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issue 38
summer 2018

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inside

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Managers in Partnership is the trade union organisation providing support and advice to senior managers in healthcare in the UK on employment matters, careers and management practice. We represent their views to policymakers, employers, the media and the public.

Craig Ryan
Editor

As it reaches its 70th birthday, it's clear the NHS is as popular with the public as ever. Despite everything that's thrown at it – underfunding, constant jarring reform, our ageing population, Brexit – the NHS has continued to function, and for the most part function well.

Few private companies, or even other public services, could withstand the political, financial and expectational pressures on the NHS, and survive with their basic sense of purpose intact.

The NHS is resilient because it's a fundamentally good idea put into practice by hard working people who believe in it – and the public understand and appreciate that. We have work to do to persuade the public to value NHS managers, but we shouldn't doubt that they value the fruits of your labour.

The principles underpinning the NHS are in many ways similar to those underpinning trade unionism – efficient collective provision, sharing the burden of individual adversity among all, democratic accountability, equality. But as Jon Restell writes on page 3, those values are under the most sustained attack we have seen since the pre-NHS days of the 1930s. The NHS was conceived in anti-fascism, and its values reflect that. We can't effectively defend the NHS unless we're prepared to defend those values too.

heads up

News you might have missed, and what to look out for

MiP national committee and staff

Sam Crane re-elected

TOM HAMPSON

Sam Crane, national committee member for Wales, was unanimously re-elected as MiP chair for a second two-year term at the new national committee's first meeting in April. Vice chairs Zoeta Manning from the West Midlands region, and David Cain from the North West, were also re-elected to serve for another two years.

Sam, manager of out-of-hours and 111 services for Aneurin Bevan University Health Board in South Wales, has been MiP chair since 2016 and a member of the national committee since 2008.

Speaking after her re-election, Sam said: "I'm very proud to continue to be part of leading this union. As a jobbing senior manager in the NHS, I'm aware that we can never lose sight of the fundamental issues that our members experience daily – the pressures in the system, the need for individual support to ensure wellbeing and the need to listen to the members we represent about what's important to them.

"I believe our role as a committee is about representing our constituents and ensuring we find the right balance between working behind-the-scenes to influence policy decisions on the big political items, and representing and supporting individual members," she added.

One of the new committee's key objectives is to strengthen links between committee members and their local areas. From this autumn, committee members will be publishing regular email updates to MiP members in their region, with news and information on committee discussions and local MiP activities. The updates will also be available from the new MiP website, which is due be launched in the autumn (see page 22 for a preview of the new site).

David Cain has been elected as MiP's fourth representative on the executive committee of the FDA – one of MiP's two parent unions. David, who is also MiP national committee member for the North West, joins Richard Carthew, Simon Brake and Diane Lester, who were elected to the FDA's governing body earlier this year.

New faces at MiP

MiP welcomed two new members of staff this summer, and said goodbye to Jane Carter, the long-serving national officer for the Yorkshire and the North East, who retired in May.

Jane will be replaced by Ruth Smith. Ruth will look after MiP members in Yorkshire and the Humber and North East England, supporting local reps and link members and negotiating with employers in her region.

Ruth joins MiP from UNISON, where she worked as a regional organiser in the South East for 18 years. She is qualified trainer and has an MA in industrial relations.

Joining MiP in the new post of communications officer, Mercedes Broadbent will take charge of MiP's media relations, social media presence and national communications with members, build MiP relationships within parliament, and support national officers with local communications.

MiP chief executive Jon Restell said: "These are two important appointments for us. Mercedes impressed the interview panel with her commitment to speaking up for NHS managers, and I'm confident she will drive change and improvement in our communications.

"Ruth will be an asset to our team and our members," he added. "Jane [Carter] will be a very hard act to follow, but I'm sure Ruth will build on Jane's high reputation and concrete achievements in the patch."

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leading**edge**

Jon Restell, chief executive, MiP

I gave my first media interview in this job around the time of Patricia Hewitt's shakeup of primary care trusts in 2005-6. MiP had just been launched. The then *HSJ* editor asked me how the union could stop the re-organisation going ahead. My answer focused on what MiP was doing to support our members through the process. The write-up suggested this sounded like mopping up in the abattoir after the slaughter.

Not a pleasant image – especially when used to describe a group of public servants I admire and respect – but it was a fair one. I've often thought about it, and concluded that no effective defence of our members' interests and values can be narrowly based on individual representation and management networking. MiP evolved quickly after the Hewitt reforms. An organisation designed primarily for individual representation also found itself seeking to represent members collectively. On that occasion we couldn't influence the big decision, but we negotiated an HR framework that prevented many problems and injustices for individual members.

