identified as a principal risk as one of our strategic objectives. | Workforce is one of our critical delivery enablers and impacts on all our strategic objectives and obligations. Workforce together with finance and service quality are a feature of our integrated performance report. |
| 11. What is the medical vacancy rate in our hospital overall and by specialty? | This information is not collected or available in this form. | We provide this information to NHS Improvement and routinely routinely provide this to the board together with action plans on filling vacancies. Locally we have adopted the welsh methodology to calculate and deliver nurse safe staffing levels. |

# Questions for the board

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|---|---|---|
| 12. Have we adequately invested in our governance support unit? | The cost of governance support has increased. | We have benchmarked the scale and cost of governance support and invested in governance training throughout the organisation. We aim to reduce compliance costs by capturing evidence once to feed all internal and external requirements. |
| 13. Have we linked all forms of adverse information, SUIs, complaints, errors etc.? | Yes in part. | We treat all comments and adverse events as learning points. We have developed a single recording system with trends and individual serious untoward events escalated to the board within the risk tolerance framework. |
| 14. What is the ROI on information systems e.g. Rostering system? | We have carried out a simple cost benefit analysis. | All information systems are subject to ROI calculations as part of the business case investment. We have broadened the 5 treasury economic criteria to include quality as well as financial outputs. |
| 15. Are we paying temporary staff weekly? | No. we employ through a third-party agency and do not have any influence over their payments polices. | We recognise the rationale of such payments and require our collaborative and the external agencies to match our commitment to weekly payments. |
| 16. Have we banished governance jargon words not used in general speech? | No because we all understand these words. | Jargon is shorthand, but we have sought to make our board meetings and minutes comply with plain speech. |

# Questions for the board

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|---|---|---|
| 17. Does every agenda item or conversation include impact on patient safety? Why not? | Where appropriate. | We have adopted the principle of using 'in order that' to explain how plans will impact on improved patient safety and outcomes. |
| 18. Do we have a well-developed Quality Improvement (QI) team? | Yes we have a dedicated team running projects. | We have a systematic trust wide approach to quality improvement as part of our quadruple aim policy. All staff are offered training and support from our dedicated QI and Clinical Audit team. |
| 19. Do we involve the QI team in financial recovery/CIP etc.? | Not yet. | Yes. |
| 20. Have we merged our quality and financial PMOs? | Not yet. | Yes. |
| 21. Have we tri-aged our intake to remove all complicated cases to reduce costs? | We have to treat everyone who turns up. | We have agreed with our commissioners that complex cases will be transferred asap to the best care setting and/or negotiated additional charges which allows us to respond safely and appropriately |

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| 22. What systematic approach do we have to involve clinicians in financial recovery? | Clinicians are welcome to contribute comments. | We have a well-developed CIP programme which systematically involves clinicians and service users. Programmes are subject to veto if cost cutting compromises patient safety. |
| 23. How robust are our attempts to improve data quality? | We carry out regular audits by internal audit. | Parts of our information system are subjected to a rolling programme of review every year. Staff are encouraged to understand their role and responsibility in accurate data capture. |
| 24. Have we coordinated/contributed to efforts nationally when national solutions required? | We regularly attend meetings of NHS Providers/NHS Confederation etc. | Yes we accept our accountability but are active in a number of national networks and our executives contribute to regulatory inspections which also gives us a voice. We are encouraging our national politicians, our local authority colleagues and also our staff to lobby their professional organisations to support a more balance regulatory position recognising our statutory independence. |
| 25. Has board seen and read 'Time to Care: Securing a future for the hospital workforce in the UK' the Deloittes report? | No way of knowing. | Yes in summary; our board secretary is very good at preparing briefing papers on important documents like this. |
| 26. Are all staff trained in the role and operation of the systems they use? | Yes of course. | We have audited staff appreciation and competence in use of rostering and safety systems and have implemented improvements in induction and training as a result. |

