Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

**WORKFORCE & ORGANISATIONAL DEVELOPMENT COMMITTEE**
**12th May 2015**
**15.00 – 17.00 pm Room 4, Chertsey House, St Peter's Hospital**

# Minutes of meeting

**Present**

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| Philip Beesley | Non-Executive Director |
| Heather Caudle | Chief Nurse |
| Sue Ells | Non-Executive Director (chair) |
| David Fluck | Medical Director |
| Lorraine Knight | Chief Operating Officer |
| Louise McKenzie | Director of Workforce Transformation |
| Suzanne Rankin | Chief Executive |

**In Attendance**

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| Rebecca Matthews | |
| Colleen Sherlock | Head of Workforce Planning & Resourcing (secretary) |
| Phil Spivey | Deputy Director of HR |
| Tom Smerdon | Assistant Director of Operations |

**Apologies**

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| Carolyn Simons | Non-Executive Director |

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| **1.** | **Welcome & Apologies**<br>Carolyn Simons | |
| **2.** | **Minutes of Last Meeting**<br>The minutes were agreed | |
| **3.** | **Matters Arising (Action Log)**<br>• Action to check workforce issues / papers going to other meetings eg IGAC as discussions may be duplicated<br>• Note action log should read 'management time'<br>• Action for HC/CS to follow up on work in progress to ensure ward managers are able to take management time<br>• All others matters arising on agenda | PS |
| **4.** | **Strategic Objective: Skilled Motivated Teams**<br>**Focus on Clinical Engagement**<br>LMcK set the context with a short presentation on current issues in relation to clinical engagement as 1) lack of clinical engagement being an important issue for the board, and 2) following executive away day as part of discussion of workforce priorities and challenges, eg Recruitment and retention. Is there common ground between Trust leadership and consultants in terms of shared understanding of organisational objectives and being on board with them? Difficulty demonstrated in work on Emergency Care pathway in finding a methodology and getting engagement to deliver organisational change.<br>LMcK presented a model to gain consultant engagement in a structured way and will | |

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| | invite Tom Smerdon to feedback from the ECP project to assess how the model could be applied to the ECP programme, inviting views and feedback from the committee.<br><br>LMcK noted that the Trust has done a significant amount of work to make the organisation feel as one that staff can engage in. LMcK went through slides on the 'Engaging for change model'. The measure will be establishing common ground in the Trust between the organisation and clinical leaders.<br><br>Tom Smerdon fedback on the ECP programme, noting that there are some areas within the programme where engagement of clinicians is happening and delivering change, but they are not achieving a good level of engagement across all teams. The problem for the ECP programme is inability to implement changes, that have been designed with clinicians, as they don't have the buy in of the wider clinical team on the ground.<br><br>DF noted the lack of connection and leadership, eg A&E consultants have completely different view from the rest of the organisation on the change needed. And that although not everyone will buy into the common ground, someone has to say what it is and that we're doing it. PB noted that teams need to understand that not everyone will get their point of view agreed. Tom gave examples where individuals have not agreed with the change and have gone in different direction – need to gain and maintain their trust, enables better engagement as even if people don't get their view across still keep engaged.<br><br>HC asked if we make clear what contribution we expect from the consultants – what is their role? SE noted that principle for engagement needs to be consistent, ie do we engage them in solutions before we write the action plan in a PID?<br><br>LMcK circulated a model medical engagement plan to support the ECP Programme, to establish common ground with the key stakeholders/ influencers/ detractors and identify the best engagement plan.<br><br>SR will discuss this at Transformation board and TEC. SE asked how we would be able to judge if that had gone well, what assurance? SR suggested that if TEC agree that this as a good way forward and give commitment, then a good vehicle for testing this piece of work would be to use the ECP as a model. PB suggested adding agreement to implement to include a conscious action to proceed with a change.<br><br>LMcK note that there is no consequence of not engaging. SR if we are confident in the methods we have used, we can play back – here's how you would have been informed.<br><br>SR outlined that this would be the engagement model, it would sit alongside the improvement plan for the ECP, and be delivered through continuation of the engagement model. Success will be achieving 4 hour pathway and understanding the problem. SR model of engagement is great, but perhaps narrow down application to the engagement needed to deliver the urgent care centre?<br><br>SE noted that we need to get people to accept there is a problem. LK added that we assume they know there is a problem but do we all understand it the same, and accept that that there has to be change.<br><br>PB all good, but how can we be sure we'll deliver some change as we've been trying to solve the ECP for a long time. How do we make it work? Tom responded that success in other Trusts has been the result of good, on the ground clinical leadership. We have some but not in degree needed to deliver change and need the support of | |