We took the next evolutionary step during the coalition government. The scope of our collective negotiations expanded to include pensions and pay – with members taking industrial action on both issues – as both employers and unions sought to ensure the views of senior staff were properly represented.

But it was Andrew Lansley's Health and Social Care Bill that propelled MiP into the political sphere in a new way. Our conclusion that the Lansley plans were unworkable led us to oppose the legislation. No-one can say now – the evidence is everywhere to see – that we were wrong. But it was a shift in our approach over which we agonised long and hard, and which made some members feel uncomfortable.

> "Following Brexit, the election of Donald Trump and the growth of populism, we need to ask where the big decisions are now being taken, and how we can realistically try to influence them."

We decided that our job was about more than ensuring fair play once the big decisions had been taken – we needed to try to influence those big decisions themselves.

Following the Brexit referendum, the election of Donald Trump and the growth of populism in Europe and America, we need to ask where the big decisions are now being taken, and how we can realisticallytry to influence them and get our members' voices heard.

Few people can seriously question whether these developments affect MiP members as public servants, employees and members of our wider society. Brexit has profound implications for workforce supply, regulation and the long-term economic sustainability of publicly-funded healthcare. Given the potential economic consequences of Brexit, we should remember that the new money promised for the NHS is as yet unfunded and ignores social care (***see page 8***).

The election of President Trump has turbo-charged people who want to reverse so many of the changes we have seen in politics and society over the last century, especially progress with diversity, inclusion and the environment. It feels as though we must re-fight battles over equality and science, which I thought had been won. And 21st century populism – a digital phenomenon as much as anything – has created public discourse that tends towards simplistic expression of issues and problems that are often immensely complex.

This approach to politics, for example, leaves the NHS – and its managers – vulnerable to evidence-free attacks, from right, left and centre. Such attacks can be triggered at great speed: a single tweet can go around the world in a few hours.

As a union, we need to debate our response to these trends, and think again about how we present our ideas and arguments. Our summit on 6 November will attempt to do that by focusing on Brexit, long-term funding and the key values of the NHS across the UK. I believe we can deliver an effective response without unbalancing our work for individual members or collective negotiations. I also believe we can do it through the clear presentation of values and evidence.

Finally, we must not fear being accused of grandstanding. The 'MiP way' – our approach of challenge and support – is more important than ever, and we will keep it up. But I hope you agree with me that we now need to bring our voice into a wider political context than before. Otherwise mopping up might be the best we can hope for.

Agenda for Change pay

Union members back three-year pay deal in England

One million NHS workers in England, including thousands of MiP members, are set to receive their first meaningful pay rise in more than eight years, after members of 13 NHS unions voted strongly to accept the three-year pay deal negotiated earlier this year.

The £4.2bn settlement means most staff will receive pay rises of at least 6.5% over the next three years, plus a lump sum of up to £800, with transitional increases for staff below the top of the pay band. But MiP members at the top of bands 8D and 9 will see their total pay rises capped at 5.4% and 4.5% respectively.

The result of UNISON's ballot, in which MiP members took part, saw 84% of members voting in favour of the deal. MiP had recommended that members accept the offer, despite strong reservations over the "unfair treatment" of senior staff.

Welcoming the ballot results, announced on 8 June, MiP chief executive Jon Restell said: "This deal is only a start. Following the the long-term funding settlement for the NHS, we will need to see sustained investment in pay and the NHS workforce. MiP endorsed the three-year deal with reservations about the capping of awards for, and the failure to invest in, faster progression for senior staff. We will keep returning to these issues."

Restell said "the complexity of the deal, which includes increases at the top of the bands, elimination of points at the bottom of the bands, and transitional points in between, was inevitable, so it has been vital for each member to consider how the deal affects them personally".

The first rises were seen in July pay packets, with back pay from 1 April expected to be paid with August salaries. Staff at the top of the bands – just over half the workforce – receive 3% from April, while staff at the bottom of pay bands move up one point, which is also revalorised. Staff on points in between receive a rise from April, with a second transitional payment due on their personal anniversary date. NHS Employers have published a comprehensive employers tool (available at bit.ly/hcm3803) which allows staff to calculate the pay due on both dates.

UNISON head of health Sara Gorton confirmed a "no detriment" clause in the pay agreement meant no member of staff could be worse off under the new arrangements. "If anyone can find any example of a member that is worse off in pay they should contact their union rep as soon as possible – the member of staff is contractually entitled to not suffer any detriment," she said.

Restell said he was proud that MiP had taken a full part in NHS pay negotiations for the first time. "We will carry on speaking up for managers and their valuable role in patient care," he added. "Our focus now moves to securing parallel deals for members in Scotland, Wales and Northern Ireland – and for NHS directors in England, who are not covered by the Agenda for Change pay system."