# Questions for the board

| Question | Poor answer | Good answer |
|---|---|---|
| 27. Do boards read summary rostering reports and take action? | Yes of course. | Probably not, so we have developed a marketing approach to promote regular reporting with summary highlights and integrated analysis. |
| 28. Have we revisited the story/purpose of why we are doing this work- have we adequately described the future state we are aiming for? | Not recently. | Our strategic planning process describes the aspirant future states of operation and experience for patients, staff and governors. Our recruitment, training and deployment of staff is designed to facilitate these outcomes. |
| 29. Are senior execs (DON/COO) involved and understand the system? | Yes they manage these systems. | We thought so but have challenged senior staff on their understanding and use of such systems. Analysis and reporting has since improved. |
| 30. Do our staff complete job planning requirements? | Our audit has shown even after 15 years of agreement a disappointing commitment by consultants below 50%. | Since introducing team-based job planning we have managed 95% compliance. Senior staff reluctant to engage have been invited to 1:1s with the MD before being referred to the renumeration committee. |
| 31. Have we fully understood the role of the MD? | Yes, our MD is our senior medical advisor. | No this is a key role, but we don't use to full effect. A job description is being developed with external advice and our new appointment will reflect this. |

# Questions for the board

| Question | Poor answer | Good answer |
|---|---|---|
| 32. For multi site trusts; Why do we have different policies on different sites? | This reflects their disparate historical development. We aim to consolidate based on the lead site policies. | This is one trust and we have been at pains to consolidate across all sites based on best of best internally benchmarked against wider practice experience. |
| 33. Are our audits of job planning adequate? | Yes they confirm compliance is improving. | Yes we set a target of improvement for last year and the audit confirm, that we achieved both this and that the job planning has had a material affect in reducing cancellations and overruns. |
| 34. Who does/does not attend our clinical governance committees/events? | Our staff do their best but operational commitments take precedence. | We have included clinical governance meetings and departmental. |
| 35. Have we embraced team job planning? | No. | Yes, this made a significant difference to job planning compliance and efficiency. |
| 36. Do we know what our doctors are doing? | Our staff are all professional and meet operational demands. | The team job plan provides the operational activity map but we also run a monthly review of activity against actuals and a forward planning exercise to avoid unnecessary gaps due to holidays etc. |

# Questions for the board

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|---|---|---|
| 37. Have we checked payroll matches with activity? | We have audited this. | Yes we carry out checks at point of recording. |
| 38. Have we started job planning early enough in the annual cycle ? | Don't know if this is an issue. | We have recently brought job planning forward to early December to ensure winter pressures do not inhibit and there is time to ensure equity over holidays etc. |
| 39. Are we using both clinical and internal audit to review job planning is working effectively? | Audit carry out reviews, clinical audit does other things. | Our internal audit team have clinically trained capacity, and this allows them to review the job planning administration as well as to comment on impact on quality of delivery and experience. |
| 40. How challenging are our exec staff: they should be questioning how they know what is happening? | Our exec team provide us with assurances that the systems are working. | All relevant exec staff have had training in job planning and rostering systems. The monthly reviews involve a multi-disciplinary team. They report to the board when staff capacity is outside agreed tolerances. |
| 41. Is our erostering system/SafeCare live? Have we simplified the messages to the Board? | The system is complicated and will take a number of years to fully implement. Board is updated on progress. | Yes and reports to the board have been simplified with escalation when staff capacity is outside agreed tolerances. |

# Questions for the board

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|---|---|---|
| 42. What is our hours balance? Have we claimed back all hours not delivered? | What is this? | Hours balance has been managed to a tolerance of less than 1% plus or minus which is corrected in next month. All hours not delivered are reclaimed. |
| 43. Can our boards claim to have the assurance they need that staffing levels are safe? | Yes we have assurances from our executives. | Yes, but we challenge if the capacity is sustainable and deployment is improving quality. |
| 44. Have we got harmonised pay and policies across multi organisation sites? | Merger has only occurred recently and will take several years to complete. | Yes, this was part of the merger transition plan, involving staff from all sites and took less than 12 months to achieve. We took the opportunity to improve policies to best in class. |
| 45. Do we incentivise staff with e.g. voucher schemes? | No, staff are paid according to their conditions of service. | Yes, these are modest shop vouchers but are a bit of fun and do motivate staff. |

# Questions for the board

| Question | Poor answer | Good answer |
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| 46. Have we restricted agency staff in collaborative bank? | No, we do not manage the bank. | Yes, we have a system to ensure our staff have choice and are deployed first before opening the job slots to the bank. |
| 47. What benefits can we gain from the collaborative? E.g. dialogue and joint decision making in other areas just because we are talking as a bank collaborative? | Our executives still seem suspicious of our neighboring trusts and avoid much dialogue. | The collaborative has allowed cross trust discussion on several policy issues. |
| 48. How have common processes/ways of working evolved because we operate a joint collaborative bank? | No. | The collaborative has allowed development of several policies and approaches including, recruitment, training, induction, staff surveys |

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