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| | specialty leads to provide on the ground clinical leadership.<br><br>SR noted that this model gives assurance to the board that an important aspect of fixing the ECP is a planned, methodical system approach to solving one aspect of the plan.<br><br>PB recommended that the expectation of what the model will deliver and solve should be defined so we can measure that it has delivered what was expected.<br><br>Tom- not just solving the negative problem, but if we get this right, there are benefits of more engaged clinical leadership.<br><br>LM noted that we are trying to develop a structure of clinical leadership and engagement that we can apply to different projects – it's a pilot that we'll test with ECP and roll out to other projects. SR – consequence of failing should be articulated in the project. Consequences for patients and individuals | |
| **5.** | **Safer staffing nursing – 6 month review**<br>HC presented the report to the committee which describes background, process and findings. This has been triangulated with data on escorts, deaths on wards, and other quality data. It was noted in March that the report will go to Board in June to review against the patient acuity data (Shelford tool).<br><br>The recommendations are to tighten process, and assign resources to it; agree and fund the inpatient staffing increases and review the findings from the paeds review.<br><br>Staffing establishments overall reflect the numbers required, so at best this will be a redistribution of current resources.<br>PB asked if the report to the board could include a summary statement ie do we meet the staffing levels, what actions need to be taken, and what assurance? | HC |
| **6.** | **Nursing & Midwifery strategy**<br>HC presented the updated strategy reflecting changes in national picture; likely changes in the Chief Nurse of NHS Nursing Strategy with emerging focus on culture of care, leadership and raising concerns; new NMC codes. This will align existing workstreams with the emerging strategy documents. HC and ADNs will be reviewing those key developments in workstreams. Timetable gives indication of activities planned to promote and embed the updated strategy.<br><br>HC noted the requirement to have delivery mechanism for care to enable improvements in practice. The senior nurse leadership group focuses on professional, quality and practice issues and each will focus on different aspects of the strategy and a documentation strategy.<br><br>SR noted this is brilliant to have a nursing strategy, leading the way for medical and AHP strategy. It sets the standards for clinical leadership in organisation and links to work to develop organisational commitments.<br>HC noted that Bruce Keogh has said he would like a 6Cs for doctors. HC/DF meet regularly with Christine Armitage, lead for Therapies to establish more parity between professional clinical groups. | |
| **7.** | **Horizon Scanning**<br>i) SE invited the group to contribute ideas can we adopt or sell to others?<br>HC noted West Herts have used an 'onion' metaphor and applied to a delivery | |

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| | model to help people to engage. LM noted it the onion metaphor was used in their informal and formal communication. PB urged caution with a metaphor, as may not appeal to some. SE noted marketing important to tailor to different stakeholders.<br>ii) Apprenticeships – SE noted opportunity for growth and retention to keep people if they've come for an apprenticeship.<br>CS confirmed that we have apprenticeships in place and will be meeting Nikki Hill to learn more about their scheme. SR noted good link to connect back to local community and generate more flow in to the workforce<br>iii) LM/SR / HC/ LK/ RP going to NHS Confederation for first time and this will be good for horizon scanning. LMcK invited to closed session with NHS England and NHS Employers.<br>**iv)** SR noted proposal to create medical school at Royal Surrey | |
| **8.** | **Workforce Report**<br>Focus in this report on turnover and cost of recruitment. HC / LMcK noted the need to assess the time, money, retention, quality of the nursing. SR noted that individuals in the early part of their career will move on and we should expect some turnover, and plan for that. SR asked if we can we map turnover across age/ seniority of nursing.<br>Mandatory Training - CS described the reset programme. Endorsed by group.<br>Agreed for next Workforce report – include the summary with the data as an appendix. | CS<br>CS<br>CS |
| **9.** | **Equality & Diversity Minutes**<br>The group noted the draft minutes of the most recent meeting. We are developing strategic priorities around E&D, and a delivery plan. Of particular interest is the compassion research project that HC is leading, linking with an International care ethics committee. | |
| **10.** | **Any Other Business & Contingency Time**<br>i) RNNWB - HC informed the group of a proposal to roster specialist nurses in the clinical areas for specific shifts each month, to be implemented by September, and this will support their revalidation. SR they are job planned to deliver activity at present, so need to ensure we aren't reducing their specialist clinical capacity to add to the ward capacity – will work through case by case. PB asked for an FAQ on the common questions for NEDs to be able to support HC with any queries. | |
| **11.** | **Date of Next Meeting**<br>14th July 2015 | |
| **12.** | **ER Report plus Professional Referrals**<br>PS presented the report – and will review the criteria for reporting on the cases. SE asked what particular issues were being addressed? PS noted that most cases have a | Enc 6 |

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| | clear plan in place to manage the issue. The committee discussed the number of cases, and type and timescales were reviewed.<br><br>SR noted the plan to build HR capability in the organisation to develop the HRBPs to be more strategic, to support the organisation to develop better skills. This is development opportunity for this year. | |
| **13.** | **Assurance process in relation to employee relation activity**<br>It was noted that the Board should have oversight of ER activity by receiving the minutes of the WOD committee, noting trends, but not a separate report to Board . CS to ensure that the minutes reflect discussion of cases | |
| **14.** | **Any Other Business** | |
| **15.** | **Feedback on the meeting**<br>Good to have sufficient time to discuss the engagement issue, at the top of the agenda. | |