Full details of the pay settlement are available on the unions' pay website at nhspay.org. If you have any questions or concerns about your pay award contact your MiP national officer or MiP head office for advice.

Scotland and Wales make three-year pay offers

NHS unions in Scotland are consulting members on a new three-year pay offer from the Scottish Government, while unions in Wales are set to ballot members on a similar three-year deal following the conclusion of negotiations with employers at the end of July.

The negotiations followed the Treasury's agreement to fund a £4.2bn pay settlement for staff in England, which led to extra cash being made available for Scotland and Wales under the Barnett formula.

In Scotland, the £410m offer will see most staff receive cumulative pay rises – combining cost of living increases, incremental progression and changes to pay bands – of between 9% and 27% by 2021. But, as in England, the Scottish Government insisted on capping rises for some senior staff. Pay rises for managers at the top of band 8D will be restricted to 5.7%, while those at the top of Band 9 will receive 4.7% – in both cases this amounts to a cash increase of £1,600 for each of the three years of the deal.

> "We welcome the first meaningful pay rises for members after a long pay freeze which has eroded the value of salaries in the NHS."
>
> **ANDY HARDY, MiP**

Under the deal, the minimum NHS salary in Scotland will be raised to £17,460, and some staff will benefit from improved starting salaries and faster progression through their pay bands – although progression rates for MiP members in Bands 8 and 9 remain unchanged.

Full details of the NHS Scotland pay offer are available on the unions' pay website at nhspayinscotland.org. MiP members are being balloted as part of UNISON, which is recommending that members accept the pay offer. The ballot closes on 14 August.

MiP chief executive Jon Restell said: "We're very disappointed that the Scottish Government has chosen to follow NHS employers in England by unfairly capping pay rises for some senior managers and failing to improve their progression rates. Many MiP members in Scotland, like their colleagues in England, will feel that their government doesn't properly value the skilled and experienced managers who work hard to run NHS services under the most trying circumstances."

In Wales, union members are to be consulted on a Welsh Government offer from which also closely mirrors the three-year deal in England. Under the offer, most staff would receive cumulative pay rises worth 6.5% by April 2021, with higher increases for staff below the top of their pay band, and improvements to starting salaries. All staff would also receive a cash lump sum in 2019-20, worth 1.1% of salary.

As in England and Scotland, the Welsh Government is proposing to cap pay increases and lump sum payments for staff at the top of Bands 8D and 9 by restricting them to the cash value of awards for staff in Band 8C.

Commenting on the negotiations, MiP national officer for Wales Andy Hardy said: "MiP welcomes the end of the pay cap policy in Wales and the aim of matching, and in some ways going beyond, the deal in England. We also welcome the first meaningful pay rises for members after a long pay freeze which has eroded the value of salaries in the NHS.

"However, we are deeply disappointed that the government here has chosen to mirror the capping of awards in England and Scotland for some senior staff, and failed to invest in shorter progression arrangements for staff in bands 8 and 9," he added.

NHS unions in Wales are recommending that members accept the offer, with ballots taking place during August and the results expected in early September. As in England and Scotland, MiP members will be balloted as part of UNISON. Full details of the final offer will be sent to all members in Wales by email, and will also be available from the unions' NHS pay website at nhspay.org.

At the time of going to press, pay talks in Northern Ireland remained at an exploratory stage due to difficulties in establishing a pay policy while the Northern Ireland Assembly Government is suspended. Unions will be pressing for a deal that at least matches the one in England, using the funding available to the assembly under the Barnett formula. Further details will be sent to MiP members in Northern Ireland as soon as they are available.

Politics

New health secretary promises action on NHS workforce

Matt Hancock used his first speech as health secretary to hit out at the lack of diversity at among top NHS managers and call for an end to "tribal barriers" between managers and clinicians.

In a speech at West Suffolk Hospital on 20 July, ten days after he replaced Jeremy Hunt as health secretary, Hancock said diversity among the NHS leadership was "critical", pointing out that only five NHS chief executives come from a black or minority ethnic (BME) background. "That has to change," he warned.

"In many areas diversity is thriving. But not everywhere. And speaking frankly, the NHS leadership community must do more to reflect the wider workforce," he added.

Hancock said he was "horrified" by the results of the 2017 NHS Staff Survey, in which 12% of all staff, and 24% of BME staff, said they felt discriminated against at work. "The same trends apply to social care and we know its leadership does not fully reflect the diversity of its incredible workforce," he warned.

"People cannot be expected to deliver world class care when facing bullying and harassment on this scale," Hancock said. "So the culture must change, the NHS will be the better for it and I am determined to lead this change."

