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Royal Cornwall Hospitals NHS Trust update: With a new (interim) Chief Executive, could a change in culture be on the way?

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Who's in charge at Treliske?

Last week, I reported on the recent resignation of Kathy Byrne as Chief Executive of the Royal Cornwall Hospitals Trust (RCHT).[1] Judging by precedent, we might have thought we were in for another extended period of searching for a replacement, and perhaps we are, but on the RCHT website today we find Kate Shields, who was previously Kathy Byrne's deputy (i.e. Deputy Chief Executive), described as Chief Executive:

> Kate joined the Trust as Deputy Chief Executive in 2017 and took on the role of Chief Executive in July 2018.[2]

Not 'acting', not 'interim', just 'Chief Executive'. And in the small print on the agenda for the meeting of the Trust Board that took place last week, on August 2nd, we again find her listed as 'Chief Executive'.[3]

It took a phone call from the editor of Cornish Stuff to the RCHT press office to elicit the fact that Kate Shields' appointment is an interim one, so it will last only until an appointment proper is made.[4] This could be twelve months away. Clearly one of Kate Shields' first tasks will be to address the shortcomings of her central administration and press office.

The need for systems reform at Treliske

But there is a major job of work calling for her attention. The reports by the Care Quality Commission (CQC) on RCHT's main hospital at Treliske in July 2017 and January 2018 criticised not only particular services but *systems*:

> We had serious concerns that systems to assess, monitor, and mitigate risks to patients receiving care and treatment were not operating effectively. We also had concerns that governance systems and processes were not operating effectively.[5]
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> [We had] serious concerns that systems to assess and deal with risks to patients in maternity and surgery were not operating effectively. Governance systems were not operating effectively in critical care and the fracture clinic … Systems and processes to ensure equipment was of good repair and properly maintained were not operating effectively. Nor were there effective systems for the management of incidents and Never Events, or to comply with the requirements of the duty of candour.[6]

Problems with governance and systems are invariably deep-rooted. Solving them requires capable leadership. So when such problems persist, they are indicators of defects in leadership. The leadership model operated by Kathy Byrne appears to have been of the classic 'command and control' type,[7] which – as The King's Fund and NHS Improvement have identified – is not fit for purpose in today's NHS. Something different is needed.

Kate Shields has to make a choice

What are Kate Shields' options as interim Chief Executive? There are basically two. One is to simply hold the fort until a permanent appointment is made. That clearly would not address the system problems identified by the CQC. And it would amount to a surrender to whatever 'occupying forces' are sent in to inflict 'special measures' on Treliske.

Her other option is to take the initiative. What should she do?

Her opportunity comes at an interesting time for 'leadership' in the NHS. The report by Sir Robert Francis QC on whistle-blowing in the NHS – *Freedom to Speak Up*, published in February 2015 – stressed that culture is a highly important factor within NHS organizations:

> I have concluded that there is a culture within many parts of the NHS which deters staff from raising serious and sensitive concerns and which not infrequently has negative consequences for those brave enough to raise them.' [8]

This focus on the culture within NHS organizations has been followed up by NHS Improvement[9] and the King's Fund. It is now widely accepted that healthy cultures in NHS organisations are crucial to ensuring the delivery of high-quality patient care. The King's Fund has identified six characteristics as being fundamental to a healthy culture: (1) Inspiring vision and values; (2) Goals and performance; (3) Support and compassion; (4) Learning and innovation; (5) Effective teamwork; and (6) Collective leadership.[10] (These are reproduced in the Appendix to this report on pages 4-5.) Such a culture – the King's Fund model – differs in significant respects from the 'command and control' model which seems to have guided Kathy Byrne.

So we have this question: can Kate Shields move the culture of Treliske towards the King's Fund model? What do we know about her?

Her career is briefly summarized on the RCHT website:

> Kate is an experienced NHS leader having worked as Director of Strategy and Partnerships at University Hospitals Leicester. She was a registered nurse and mental health nurse at the beginning of her NHS career. Kate has also worked for NHS England as a Regional Director of Specialised Commissioning and as the National Head of Specialised Commissioning.[11]

We can cautiously take encouragement from the fact that she has experienced working as a nurse, at the 'sharp end' of hospital care. So she should be familiar with hospital cultures, and the mix of departmental hierarchies and professional 'territories' that are found within hospitals, and – one hopes – she will have developed the personal and interpersonal skills necessary to create an atmosphere of trust and mutual understanding in such a context.

Kate Shields' clinical background may give her an advantage over Kathy Byrne, who describes herself on 'LinkedIn' as having 20 years' experience as a 'chief executive in public, commercial and not for profit organisations with particular achievement in customer focused service outcomes, business transformation and enablement through technology', and as having 'a significant track record in strategic and operational leadership, change and innovation in challenging environments in five States and Territories of Australia'. She does not mention hospitals.

What role for patients and the public?

