REVIEW OF RELATIONSHIPS IN HOSPITAL SERVICES DEPARTMENT, COLINDALE
SUMMARY REPORT

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1. INTRODUCTION

1.1 Owing to a number of behavioural/relationship issues that have been ongoing for some time an independent review of relationships in the hospital services department at Colindale was commissioned by Peter Lidstone, Director of Manufacturing and Logistics and in partnershjp with staffside.

1.2 The purpose and scope of the review was agreed as being:

- To identify the root cause of the unhappiness within the department and begin to uncover where the behavioural/team dynamics are an issue so that work could be done to try and resolve it
- Provide reassurance to all that there was no "hidden agenda" or pre-conceived ideas about the department that could influence the discussions and findings
- To complete the review in a timely manner and minimise the "pull" on operational activities
- To engage national staff side, and to seek their agreement as to the scope of the investigation

1.3 I was commissioned as an external HR Consultant to undertake the review.

2. METHODOLOGY

2.1 In consultation with HR representatives, Staff Side Officers and Hospital Managers a schedule of staff with whom I would meet was identified. I conducted 41 face to face interviews, covering all grades and patterns of working and held one telephone interview. The interviews took place over 7 days in August and September 2016. 8 members of staff were accompanied by staff side representatives.

2.2 Summary notes of staff interviews/telephone calls were made and forwarded to individuals, which they were asked to sign and return. At the point of writing this report 26 sets of signed notes and 1 unsigned have been returned.

2.3 Telephone conversations with 2 members of the Organisational Workforce Development Team who had been involved in learning and organisational development interventions in the department were also held.

2.4 Various documents were reviewed to supplement the information obtained from interviews,

2.5 Information gathered from staff conversations, documents, emails were cross-referenced and have supported the themes and findings outlined in this report.

2.6 Despite the difficulties within the department, the continuing commitment of staff to the continued success of the department, and their sense of the contribution they make to patients' lives, should be acknowledged. I would like to thank all those staff who met with me as part of this review and those individuals who provided me with copies of documents that I requested.

3. ISSUES IMPACTING ON RELATIONSHIPS IN THE DEPARTMENT

3.1 **Historical Context -** In 2012 a decision was taken to consolidate services across London with Colindale becoming the only manufacturing site. This meant a great deal more activity coming out of Colindale, putting additional pressure and stress on staff. Some Issue Specialists (shifts) were working excessive hours, sometimes working 100+ hours overtime per month. It was acknowledged by the Hospital Services Manager that staff did everything possible to support the consolidation exercise. A workforce plan to support the changes was developed but was not approved until August 2014.

The consolidation programme was overtaken by a national consultation to harmonise hospital services structures, job banding and shift arrangements. Four outcomes from the national consultation had a detrimental impact on the Issue Specialists (shifts) (retitled as Hospital Services Supervisors).

- The down banding of the Issue Specialist role (shifts) from band 6 to band 5
- The removal of staffing supervisory responsibilities from the Issue Specialist role (shifts)
- The retention of band 6 for the Issue Specialists (non-shifts)
- The introduction of new rotas and, as a by-product a reduction in shift allowance

Hospital Services Supervisors did not consider that the size or specialist role of Colindale was taken into consideration when reviewing banding of roles. There remains a resentment that Hospital Services Team Leaders remained at band 6 and this has created a division between the two groups of staff, which continue to drive relationships in the department today.

Dissatisfaction was expressed at the way in which the consultation exercise was conducted. Staff considered that communication was poor to non-existent, that they were relying on staff from other centres to provide them with updates, and that they were misled about what other centres had agreed. In particular they considered the Hospital Services Manager should have done more to support their cause

Hospital Services Supervisors said that prior to the announcement of the down-banding, the staff management elements of their role were gradually eroded and transferred to the Hospital Team Leaders.

Some Hospital Team Leaders expressed sympathy with Hospital Services Supervisors about the down-banding decision.

Following the national consultation exercise a number of complaints were made to the Hospital Services Manager about alleged bullying behaviour. The outcomes from investigations into these matters have not supported the development of relationships. Although a number of interventions were put in place, supported by the Organisational Development Department, there continues to be divisions between the Hospital Team Leaders and the Hospital Services Supervisors, and within the Hospital Services Supervisors Team itself.