Hancock announced he was setting up a "consultation exercise" on workforce issues, to be led by a panel of clinical and professional advisers from across the NHS and social care. "I want everyone who gives their lives to this amazing vocation to respond to our consultation with their views," he said.

MiP chief executive Jon Restell said: "It's good that the secretary of state has spoken about the diversity of NHS leadership, but our BME members will want more than another white leader calling out under-representation. We need a clear action plan with accountability, outcome measures and specific actions such as BME representation on appointment panels, resources for networks and culture change at middle management level."

PA WIRE/IMAGES

Warning that bullying in the NHS "starts at the very top, in Whitehall and among regulators", Restell added: "We must stop blaming individual senior managers for system-wide problems. The secretary of state needs to understand the intense operational pressures on this group of leaders, over half of whom have been in post for less than three years."

In his wide-ranging speech, Hancock also promised to break down barriers between NHS professions and boost leadership training across the health and care system.

"It matters to clinical staff that their managers are good – everyone has their part to play," he said. "Too often, getting the right people into these roles has been a struggle and I know some of you in management can feel overlooked or undervalued."

He pledged to break down "the tribal barriers between management and clinicians to build a shared leadership agenda for the health service" and "remove obstacles" in order to encourage more doctors, nurses and health professionals to take charge of NHS organisations.

Restell welcomed Hancock's early focus on the NHS workforce, but warned that "managers will be disappointed to hear nothing about social care funding – a huge missing piece of the jigsaw".

Hancock, a former Bank of England economist, was previously the culture secretary, and is a particular enthusiast for the digital agenda in government. He replaced Jeremy Hunt, Britain's longest-serving health secretary, who became foreign secretary following the resignation of Boris Johnson on 9 July.

Congratulating Hancock on his appointment, Restell said: "It's both a tough and rewarding political job of huge importance to everyone in the country. As health and care managers, MiP members urge the new health secretary to make the workforce and social care funding his top two priorities.

"We would also welcome an early indication from Matt that he values the role of managers and other members of the support team in modern healthcare, and sees them as part of the solution to problems," he added.

Read Matt Hancock's speech in full at: bit.ly/hcm3802

MiP Summit: Managing for our Future

6 November 2018, Congress House, London WC1

Building on our successful new-look gathering last year, this year's Members' Summit will celebrate the 70th anniversary of the NHS and look at the role of managers in shaping the future of our health and care services. We've invited Simon Stevens to speak again, and the programme will give prominence to Brexit and the long-term funding of health and social care, alongside our popular regional networks and workshops on pensions, workplace culture and the future of management.

Don't forget your Summit is CPD-accredited, and will give you plenty of opportunities to network, share information and best practice, and get practical help with your career. The Summit is free to all MiP members.

For further information and to book your place, visit the Summit website: connectpa.co.uk/events/mip-members-summit-2018. In 2019, we'll be bringing the MiP Summit to Birmingham. Venue and further details coming soon.

Workforce

Fear of 'decapitation' leads to empty board posts, report finds

"Near-toxic" pressures on NHS organisations and a culture of blaming individual leaders for failures beyond their control are behind worryingly high levels of vacancies at board level, says a new report from The King's Fund and NHS Providers.

Survey data from 145 trusts found that 8% of board-level posts currently lie unfilled and more than a third of trusts had a least one executive director post vacant. Trust boards also lack experience, the report found, with 54% of directors having spent less than three years in the job and chief executives also serving for an average of less than three years.

Struggling NHS organisations are having the most difficulty recruiting and retaining senior staff, the researchers found. Trusts rated inadequate by the Care Quality Commission (CQC) had 14% of executive director posts vacant, with a staggering 72% of board members having been appointed within the last year. This compares to 3% and 20% for the best performing trusts.

> "Responsibility for leadership is everyone's business. NHS leaders should be central to the NHS 10-year plan and the work of the national bodies."
>
> **SUZIE BAILEY, THE KING'S FUND**

The report says many NHS leaders interviewed for the report "highlighted an increased risk of regulatory 'decapitation', suggesting that the consequences of poor performance or failure are perceived to be increasingly 'personalised' and laid at the door of individual leaders by some national bodies, politicians and the media. This can lead to a greater unwillingness to take on these challenging roles and can discourage bold leadership once in a role."

"Leaders in today's NHS operate in a climate of extreme pressure: staffing vacancies

are rife, there are widespread challenges in meeting financial and performance targets and demands on services continue to increase, said Suzie Bailey, director of leadership and organisational development at The King's Fund.

"Responsibility for NHS leadership is everyone's business – attracting and supporting the right kind of future NHS leaders should be central to the NHS 10-year plan and the work of the national bodies," she added.

