Thought Piece - compact

The NHS is changing and historic leadership behaviours that prevailed are slowly making way for compassionate and inclusive leadership to flourish at all levels. Evidence shows that good leadership behaviours directly influence both patient safety and staff retention[1] – which is why it is vitally important

One mechanism to accelerate this will be through the co-creation of a common understanding of the behaviours expected of our leaders, supported by a compact to ensure mutual accountability between individuals and organisations.

Interim People Plan p.17 states - *As NHS England and NHS Improvement come together to establish new structures and ways of working, we have a valuable opportunity to co-produce* ***a new 'compact' between leaders that sets out the 'gives and gets', to shape the recruitment, development and appraisal of our NHS leaders****. As part of developing this 'compact' with our senior leaders, we will consider the recommendations from Empowering leaders to lead by Sir Ron Kerr and the Review of the Fit and Proper Persons Test by Tom Kark QC.*

Why is a compact needed?

This short thought piece sets out a small amount of the research that has been undertaken in the development of an NHS Leadership Compact.

To ensure the compact is developed from an appreciative stance, the Academy firstly undertook a piece of desktop research to understand the existing evidence base. We explored who is using such approaches, the content and how they are applied in practice from a wide range of organisations. We refined the research dimensions to "leadership" including codes and compacts within the search criteria, we also looked at the success – or otherwise - or non-adoption of approaches like this specifically in the NHS. Given the diversity of organisations, cultures and professions within the NHS it is not surprising that there is a diversity of products in place answering this description.

It is important in this to acknowledge the **NHS Constitution** although not a code as such, it is one universally adopted document. Made up of seven principles and six values of the NHS in England, it sets out rights to which patients, public and staff are entitled, contains pledges, which the NHS is committed to achieve and is enshrined in law. The **NHS Constitution** underpins this this dialogue and should set the tone for any tool that is developed. However, it will not come as surprise that even prior to the constitution back in 2002, the NHS was looking at a Code of Conduct for Managers This was in response to *'Learning From Bristol - The Report of the Public Inquiry into*

[1] West, MA & Chowla, R 2017, Compassionate leadership for compassionate health care. in P Gilbert (ed.), Compassion: Concepts, Research and Applications. Routledge, London, pp. 237-257. https://doi.org/10.4324/9781315564296

children's heart surgery at the Bristol Royal Infirmary 1984-1995' by Professor Sir Ian Kennedy 2001.

Whilst concentrating on 'management' as opposed to leadership, the code did reflect several working practices that are now widely recognised as leadership including teamwork, professional development and inclusive practice. With poor adoption of this, mainly due to ambiguous guidance on how and consequences for noncompliance, over a decade later, The Francis Enquiry [2013] into Mid Staffordshire NHS Trust stated failings of leadership and that strengthening leadership was needed. It too called for the regulation of managers, stating that if the recommendations of the Bristol inquiry had been fully acted on, then some of the failings at Mid Staffs may have been avoided. This led to a more comprehensive approach to capability raising including the centralisation of the delivery in the development of leadership behaviours in the creation of the NHS Leadership Academy, which is demonstrating impact at many levels (Ipsos Mori 2018). There is still a lack of consistency however, with the engagement and adoption of good leadership practices. The report of Dr Bill Kirkup into failings at Liverpool Community Health NHS Trust [2018] the Kark Report [2019] and NHS Long Term Plan [2019] again suggest the way forward is a set of measurable standards for those in positions of leadership and management that unify practice based on the best possible.

Codes and Compacts already in use

NHS Scotland has had the "Delivering Quality Through Leadership Framework' since 2005. The original 'NHS Scotland Leadership Qualities Framework' was developed by the leadership team (precursor to the National Leadership Unit) in the Scottish Executive Health Directorates, on behalf of NHS Scotland. Contained within this is the Leaders and Managers Code of Personal Governance – a series of statements, which outline personal accountability for leadership behaviours. Interestingly, the code is presented as an appendix to the Qualities Framework and not as an entity in its own right

The only reference to a specific Leadership Code in the NHS in England was found in a publicly available Board paper[2] setting out an action plan resulting from a recent Well-led Review for Birmingham Community Healthcare NHS Foundation Trust. The action plan states, *"the Trust has developed and published a Leaders' Code that explains the expected behaviours to be modelled by its leaders".* this Code is currently being reviewed alongside a vision and values refresh, and at present it is not in use.