3.2 **Current Issues -** The most common reasons put forward by staff for the problems in the department were:

- Tension within the Hospital Services Supervisor group.
- A disconnect between the Hospital Services Supervisors and Hospital Team Leaders with a culture of “Us and Them” developing.
- Pressures of workload, low staffing levels and onerous rotas.
- Ongoing relationship issues between staff and supervisors which in some cases referenced specific supervisors.
- The development of cliques or groups, left unchallenged and unmanaged.
- Various forms of bad behaviour.
- Lack of confidence in the management team to manage the situation.

Some reported that relationships within the department were having a negative effect on them as individuals. Some people reported wanting to leave their job.

3.3 **Departmental management -** 28 members of laboratory staff interviewed raised concern to some level over the way in which the department was managed. The issues raised span all areas of staff and departmental management. I believe that the initial instigators for the views about management are:

- The disaffection felt by some of the Hospital Services Supervisors.
- The perceived lack of management of allegations of bullying in the department.
- Lack of management skills displayed by some of the Hospital Team Leaders.

Concerns over management fell into two main categories: -

3.3.1 **Poor management and leadership** –Views were expressed that managers were reactive, rather than proactive and lacked the required management skills. Some of the issues raised were:

- Team Leaders leaving between 3 and 4 p.m. which portrayed a lack of interest or knowledge about issues facing the late/night/weekend shifts
- A lack of visibility by Hospital Team Leaders in the laboratory
- Inability of Hospital Team Leaders to help support the shift and a view they should be trained to a level of competence in the laboratory
- Lack of support/intervention of the managers when complaints were raised with them
- The inability of managers to manage various “cliques” and groups that have developed
- Inability to manage conflict.

Managers were seen to never praise staff but were quick to criticise and raise issues with them.

Some of the Hospital Services Supervisors said that the concept of a management team comprising only the Hospital Team Leaders Team was constantly put forward and was regularly referred to by the Hospital Services Manager “as my management team,” thus excluding the Hospital Services Supervisors from this elite.

Comments about managers varied from referring to one as being a “bully” through to them being “friendly, helpful and approachable.”

3.3.2 **Unfair Management Practices -** A range of issues perceived as being unfair management practices were highlighted by individuals across the grades. It was not

part of my brief to review every individual's complaint. I did, however, review some documentation in order to gain a picture of how staffing issues are managed within the department. These unfair practices covered:

- Management of Sickness Absence.
- Time Off to attend Interviews.
- Changes to Hours.
- Allocation of annual leave.
- Management of poor performance.
- Recruitment.
- Signing in/out book.

In 4 instances staff felt this bordered on discriminatory practice.

I reviewed some documentation in respect of issues raised. Whilst staff do not always understand how human resources practices might need to be managed, I believe a number of day to day staffing issues have not always been well-managed or rules and procedures implemented in an appropriate, transparent and understandable way to staff.

There has been a serious failure over a sustained period of time to adequately identify and resolve problems which has contributed to the breakdown of relationships. There is a lack of trust and confidence in management, which will need to be addressed.

Poor managerial practices are not exclusively related to the Hospital Services Manager and Team Leaders, but also Hospital Services Supervisors. There is a division in the Hospital Services Supervisors Group which lead to poor levels of communication between them, separate groups being formed and staff being "warned" about colleagues. There are reports of the longer serving Hospital Services Supervisors making it clear they did not like the newer ones. This division is acknowledged by the group themselves.

Staff feel frustrated when they raise any questions or concerns with the Hospital Services Supervisors being told to take these up with Hospital Team Leaders. Some staff feel there is being challenged but in an underhand and informal manner.

Some staff feel that the workload is unfairly allocated - this could either be because the member of staff was not part of a favoured group, or conversely because they were hard workers and could be relied on. This unfair allocation of work is usually related to specific Hospital Services Supervisors.

Hospital Services Supervisors made it clear they considered their staff management responsibilities did not extend beyond processing the shift, with anything else the responsibility of the Hospital Team Leaders.

A "Team Time Out" was planned to begin to address relationship issues between the Hospital Services Supervisors and Hospital Team Leaders. However, operational difficulties were cited and the event was only attended by Hospital Services Supervisors. One Hospital Services Supervisor said that "it spoke volumes" that the Hospital Team Leaders had not engaged with this day and, in their view emphasised the "us and them" culture.

Whilst the intention of this event had been to identify the underlying causes of dysfunction within the team and to focus on behaviours using NLP techniques and develop some core behaviours for the team, it centred on issues the Hospital Services Supervisors had with the Hospital Team Leaders.

The Hospital Services Supervisors all held the view that there were very few outputs from the day, whilst the OWD facilitator reported that there had been agreement to 5/6 core behavioural changes with a view to these being taken out to the wider team for discussion.