Saffron Cordery, deputy chief executive of NHS Providers, said trusts needed support to ditch "the revolving door approach" and do more to develop their own leaders.

"This includes finding ways of enticing high-performing leaders into struggling trusts, but that isn't easy to do when a culture of blaming individuals for perceived failures exists," she explained.

"One of the solutions to our leadership challenge is to bring through a new generation of leaders that is more diverse and reflective of the communities the NHS serves," she added. "While there has been some progress in recent years, there is still a huge amount to do on this front."

MiP chief executive Jon Restell praised "great work" by the report's authors in identifying the causes of the staff shortages at board level. "The NHS is running out of heads to put on the spikes," he said. "It's time to nurture this tiny part of the workforce that has such a big impact on staff and patients."

Read the full report 'Leadership in today's NHS: delivering the impossible' online at: www.kingsfund.org.uk/publications/leadership-todays-nhs.

Analysis

The government's NHS funding settlement brings some welcome relief for struggling services, but leaves many tough questions unresolved. **Craig Ryan** reports.

The gift that keeps you guessing

The NHS's 70th birthday present from the government was a bit like one of those gift cards from posh shops that don't tell you how much they're worth – when you finally get to the till, it's always a bit less than you need.

We know quite a lot about what the "long-term funding settlement", unveiled on 18 June, is not. It's obviously not, as Theresa May suggested, a "Brexit dividend" – that claim has been so comprehensively rubbished that there's no need to go over it again here. Neither is it worth £600m a week, as some ministers claimed. That figure is based on the total increase in the NHS budget by 2023 – at 2023 prices, which are meaningless in 2018. In fact, right now it's worth precisely nothing, as there won't be a penny of new money until April. And, with another tough winter looming, for many MiP members, it's right now that counts.

Neither is it much of a "settlement", when so much remains to be settled. We don't know where the money will come from, or if other vital services will be cut back to pay for it. We don't know if there will be any new money for social care services that are on the brink of collapse. We don't know much about how the new money will be spent, or how the strings attached by the Treasury will operate (see opposite). And we don't know to what extent public health services and staff education, excluded from the announcement, will continue to be starved of funds.

These issues may not be settled until November's budget or even next year's scheduled spending review. And with the fate of the government hanging in the balance as I write, who knows if either of those things will happen as planned? So, the 'long-term' funding settlement may not be very long-term either.

In NHS circles, there is near-unanimous agreement on another thing the government's 'settlement' is not – and that is 'enough'.

What we do know is that the government has promised to increase NHS England's budget by £20.5bn by 2023, with corresponding increases of £2bn for NHS services in Scotland and £1.5bn for Wales. For England, this equates to real terms growth of 3.4% per year for the next five years: an undoubted relief after years of painful austerity, but actually the same level of investment made between 1979 and 1997 by those notorious tight-wads Margaret Thatcher and John Major.

"Managers will obviously welcome the easing of underfunding," says MiP chief executive Jon Restell. "That said, the new money will not stretch to everything the government wants to do, such as investing in integrated health and social care, and moving more care out of hospital. And we're in the dark on some important budgets such as public health, staff training and capital projects. Plenty of tough choices still remain."

A month before the funding announcement, the Health Foundation and the widely-respected Institute for Fiscal Studies, with support from the NHS Confederation, published a comprehensive survey of health and care funding. Securing the Future made clear that funding growth of 3.3% was the absolute minimum needed to maintain current standards. 4% growth would allow for some modest improvements, the report said. But to invest properly for future health needs and to deliver the government's own policies on things like integration and moving services into the community, above 5% will be required. The OBR has similar views: its projections reckon annual increases of 4.3% are the minimum needed to meet the government's objectives.

The government's plans "will help stem further decline, but it's simply not enough to address the fundamental challenges facing the NHS or fund essential improvements to services that are flagging", warns Anita Charlesworth, the Health Foundation's director of research.

The big black hole in the government's plans remains the funding of social care. Speaker after speaker at last month's NHS Confederation conference spelt it out: we need a comprehensive funding settlement for both health and social

20 billion quid pro quo

The Treasury and the Department for Health and Social Care have set five "financial tests" for the NHS to meet in return for the new money. At the time of writing, it remains unclear how the tests will be assessed and what will happen if they're not met.