Searches for leadership, **values** and behaviours resulted in many examples of NHS organisational values. Work on values, most often related to people and organisational development strategy, has become commonplace since the Francis Report (2013)[3], with a clear focus on transforming organisational culture. Searches

[2] http://www.bhamcommunity.nhs.uk/EasysiteWeb/getresource.axd?AssetID=28360&type=full&servicetype=Attachment
[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279121/0898_iii.pdf

indicate that organisations have progressed values work to different levels of depth and purpose. Most organisations have publicised values, others have developed these to describe **values-based behaviours,** and/or have incorporated their values into recruitment, performance and development frameworks. Many organisations also define behaviours in terms of what they 'love' to see, what they expect to see, what they do not want to see, What is not clear however, is how these behaviours are monitored, rewarded or dealt with if not upheld. There is significant evidence from the recent staff survey that many staff are not experiencing good leadership despite this wide spread focus on values-based behaviours. This is also akin to the significant anecdotal evidence around the behaviours experienced by senior leaders in frontline organisations when in contact with NHS Arm Length Bodies. Many organisations appear to have a 'way of working: **Guy's and St Thomas' NHS Foundation Trust has a Values and Behaviours Framewor**k, which differentiates values behaviours for different groups of staff, three of which explicitly relate to leadership roles.

Chesterfield Royal Hospital NHS Foundation Trust has designed a framework, **Leading the Chesterfield Way** that sets out to improve how it supports and develops leaders at all levels of the organisation. 'Leading the Chesterfield Way' is a framework for all leaders – in both clinical and non-clinical roles. The aim is that the framework shapes people development, compassionate care and quality improvement for years to come. It is seen as an integral part of making the hospital an even better place to work and as a result improving the high standards of care and service for patients. There are others readily available such as the '**Leeds Way'** across Leeds Teaching Hospitals NHS Foundation Trust and the 'WWL Way' at Wrightington, Wigan and Leigh NHS Foundation Trust.

Whilst not specifically NHS, but covering all public service, The Committee on Standards in Public Life was convened in 1994 to address unethical behaviour by politicians. The first report in 1995 gave the **Nolan Principles** which continue to form part of the Ministerial Code which sets out the standards of behaviour of all those who serve in government, but are now widely used across public sector organisations.

The seven principles are applied to all holders of public office were first published in 1995 and have undergone a number or revisions. The principles [current wording] are as follows:

- **Selflessness** Holders of public office should act solely in terms of the public interest.
- **Integrity** Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.
- **Objectivity** Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

- **Accountability** Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
- **Openness** Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.
- **Honesty** Holders of public office should be truthful
- **Leadership** Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs

Organisations using codes outside of NHS with a defined leadership component.

The **British Army**. The code described behaviours based on the army's values and standards and was developed because *"we know what good looks like. But we know that at times we don't all get it right – this is why we need the Army Leadership Code"*.

The Army Leadership Code was developed by drawing together and formalising elements of good leadership that have been practised instinctively or consciously for centuries and is a soldierly codification of what is known to work. It is based on the concept of Values-Based Leadership, which for some years now has been applied in its training establishments to great effect, and where championed has been very successful in the Field Army.

The Army Leadership Code draws from academic leadership theory with empirical evidence. At the heart of the Code are seven leadership behaviours developed from the principles of transformational and transactional leadership theory. This combination of behaviours promotes optimal human performance and constant communication of our Values and Standards.

The purpose of the Leadership Code is to translate the values and standards into desired leadership behaviours so that leaders communicate the values and standards in everything they do. This aim is others will learn these behaviours from their leaders, embedding them into everyday practice and creating high performing individuals and teams.

The Army Leadership Code sets out seven leadership behaviours, which form the mnemonic – LEADERS. These are:

- **L**ead by example
- **E**ncourage thinking
- **A**pply reward and discipline
- **D**emand high performance
- **E**ncourage confidence in the team

- **R**ecognise individual strengths and weaknesses
- **S**trive for team goals

Each behaviour is described in terms of how it links to the values. Application of the Leadership Code is supported by The Vision – Support – Challenge Framework which illustrates how the seven leadership behaviours complement each other.