There was a general view expressed by Hospital Services Supervisors that relationships between them could not be remedied by a further similar exercise. Although they had been united in their criticisms of the hospital management team they reported this unity had not extended into any other areas of their relationship and the divide remained.

This was certainly a missed opportunity for the Hospital Services Supervisors and Hospital Team Leaders to begin to address the issues between them. A more proactive approach in following up the issues raised might have been expected by the Regional Manager and Hospital Services Manager as follow-up to the event.

3.4 **Training and Development -** A number of issues related to training, learning and development were raised, from induction through to task based training and beyond to development and management development training.

3.4.1 **Induction Training -** There has been a high turnover of staff in the last 18 months, with a correspondingly high number of new starters. The induction process for them appears to have been patchy. Whilst an induction checklist is used (part of the PDP template) but the Induction toolkit referred to in that document is not used. I saw no evidence that a first PDP was being undertaken.

3.4.2 **Task-based training -**There was a consensus across the department that task based training was a major issue. Staff themselves reported a haphazard approach to task based training, with new starters often waiting several weeks for basic training. This contributes to gaps in the rota, adds to the workload pressures for other staff and impacts on quality, which in turn makes staff feel they are constantly being criticised over errors and mistakes. Training for new starters seems to be undertaken on a 1:1 basis, rather than a group approach which could improve efficiency. I saw no evidence of a planned and timetabled approach to training of new starters.

I was not convinced that task based training, or the signing off of competence was being carried out effectively, – there are newly qualified SHTOs and Hospital Services Supervisors in post and their ability to deliver training to the appropriate level has not been audited. Staff reported a training approach of “sitting next to nelly.” Three people reported they did not feel fully competent at the time of sign off. The newly appointed Development Hospital Team Leader did state that she wanted to make changes in the system.

The ability to undertake task based training is dependent on the availability of Hospital Services Supervisors and Senior Healthcare Technical Officers, which in turn is dependent on whether or not they are required to cover gaps in shifts. It was brought to my attention that the proposals being made around the current review of rotas, whilst improving staffing on the late and weekend shifts, would potentially have a detrimental effect on capacity to undertake training.

The Development Team Leader post-holder will, in my opinion, require additional support to deliver the training requirement.

3.4.3 **Management Development -** In light of the negative comments made about Hospital Team Managers I was interested to know how management development needs were identified and managed. There does not appear to be an overarching approach to the identification of management development needs – this is allied to the PDPR process. The opportunity to attend a 2-day ELM course had been given to Hospital Services Supervisors and this had been seen as something positive. However, some staff expressed dissatisfaction that they were unable to attend the AIM course being offered as part of the "Passport"; one staff member stated they had offered to attend in their own time, but this had still been refused by the department.

3.5 **PDPR Process -** In the light of the reported issues about training, recruitment and lack of career opportunities I was interested to explore how the PDPR process was implemented. This was generally viewed by Hospital Team Leaders as being a "tick box" exercise. A few of the staff had found the process useful, but mostly mirrored the feeling of it being a "tick box" exercise. I reviewed a cross-section of PDPRs and found little evidence of objective/goal setting, or of learning needs analysis associated with those objectives/goals. Staff and Hospital Team Leaders reported that it was left to the individual to identify courses they wished to attend, but in any event, it was almost impossible to meet those identified courses because of gaps in the rota. This needs to be addressed – learning and development plans need to be integrated into a positive PDPR process, with goal and objectives being agreed, and discussions about learning and development requirements; this, of course, may not always be about attendance at courses.

3.6 **Career Development -** Some staff reported feeling "stuck" in their roles; this is sometimes related to poor performance at interviews, a lack of talent management, or that they are too useful if working on a shift rota. Conversely, some staff are seen as leap-frogging grades, without having gained relevant levels of experience and knowledge. An issue within the department is the growing trend towards recruiting people holding degrees at band 2 level. The educational qualification requirement at bands 2, 3 and 4 does not require a degree. It was reported that Individuals see this as an entry into the NHS, quickly gain promotion either within the department or with another department, other members of staff are unable to compete at interview leading to the feeling of being "stuck" at their level. In turn, the department is constantly recruiting, which exacerbates the training gap – another vicious circle.