Patients and the public in Cornwall should be heartened to read in the King's Fund report that

- patient-centredness and responsiveness are core
- patient feedback, allied to clear goals, is a necessity
- there has to be an emphasis on learning within the system, and there is a role here for patients' views and feedback
- collective leadership in the NHS should include patients taking on leadership roles, both in determining their own care and in shaping their health care organisations (via patient representatives and patient groups).

It is important to highlight these, because not only do they specify a proactive role for patients: they provide terms of reference for Kate Shields and they also provide us with a set of criteria by which patients and the people of Cornwall, as well as her own staff, can judge how well she is performing in her role.

So can patients and the public make a useful contribution? And if so, how?

To answer these questions we need to look not both at services and at systems, as highlighted by the CQC. The King's Fund report is clearer about services: patients can give feedback, and ask what has been learned from it and how it has been acted on: this is a necessity, as is learning from such feedback. Patients can be involved not only in the day-to-day provision of services but also in their management, e.g. through consultation when decisions – on the allocation of resources, for example – have to be taken. (They can exercise influence simply by asking questions: it does not follow that clinical autonomy has to be sacrificed.) Even if they do no more than ask questions, they are helping to ensure that learning is taking place.

There can also be a useful role for patient representatives and groups in designing systems, as is badly needed at Treliske. By describing their experiences, they can ensure that the patient experience is not lost sight of but heard and appreciated. Importantly, they can make a worthwhile contribution by asking questions and by scrutinizing proposals for change and teasing out their implications. Many lay people in this day and age have experience of systems, of many different kinds, and it would be silly not to take advantage of this. Moreover, people outside the NHS may be well placed to provide support for proposals and requests for funding when the NHS encounters politics.

Can we expect culture change at Treliske?

Now that Kathy Byrne has completed her contribution to 'leadership churn'[12] at Treliske and Kate Shields has taken the helm, albeit on an interim basis, what can we expect? It was encouraging to learn that at the beginning of this year she and Jim McKenna (then Chair of the Trust) had written to staff to thank them for everything they were doing for patients during a very challenging time. 'We wish you a happy new year and let's make sure we look after each other and support one another in the year ahead.' The letter also asked for feedback from staff about the current service pressures, including what they were doing well and not so well. 'We

will have made mistakes in recent weeks and we need to learn if we are to improve the care we provide and meet the needs of the local population.'[13] The sentiments in this final sentence do credit to her: that they justify the description 'extraordinary' is a mark of how unusual they are.

The role of Chief Executive of an NHS hospital trust is a lonely one. And Kate Shields will be taking on not only the role of heading the Royal Cornwall Hospitals Trust but also the demanding high-level political/strategic role of finding a place for RCHT in some kind of integrated health and social care organization within Cornwall's devolution scheme. From the point of view of patients and the wider community in Cornwall, we can only say that if she manages to ride both these horses simultaneously and successfully, and to be open to the involvement of patients and the public, she will earn our unstinting gratitude and support. We wish her well.

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[With thanks to my fellow-members of the committee of West Cornwall HealthWatch for their insightful comments and suggestions.]

Appendix: The King's Fund on 'the characteristics of a healthy culture'

The King's Fund has identified six characteristics as being fundamental to a healthy culture: (1) Inspiring vision and values; (2) Goals and performance; (3) Support and compassion; (4) Learning and innovation; (5) Effective teamwork; and (6) Collective leadership. Here is a very slightly edited version of what The King's Fund says.

1. Inspiring vision and values. Leaders at every level should communicate an inspiring, forward-looking and ambitious vision focused on offering high-quality, compassionate care to the communities they serve. There should be clear values that set expectations for how staff conduct themselves and interact with colleagues and patients. Values are set out in the NHS constitution, and patient-centredness and responsiveness are core. Good leaders reiterate at every level the message that high-quality, compassionate care is the core purpose of all staff, so that everyone understands and acts on this commitment. This takes time, sustained energy and dedication.

2. Clear goals and performance feedback. There must be clear goals, supported by performance feedback. Goals must be set at every level from the board to frontline staff. Board goals should be shaped by patient input. Performance feedback should be based on patient feedback and patient outcomes. Staff in health services report that they are often overwhelmed by their workload and are unclear about the goals they are working towards. This produces stress, inefficiency and poor quality care. Such situations can arise when senior managers insist on too many priorities. A clear vision and mission statement about high-quality, compassionate care provides a directional path for staff. But this must be translated into clear, aligned, agreed and challenging goals at all levels of the organisation. It must be matched by timely, helpful and formative feedback for those delivering care if they are to continually improve quality.