- **Improving productivity and efficiency**
  Sources say the Treasury is pushing for a headline target of 1.8% for annual productivity growth in the NHS, more than twice the long-term average of 0.8%
- **Eliminating provider deficits**
  Tight financial controls on trusts are unlikely to be loosened much, but new money means fewer trusts will find themselves in financial special measures, leading to a more intense focus on those with the deepest problems.
- **Reducing unwarranted variation in standards**
  Greater use will be made of NHS Improvement's still-embryonic Model Hospital tool, together with the Getting It Right First Time and Right Care programmes.
- **Manage demand effectively**
  A vague test, which may involve channelling funding towards collaborative projects and schemes which reduce demand at health economy level.
- **Make better use of capital investment**
  Capital investment was excluded from the 18 June settlement, so this test will focus on better targeting of existing schemes, including revisiting the Sustainability and Transformation Plans submitted in 2016 and tighter control of technology funding.

care. The two have been yoked together since birth (our modern social care services are also celebrating their 70th birthday this year - who knew?) and never more tightly than now.

The Health Foundation/IFS report found that social care spending will need to increase by at least 3.9% in real terms for the foreseeable future, just to maintain current (poor) levels of service. Social care underfunding "has a direct impact on the NHS", warns the report, "including rising numbers of emergency attendances, admissions, and patients facing delayed discharge due to a severe lack of care available in the community".

"It's worrying that we still don't know about funding for social care," adds Restell. "Social care needs 4% a year in real terms. The public don't see where social care ends and healthcare starts – but they know more money is needed. The government must make a parallel settlement for social care as a matter of urgency."

Adding to this uncertainty is the fact that the new money applies only to NHS England's budget, and not to all spending by the Department of Health and Social Care (DHSC). This is not a technical point – according to the Health Foundation/IFS report, this narrow definition of NHS spending is a "mistake" which has already "led to damaging cuts to public health programmes, capital investment and the education and training of NHS staff".

Amazingly, this means the government's settlement ignores the area where the crisis is most acute: the training and recruitment of skilled NHS staff. At the end of March there were 92,000 vacant posts in NHS providers alone. Health Education England admits that, on current trends, the NHS will manage to recruit barely a third of the clinical staff it needs over the next ten years.

"We also need a long-term workforce strategy to support the funding settlement," says Restell. "The NHS's recovery will need managing very carefully, and it's critical we now invest in our staff – including support staff and managers."

While it's always churlish to quibble over the value of a gift, the funding announcement isn't really a gift at all – simply a response to mounting political pressure. The public have made it clear time and time again that they expect NHS services to be properly funded. The new money is a step in the right direction, but in many ways it simply kicks the can down the road. We shouldn't be too polite to say so. ■

Introduced four years ago, the Fit and Proper Person Test remains a source of confusion and sometimes trepidation for many NHS managers. **Alison Moore** explains how the test works and examines options for reform.

Fit for purpose?

Most NHS staff behave well and live its values: a handful don't and in extreme cases this can mean they are disciplined either by their employers or their regulatory bodies.

But dealing with poor behaviour at the top of organisations can be hard – making it even more important that people appointed to top jobs have the right attitudes, behaviour and record. Since 2014, those at board level in NHS provider organisations have had to pass the "Fit and Proper Person Test" (FPPT) – a measure introduced in the wake of the Francis Report.

While the FPPT can't guarantee how directors will behave in the future, it does – in theory – exclude people with a history of unsuitable behaviour from board-level jobs, either as executives on non-executives. The consequences of being judged not 'fit and proper' are severe: managers could be denied a new job or removed from an existing one.

This process is now under review by QC Tom Kark, who will report back to the Department of Health and Social Care by the autumn. The test may be refined to include clearer definitions of what constitutes "misconduct" and extended beyond provider organisations to cover CCGs and national bodies.

The review has generally been welcomed, with both managers and employers grateful for the prospect of greater clarity. But there are deeper concerns about the FPPT and whether it achieves what it is intended to do.

Dido Harding, the new chair of NHS Improvement, has called for an end to the "heads on spikes" approach to managing NHS failures.

For MiP chief executive Jon Restell, one of the issues is the lack of clarity about how the test judges managers making difficult and sometimes unpopular decisions. "How do you distinguish between a bad apple and someone in a difficult job?" asks Restell. He argues that any system of "regulating" individual managers faces a challenge because managers are working within a complex system with many decision-makers and performing difficult balancing acts between different priorities.

While a fraud conviction against a manager, for example, would make the application of the FPPT straightforward, a lot of the dilemmas managers face are less clear-cut. If a finance director delays payments to contractors to help the trust's liquidity and ensure staff are paid on time, how should they be judged under the FPPT? And what about executives who make decisions which disadvantage their trusts, but benefit the local health economy or sustainability and transformation partnership? Many managers are currently being encouraged to do this, but technically could be in breach of their statutory duties towards their trusts. This is just one of the grey areas senior NHS managers have to operate within.

There is also some confusion about who should be subject to the test – and some evidence that it has been used against staff members who are not at director or an equivalent level. The CQC now claims that it applies to associate directors and says it's irrelevant whether an individual has voting rights on the board. It is now clear that it applies to those holding director positions temporarily – so interims and those acting up will be caught by it.