3.7 **Staffing Levels -** Differing views were expressed about levels of laboratory staffing; some members of staff felt there were insufficient staff numbers, particularly on the late and weekend shift. There was an agreed significant increase in the staffing numbers in 20I4, although the department has rarely worked at full establishment because of turnover, sickness, etc. There is a view that the numbers on the late shift remain insufficient for the increased workload; I understand that proposals put forward on the revised rota would address this issue. On balance, most of the problems of perceived staff shortages appear to be related to high turnover, lack of training resource and non-filling of gaps in the rota because of annual leave, sickness, etc. This in turn leads to added stress, poor relations amongst staff, and increased quality incidents.

Staff on shifts find this onerous, particularly during cover weeks. This needs to be addressed as part of the current review of rotas.

3.8 **Roles and Responsibilities -**There is a lack of understanding of job roles and responsibilities that extends throughout the department.

Part of the disconnect between Hospital Team Leaders and staff working in the laboratory is a lack of understanding of the Hospital Team Leaders roles. The Hospital Team Leaders themselves struggle to balance their primary roles with that of staff management, which are unclear. Hospital Team Leaders did not enjoy, or place the same level of importance, on staff management issues as their other duties

People are unclear about lines of accountability, which adds to the general confusion and supports poor decision-making.

There is an on-going "battle" between the Hospital Team Leader and Hospital Services Supervisors regarding who is responsible for obtaining cover for rota gaps.

Problems are being encountered between the band 2, band 3 and band 4s, which in part is due to the rapid promotion through bands of some staff.

Hospital Services Supervisors also feel they are not adequately consulted about staffing levels and the best utilisation of staff to cover the shifts. They feel that their ideas are not welcomed and only seen as hostile criticism by the Hospital Team Leaders.

Whilst I understand that one of the aims of the consultation exercise was to have consistent structures across hospital services departments it is clear that this is not supporting relationships at Colindale. There needs to be a review of departmental structure, with clear reporting lines and job roles identified.

3.9 **Communication -** Most people expressed dissatisfaction with the level of communication that took place in the department. Although some action has been taken during the time of this review to improve the meeting arrangements, it was reported that meetings were infrequent, had no set agenda, and no feedback or any follow-up to issues. A number of staff never had an opportunity to attend meetings because of their working hours. Most communication was reported to take place by email.

Some staff referred to the Gemba walks undertaken as part of the LEAN process. Staff felt managers should take time to speak to a cross-section of the staff on shift at the time and that they should take place at different times of the day to gain a better perspective of the pressures on other shifts.

3.10 **Bad Behaviours -** A range of perceived bad behaviours across all grades have developed and are symptomatic of the relationships within the department.

3.10.1 **Spreading Concerns and Rumours** - This takes different forms. Some people reported being warned they needed to "watch their backs" and/or that they "needed to be careful about their jobs." One person mentioned she had been specifically warned to "watch out for (Hospital Services Supervisor)". This is another reaction to the previous process but those staff engaging in this type of behaviour need to understand this is harassment, and exacerbates poor relationships, demotivates and upsets staff and supports other bad behaviours within the department.

5.10.2 **Shift Management** – There continues to be reported issues with orders and work not being properly managed during shift and work being left over to the next shift

3.10.3 **Bullying Behaviour** – Some of the examples of perceived bullying behaviour are historical and need to be separated out from this review. However, some recent examples of this type of behaviour repeating itself have been raised.

3.10.4 **Cliques and Groups** – A number of cliques and groups were reported, although others in the department said they did not see this. There is a divide within the Hospital Services Supervisors group, which has failed to resolve despite some interventions e.g. the Team Time Out. Staff reported they were sometimes put under pressure to be part of a particular group, others felt targeted if they were not part of a group. Some staff reported they felt this took the form of being "picked on" to do the harder tasks, or being given an unfair allocation of work.

There are reportedly some small racial groups. In particular staff reported feeling uncomfortable when some staff spoke in their own language, excluding others from the discussions. This was acknowledged by some but only used to greet each other rather than ongoing discussions. This however, needs to be addressed

3.10.5 **Negativity –** Several staff reported that people would make general complaints, and make negative comments about the job and the department. This had a detrimental effect on how they felt about coming into work, and was generally demotivating.

3.10.6 **Poor Behaviours towards each other –** A lot of the examples again stemmed back to the previous process; however, there have been two incidents involving the same members of staff in recent months.

3.10.7 **Communication between Supervisors –** Several staff reported they felt there was poor communication between supervisors – this was perceived during the hand-over period, being told something different by different supervisors, messages not being passed between supervisors.