3. Support and compassion. If we want staff to treat patients with respect, care and compassion, all leaders and staff must treat their colleagues with respect, care and compassion. Directive,

aggressive or brusque leaders dilute the ability of staff to make good decisions, deplete their emotional resources and hinder their ability to relate effectively to patients, especially those who are most distressed or challenging. There are clear links between staff experience and patient outcomes. Staff views of their leaders are strongly related to patients' perceptions of the quality of care. The higher the levels of satisfaction and commitment that staff report, the higher the levels of satisfaction that patients report. If leaders and managers create positive, supportive environments for staff, they in turn create caring, supportive environments and deliver high-quality care for patients. Such leadership cultures encourage staff engagement.

4. Learning and innovation. Sustaining cultures of high-quality care involves all staff focusing on continual learning and improvement of patient care. Learning and quality improvement are dependent on continual patient input – innovation is most likely where patients' views and feedback play a strong role. A focus on improvement should ensure that: (a) teams at all levels collectively take time to review and improve their performance; (b) quality and patient safety practices are an ongoing priority for all; and (c) there are high levels of dialogue, debate and discussion across the organisation to achieve shared understanding about quality problems and solutions. All staff should encourage, welcome and explore feedback and treat complaints and errors as opportunities for learning across the system rather than as a prompt for blame. This encourages collective openness to and learning from errors, near misses and incidents.

5. Effective teamworking. Where multi-professional teams work together, patient satisfaction is higher, health care delivery is more effective, there are higher levels of innovation in ways of caring for patients, lower levels of stress, absenteeism and turnover, and more consistent communication with patients. Leadership that ensures effective team and inter-teamwork (both within and across organisational boundaries) is essential if NHS organisations are to meet the challenges ahead. Shared leadership in teams is a strong predictor of team performance.

6. Collective leadership. Leadership in the NHS should be collective and distributed rather than located in a few individuals at the top of organisations. Collective leadership means everyone taking responsibility for the success of the organisation as a whole – not just for their own jobs. It requires organisations to distribute leadership power to wherever expertise, capability and motivation sit within organisations. This includes patients taking on leadership roles, both in determining their own care and in shaping their health care organisations (via patient representatives and patient groups). Collective leadership should also be collaborative, with leaders working together – and with a common style of supportive, enabling and empowering leadership to prioritise quality of patient/service user care overall, not simply in their own areas of operation. It is through collective leadership that cultures of high-quality, compassionate and continually improving care will develop and thrive. Every interaction by every leader at every level shapes the emerging culture of an organisation.

Notes and references (All online sources last accessed 10 August 2018)

[1] http://spr4cornwall.net/royal-cornwall-hospitals-nhs-trust-is-one-person-able-to-do-the-chief-executives-job/

[2] https://www.royalcornwall.nhs.uk/our-organisation/about/your-trust-board/

[3] https://doclibrary-rcht.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/ChiefExecutive/TrustBoard/Minutes/1819/201808/Agenda.pdf

[4] https://cornishstuff.com/2018/08/10/deputy-is-new-treliske-boss-for-a-year-at-least/

[5] Care Quality Commission, *Royal Cornwall Hospital, Quality Report*, 5 Oct 2017, p.2 https://www.cqc.org.uk/sites/default/files/new_reports/AAAG6980.pdf

[6] Care Quality Commission, *Royal Cornwall Hospitals NHS Trust, Quality Report*, 5 April 2018, p.5 https://www.cqc.org.uk/sites/default/files/20180405_Royal_Cornwall_Hospitals_NHS_Trust_REF.pdf

[7] A major improvement in the functioning of the Emergency Department at Treliske earlier this year has been attributed by the Trust to the 'Gold Command' system that had been put in place. Overlooked was the fact that the new system depended heavily for its success on people 'pitching in together', i.e. on collective behaviour. See *Credit where credit is due! So well done to everyone who helped turn round the situation in A&E at the Royal Cornwall Hospital, Treliske (Truro). Now the right lessons must be learned.* http://spr4cornwall.net/credit-where-credit-is-due-so-well-done-everyone-who-helped-turn-round-the-situation-in-ae-at-the-royal-cornwall-hospital-treliske-truro-now-the-right-lessons-must-be-learned/

[8] Sir Robert Francis, *Freedom to Speak Up*, February 2015, p.8 http://freedomtospeakup.org.uk/the-report

[9] NHS Improvement, *Why is culture important?*, September 2017 https://improvement.nhs.uk/documents/1629/01-NHS101_02_Improvement_Mini_Guide-Why__100417_I.pdf

[10] The King's Fund, *Improving NHS Culture*, 25 August 2015 https://www.kingsfund.org.uk/projects/culture

[11] As [2]

[12] On 'leadership churn', see The King's Fund, *Leadership in Today's NHS: Delivering the Impossible*, 18 July 2018 https://www.kingsfund.org.uk/publications/leadership-todays-nhs

[13] Ginette Davis, The extraordinary thank you letter sent to NHS staff in Cornwall, *Cornwall Live*, 10 January 2018 https://www.cornwalllive.com/news/cornwall-news/extraordinary-thank-you-letter-sent-1037593