Unlike many other regulatory tests, the FPPT is black and white: if a manager

FPPT: HOW IT WORKS – OR SOMETIMES DOESN'T

- Trusts have to ensure that anyone appointed to an executive director or equivalent role, or as a non-executive director, is not automatically barred from holding that office and meets certain professional standards. Some reasons to get barred are straightforward – such as being an undischarged bankrupt – but others are more subjective – such as having been responsible for, privy to, contributed to or having facilitated "serious misconduct or mismanagement". In addition, directors must have the necessary qualification, skills and experience, and be of "good character".
- It's the responsibility of the chair of the organisation to ensure that directors meet the FPP test and are excluded if they are caught by the "unfit" criteria. The CQC expects providers to be able to show that "appropriate systems and processes" are in place, for vetting new appointments as well as existing directors.
- The CQC does not make judgements about individuals, but can raise concerns (e.g. as a result of whistleblowing) and undertake a focused inspection or other regulatory action if it is not happy with the provider's processes. Such action is rare but not unknown: since April 2017, the CQC has taken at least two regulatory actions against NHS providers under the FPPT and issued one warning notice.
- Since the FPPT was introduced, a number of trusts have been criticised for employing directors whose past actions could be seen as having brought their fitness into question. Paula Vasco-Knight was appointed acting chief executive at St George's Hospital in London, despite being implicated in the victimisation of whistleblowers while chief executive at Torbay and Devon. She later pleaded guilty to fraud. The CQC took action against St George's over its FPPT processes.
- Phil Morley resigned as chief executive of Hull and East Yorkshire Hospitals Trust shortly before the publication of a report saying staff had been subject to "aggressive bullying" and while investigations into the trust's spending were already underway. Despite this, he was appointed to the same role at the Princess Alexandra Hospital, Harlow, but was later forced to step down.

fails it, there is no recourse to a lesser penalty or opportunity to improve or re-train. Restell points out that with other forms of regulation "the disciplinary part is quite rare", but the FPPT is about identifying "people who can't be helped in their work". Being found to be not fit and proper is a life-changing moment which could end managers' careers in the NHS and even make it difficult for them to find jobs outside.

The test is administered by the employer, whereas the regulation of other healthcare professionals relies on an external panel with employer involvement limited to, at most, referring an individual or acting as a witness. This increases the possibility of the regulatory regime being misused for general disciplinary purposes.

Restell also raises the issue of proportionality. "The costs of investigating the behaviour of an executive, sometimes based on anonymous allegations about incidents many years ago when they were more junior, can run into tens of thousands of pounds," he warns. "Yet trusts often feel obliged to launch such investigations once they are given information."

NHS Providers, which represents trusts, is also concerned about the lack of clarity surrounding the FPPT. Recent guidance from the CQC has gone some way to clarifying who counts as a 'director', but NHS Providers points out that organisations still have to decide whether a director is "of good character" and whether they have done anything which amounts to "serious misconduct and mismanagement" – which is ultimately often a subjective decision.

Confusion also surrounds the status of Disclosure and Barring Service checks, which many CQC inspectors expect to be in place for all board level appointees, although the DBS refuses to carry out these checks on directors who are not directly involved in regulated activities.

NHS Providers policy officer Georgia Butterworth points out the FPPT process can't be expected to do everything. "Healthcare is a risky business and trusts are very complex organisations – the fit and proper person test is only one part of the picture," she says.

Restell sees signs that Dido Harding, the new chair of NHS Improvement, appreciates some of the concerns about the FTTP and is encouraged by her talk of "not decapitating" managers. "But she will have a difficult job balancing that with the fit and proper person regulations as they stand," he warns. "The danger is that good intentions dry up in the heat of bad publicity." ■

NHS guardians have a tricky but increasingly powerful role in tackling the causes of poor care and changing the way organisations listen and respond to staff. National Guardian Henrietta Hughes speaks to *Healthcare Manager*'s **Matt Ross**.

Nice but tough

Too often, says Henrietta Hughes, "the policies of the past have not fostered a culture where people feel safe to speak up". And those policies had a price – one paid by the patients, carers and staff caught up in the care scandals that periodically hit NHS organisations.

When NHS workers' warnings about poor care, unsafe practices or bad management are not heard and acted on, says Hughes, "we see the consequences. Look at Gosport: when staff haven't been able to speak up, haven't been listened to, when the right actions haven't been taken. It doesn't produce good news stories for those organisations."

For years, patients' families and staff warned of the excessive opiate use at Gosport War Memorial Hospital – blamed for the early deaths of up to 650 people – "and the evidence is that if they'd been listened to back in the 1990s, we wouldn't have this massive scandal now. If people say: 'We want to learn, to fix things, to nip them in the bud,' then problems don't become intractable."