4. OTHER ISSUES

4.1 **Upward Reporting of Concerns and Issues -** A culture of upward reporting of issues and complaints has developed, which has taken various forms, including:

- Hospital Services Supervisors reporting minor issues relating to the management of the shift to Hospital Team Leaders.
- Staff by-passing Hospital Services Supervisors and taking minor shift management issues to Hospital Team Leaders.
- Anonymous letters being sent to Directors and the Chief Executive of NHSBT.
- Issues being reported direct to Directors.

The upwardly reporting of issues in the department is fuelled by a lack of clear understanding of reporting lines and responsibilities. Staff also report that when they raise anything other than directly relating to the shift, Hospital Services Supervisors refer them on to Hospital Team Leaders; Hospital Services Supervisors stated to me that they did not consider they had a role in staff management.

Hospital Team Leaders and Hospital Services Supervisors have been the target of anonymous letters. Individuals expressed concern that they had been brought to the attention of Directors in this way and that this was not good for their reputation.

Members of Hospital Services Department and individuals from outside the department, but also with a wider organisational responsibility have reported issues to Directors without first engaging with the local managers.

Whilst it is appreciated there are policies on whistle-blowing designed to help improve services and protect whistle-blowers, some of this reporting *may* have been malicious behaviour by individuals. Actions following this review need to be put in place to address the difficulties in the department, clarify roles and responsibilities and restore trust and confidence, thus putting an end to this type of reporting behaviour. Management of the department must be firmly put back to the Regional Manager, and supported by the Executive.

4.2 **Staff Records -** I requested to view a number of staff records whilst undertaking this review. These were not always readily accessible, and were maintained by different individuals, in various locations and various formats. The department was unable to provide me with a comprehensive schedule of management development activity. This needs to be reviewed to ensure adherence with the standards set out in Records Management Code of Practice for Health and Social Care 2016 (Information Government Alliance).

4.3 **Human Resources Support -** Hospital Team Leaders did not feel they always received the required level of support, or consistent advice from the human resources department. I understand that HR Direct is also available to Team Leaders. I recommend that the type and level of support available is clarified. A regular meeting with a member of the human resources department with the Hospital Services Team Manager and Hospital Team Leader (staffing) might prove beneficial.

5. CONCLUSION

5.1 This is a dysfunctional department, the foundations based in historical processes, which are well-known and understood. The national consultation exercise and resultant down-banding of Hospital Services Supervisors has had a far-reaching effect on a handful of that group. It is clear that the “blame” for this was directed at the Hospital Services Manager in respect of his perceived management of the local situation; there was a feeling of being let down, and that the size and complexity of the work at Colindale was not recognised in the decision on banding. Hospital Services Supervisors consider they take the greater responsibility for the department, and are the first to shoulder blame when issues arise. The role of the Hospital Team Leaders is not recognised as important and there is a continuing resentment that their role remains at a band 6 level. The shift rota is seen as onerous, particularly the cover arrangements, and as a result of the changed rota, shift allowances have been significantly reduced.

5.2 Some of the affected staff group directed their anger and resentment of the down-banding decision towards more junior staff members, and an ensuing series of bullying and harassment incidents reported to managers. Staff in turn reported feeling unsupported as they did not consider these incidents were taken seriously or managed appropriately.

5.3 There are some allegations of ongoing low-level, subtle bullying taking place, as well as a suggestion that situations have been created with the intention of making problems for the shift following on. This situation needs to be addressed.

This all leads to a general distrust between individuals that runs throughout the department. This is all impacting on the morale and motivation of staff.

Consideration needs to be given as to how this can be remedied as quickly as possible.

5.4 There has been wide-ranging and far reaching criticism of the Hospital Services Manager and Hospital Team Leaders relating to their management competence and the way in which management practices and decisions are taken.

I acknowledge the difficulties faced by Hospital Team Leaders – their roles are not clear and confusion continues so they are not appreciated by the laboratory staff; their staff management role has developed by default rather than by job design. Their roles need to be clarified, and how they fit within the management structure reviewed.

I consider the Hospital Services Team Manager role to be pivotal to this process.

The Regional Manager has not been entirely exempt from criticism and the early signs of leadership have not been viewed by staff as being sustained. I think this in part this has been a symptom of (a) the heavy involvement of Executive level officers which has not always empowered her to take control, and (b) the regional role she performs. Delivery of a programme of radical change that addresses the issues raised by this review should rest firmly with the Regional Manager. This might require a re-shaping of her role for a period of time, with some concentrated support.

As part of this roles and responsibilities across the department need to be clarified and communicated.