The Civil Service Leadership Statement[4], was developed following the 2014 Civil Service Reform Progress Report and Talent Action Plan to explicitly set out the behaviours expected from all leaders across the Civil Service. Unlike the Army's Leadership Code, there is no obvious link made between the statement and the Service's values which apply to all staff. However, it was envisaged such a Statement would explain the difference people wanted to see and provide the first step towards further cultural change. A Leadership Statement blog[5] is available on the Civil Service's website to support the initiative, however the latest entry was in 2016 which may indicate that codes lose their relevance over time unless reinforced through other aspects of organisational life. At its inception Civil Servants across the country were consulted and a clear Statement was produced to reflect their comments about the positive attributes they wanted to see in their leaders. This was incredibly useful evidence around how to be inclusive and develop a coproduced "product" helping to develop the thinking taking place around how it could be developed.

The totality of these examples demonstrate that while some organisations have attempted to develop and uphold a standard for leadership behaviours it is not comprehensive and sustainability has been an issue in many cases where it has not been a lived code. While having many similarities in their themes each reflect the type of organisation and method of inception with many being top down in approach. While NHS have led with values-based codes this work by individual organisations is not reflected or standardised across the NHS or wider health and care system. However, with the widespread organisational change in NHS England/Improvement and the development of a Peoples Directorate the appetite and timing for developing a method of upholding good leadership behaviours and holding people to account in its delivery can be viewed positively.

Why a Compact not a Code?

Agreements in the NHS and public sector services

A compact provides the framework for organisations to work together to a common understanding. It is not a legally binding agreement, nor is signing up to the compact

[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/462305/Leadership_statement_pocket_guide_A5__4_.pdf

[5] https://civilservice.blog.gov.uk/category/civil-service-reform/leadership-statement/

compulsory, yet it sets out the expectations on both sides for how leadership in the NHS will be and to bring lasting benefit through realising the ambitions of the NHS People Plan.The idea of a Leadership Compact is not new, The NHS Leadership Academy started the work to create a leadership compact for the NHS at its inception but the timing was wrong, therefore asking organisations to sign up to a Leadership Compact at that time was not appropriate.

The research shows a number of compacts have been developed across the NHS but all appear to be at either a local level or in relation to a specific service. There is little of the scale and seniority required within the People Plan. The closest evidence that could be found to a national compact within the public sector was the Compact Agreement between the UK Coalition Government and the Office for Civil society which began in 2010. This compact set out the agreement between the government and all Civil Society Organisations nationwide. The document is now expired but the process and mechanism for its implementation is available at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/61169/The_20Compact.pdf

http://www.compactvoice.org.uk/sites/default/files/the_compact.pdf

Interestingly, whilst the main compact is no longer live, there are many, many local compacts that have taken the original framework and created local versions, based on local need, but aligned to the main themes found in the original document.

Most of the compacts available appear to be ‘on a page’ and produced in the same format of two columns stating the ‘give and get’ of the agreement. Typical examples are given below:

NHS England

Compact

Between Specialised Services Clinical Reference Groups & the Association of the British Pharmaceutical Industry

The establishment of NHS England Specialised Services National Clinical Reference Groups (CRG) offers a real opportunity to develop new partnership ways of working between those designing future services and commercial organisations, building capability and products for the delivery of healthcare. The compact provides a framework for staff in the NHS and individuals in the commercial sector to look ahead to new ways of working. The use of these compact principles aims to bring intellect, creativity and energy to improve healthcare in ways that add value to the patients, the NHS and the partnered commercial organisations[1].

What can the NHS England CRGs expect from a partnership with a pharmaceutical organisation?	What can the pharmaceutical organisations expect from a partnership with a NHS England CRG?
Partnership to drive the delivery of high quality treatments and services for patients and the promotion of joint working which will follow the principles in the Joint Working Toolkit	To be involved in the formation of clinical access policy development that relates to their product or specifications to a field of interest
Access to information, analysis and insight, respecting confidentiality and the development of shared governance of data	The sharing of non-patient identifiable data on variations in patient access and clinical outcomes
The promotion of the expertise of the CRGs among global colleagues, encouraging them to consider their input into development of new medicines	A collaboration in developing research including developing methods of collecting real world data, developing and managing data registries, and non-intervention studies
Development of the means to share skills and expertise of the industry	Access to the expertise within the CRG - both clinical and the patient and public voice
Optimisation of the quality of the engagement, which includes having appropriate individuals with the right knowledge and skills	A single point of contact for each CRG (this may be a different member to the Chair)
The development of processes to provide medical information on the use of unlicensed medicines [subject to a documented request from a CRG] when there is clinical need in individual patients and no suitable licensed alternative	A collaboration on the development of paediatric drug research and shared input to commissioning products
The creation of a new industry group tasked with developing the strategic partnership	A stakeholder engagement plan that includes the industry with parity of esteem to other stakeholders
Help to identify where on pathways of care efficiencies (quality and productivity) can be made	Inclusion in the work to evaluate pathways of care
Support implementation of service policies where appropriate, and the adoption of new medicines	Support for the implementation of service policy across the health economy
Transparency about engagement, in particular around any resources provided	Facilitation of meetings with individual or multiple companies with stakeholder interest in a particular therapy area
Provision of timely and appropriate advance product information to support Horizon Scanning and impact assessment, to help inform planning decisions, i.e. new chemical entities, new indications and formulations for existing products[2]	Provision of effective and timely clinical expertise into NHS England evaluation processes Provision of service expertise in Horizon Scanning
ABPI will host an annual meeting between representatives of the CRGs and industry	The organisation of a national conference for Specialised Services to include all stakeholder companies

The principles of the ABPI Code of Practice will provide a framework for the governance of industry engagement and the code will be periodically reviewed to ensure relevance

[1] The compact is based on thinking from 'Leading Physicians Through Change', by Jacob B Sliversin

[2] Subject to usual terms and conditions about provision of commercial in confidence data

2 Southern Health NHS Foundation Trust

Southern Health NHS
NHS Foundation Trust

STAFF COMPACT

Organisation's Behaviours	Staff Behaviours
Person & Patient-Centred Care • Recognise and reward exceptional contributions to patient care and organisational goals • Constructively challenge behaviours which are not aligned with organisational values • Make decisions on the basis of quality rather than just cost	**Person & Patient-Centred Care** • Practise quality medicine which ensures good patient, carer and stakeholder experience and improves outcomes • Encourage patient, carer and commissioner involvement in care and treatment decisions • Insist on seamless services and participate in quality improvement • Ensure that appraisal and revalidation are used to improve care
Releasing Ambition • Support career development and professional satisfaction through appraisal of performance and behaviours • Develop and nurture leadership potential through providing individual and team development opportunities throughout your medical career at SHFT • Ensure job planning is fair, equitable and constructed to release ambition	**Releasing Ambition** • Align professional goals with Trust objectives through annual PDP in line with your Divisional Business Plan • Lead on changes which will deliver better quality care through integration and contribute to the reputation of the Trust • Participate in and value Trust commitments to individual and team development, Trust appraisal processes and statutory/mandatory training
Value through Innovation • Create opportunities to participate in research and quality improvement activities • Clarify research priorities • Provide a mechanism where innovative ideas can be shared • Strive to provide state-of-the-art technology to drive best patient care • Provide clinicians with individual and service outcome data to facilitate continuous improvement	**Value through Innovation** • Work with the organisation to develop clinical outcome measures relevant to your practice • Participate in and/or lead innovative solutions to the benefit of patients by working with key departments in the Trust (Business Development, HR, Finance etc) • Take responsibility for ensuring that money is spent wisely and unnecessary costs are removed
Forging Relationships • Share information regarding strategic intent, organisational priorities and business decisions through appropriately resourced CSDs • Demonstrate the value placed on the medical workforce by encouraging participation in organisational decision-making by sharing financial Information to help with resource allocation • Treat all staff with respect, listen, communicate and promote a culture where talk and action are coherent and consistent	**Forging Relationships** • Develop relationships internally with Clinical and Divisional Directors, CSDs, Area Directors and multi-disciplinary Team Members • Collaborate with external partners eg GPs, Police, Social Services • Treat all with respect, listen, communicate and participate in a culture where talk and action are coherent and consistent • Constructively challenge organisational behaviours not aligned with organisational values through established Trust processes
Valuing Achievement • Recruit, retain, train and develop highly-talented medical staff • Create an innovative and non-punitive culture which encourages success , learns from mistakes and credits good performance • Clearly communicate organisational goals to clarify team objectives	**Valuing Achievement** • Create a team environment which injects fun, nurtures potential and values individuals and teams • Be a role model which inspires others to achieve best quality care • Support organisational leaders and eliminate 'them on the dark side' culture

3 Tees, Esk and Wear Valleys NHS Foundation Trust

Staff compact

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

The psychological or cultural relationship that exists between staff and the trust

Trust	Staff
Communications The trust will strive to ensure honest and timely communications at all times.	**Alignment** To work in accordance with the values of the trust and its strategic goals, mission (purpose) and vision.
Recognition The trust will recognise staff who have achieved excellence and show commitment to value adding work.	**Responsive** To respond to the changing needs of patients and people who use our services, as well as changes to the requirements of other "customers" and changes in demand for services.
Training and development The trust will invest in the continuing professional development, training and education of staff in the skills and competencies required and adhere to all agreed training commitments.	**Technical expertise** To keep skills and competencies up to date and relevant to their work, all of which will be evidence based.
Support The trust will ensure that staff will be involved in and supported through the process of change and managing the process of change.	**Embrace and engage** Willingness to support, co-operate with and contribute to quality improvement activities and especially with the testing of new ideas and innovations.
Work environment The trust will strive to provide a positive, healthy workplace for all staff which is characterised by enthusiasm and not cynicism; staff having the right equipment; the right colleagues and a good physical environment in which to work.	**Team work** To be supportive, positive and a good communicator with staff, people who use our services and all other "customers" e.g. GPs, CCGs, Social Services, etc.
Choice The trust will give staff choices to ensure no compulsory redundancies should job numbers reduce as a consequence of quality improvement activities.	**Flexibility** In the context of significant change taking place in society and the NHS, staff will be flexible with regard to the breadth of work undertaken and the location of their work.
"The trust will endeavour to be a great organisation to work for"	***"My job is to provide the best possible customer experience"***

making a difference together

In all of the above, there is an emphasis on the 'what' rather than the 'how'. One document that takes a very different approach is appears to be **NHS Thanet CCG** who have a very comprehensive compact that outlines not only compact itself in the form of the 'contract' between the Trust and its citizens but also the behaviours that it relates to. It can be accessed at the following URL https://www.thanetccg.nhs.uk/about-us/integrating-health-and-social-care/ This has since been renewed and conversations with those involved report it is a living document within the locality.

This comprehensive approach is what the NHS Leadership Compact could be modelled on as it sets out very clearly all aspects of the agreement, not just the compact itself. It clearly states the need for the compact, the shared purpose it will achieve, the strategic goals, the compact agreement items, sustainability, the culture needed to deliver the work and importantly, the names and signatures of those signed up from across the partner organisations. This is in contrast to the other compacts that appear to be 'ownerless documents'. Key within the development of a Compact, regardless of the format, it has to work together and support the other streams of activity in the Interim People Plan.

It is acknowledged that literature is awash with many texts on what makes good leadership however key insight into development of agreements or compacts where it has been available continually points to the development phase being crucial to the adoption and success of a compact[6]. As such whatever makes the cut will be as a result of a comprehensive coproduced consultation where NHS leaders have the opportunity demonstrate what is of value to them. With the process of development being as important as the finished article itself.

In conclusion, there are a number of codes, which set out desired leadership behaviours in existence across the Public sector. They are not widely used but do set out the expectations for how staff should lead and behave so are valuable in informing this work. Compacts appear more widespread but the publication of many available appears to have happened in a few years ago. Many compacts are short and set out the 'what' rather than the 'why and how'. Further investigation with those organisations that have published their compact has given insights into process, consultation methods and successful implementation. What is pertinent amongst those insights is that where a there has been sustainability it has been through ownership, role modelling, revisiting/refresh and the daily use and reference of such a document whether it is phased as a code or a compact.

[6] Integrating health and social care in Thanet; Compact Agreement 2015-2018, www.thanetccg.nhs.uk/EasysiteWeb/getresource.axd?AssetID=436233&type=..