Hence the appointment – following a recommendation in Sir Robert Francis's 2015 report – of 'Freedom to Speak Up' guardians within NHS bodies. These, says NHS Improvement, should provide a safe channel through which staff can raise concerns; guardians then monitor the organisation's response, feed back to staff, and see that appropriate changes are made to systems and policies.

The NGO's data shows more people raise concerns with guardians in high-performing organisations than in failing ones: high guardian caseloads signal a healthy working culture.

This is clearly a tricky job – one that could leave guardians caught between legitimate staff concerns and resistant organisational cultures. So who guards the guardians? That's Dr Hughes: a practicing GP and former NHS England medical director, two years ago she was made the National Guardian for the NHS – charged with overseeing the appointment and management of local guardians, providing them with training and support, and protecting guardians and staff raising concerns from negative repercussions.

Why did she take the role? "I've worked in general practice, in hospitals and in the community, and there were lots of times when I've spoken up and been listened to," she replies – but there were also, she adds, plenty of occasions when her concerns fell on deaf ears. As a medical director, she recalls, "I spent a lot of time looking at the reports after serious incidents, and it was clear that people were often aware of things that could have been done differently, but weren't – leading to harm."

So when the job came up, she saw an opportunity to "put things right before people get harmed". And over the last two years, she's found ever more evidence that an organisation's willingness to seek out, listen to and act on staff concerns is closely linked to the quality of its care.

When Hughes' National Guardian's Office (NGO) surveyed all the guardians last year, none of those working in NHS bodies with 'outstanding' CQC ratings said there were significant barriers to speaking up in their organisation; but only 45% of those in bodies rated 'inadequate' could say the same. And in outstanding trusts, 77% said that managers support staff to speak up; the figure for inadequate trusts was 18%. The NGO's data also shows that more people raise concerns with guardians in high-performing organisations than in failing ones: far from suggesting a dysfunctional organisation, high guardian caseloads signal a healthy working culture. "The key is to value that feedback, and to see it as a way of helping to make improvements," Hughes explains.

The guardians aren't intended, she

NIKLAS HALLE'N

says, to usurp line managers' roles as the first port of call for staff concerns: instead, they're an "additional conduit" for people who aren't comfortable raising particular issues with their manager – and those who've done so, but to no avail. She hopes that the appointment of guardians will, by protecting concerned staff and ensuring their warnings are taken seriously, reduce the number of people raising the alarm publicly or having their careers blighted. "It's only when organisations respond inappropriately [to concerns] and victimise people that it becomes a whistleblowing situation," she says.

The NGO does not define whether guardians should be full or part-time, where they should sit within the organisation, how they should feed concerns into the system, or what their backgrounds should be: stressing that the role is open to managers, Hughes says, "we've got nurses, doctors, therapists, chaplains, facilities managers, board secretaries – people from a whole range of professions".

Hughes' office does, however, take a keen interest in how guardians are appointed. A "tap on the shoulder" isn't appropriate, she says: "We really welcome organisations that have advertised and been through a full appointment process, or elected a guardian, or had a staff governor chosen by their colleagues." Guardians need ready access to the chief executive and the board of directors, Hughes continues; they should "be able to ask the right questions of the board, and to challenge them on actions that are underway".

Guardians also need enough time to do the job, which involves being "visible to all staff members", Hughes explains. "We expect them to work with all the other parts of the organisation, such as staff side, complaints, incidents and the risk department, so they can identify where the hotspots are." The unions have an "absolutely key" role to play, she adds. "If managers have raised concerns with their union, and the union is getting stuck, they may well find that working with the guardian can unstick that. We really would welcome partnership working between Managers in Partnership and the Freedom to Speak Up guardians."

To ensure that NHS bodies are managing the system well, Hughes explains, guardians are interviewed by the CQC on "how well this has been implemented, whether they have sufficient time for the job, and whether issues that they escalate are being acted upon" – with results feeding into the 'well-led' element of CQC ratings. That should "make organisations take note of this, and act on it seriously," she comments.

She explains that guardians use their discretion in deciding how to handle issues – from having a quiet word with a colleague of the complainant, to requesting a full-blown independent investigation. And she emphasises that their casework ranges from clinical care issues through to strategic matters such as change programmes, "bridging patient safety and organisational development in a way that I've never seen before".

Crucially, Hughes says, guardians often examine the underlying dynamics behind

problems rather than plugging the immediate gap; she cites one case in which a shortage of nurses on a ward led to a full review of recruitment practices. “This is really dramatic in terms of fixing the root cause, rather than trying to patch things up as we go along,” she says. “Maybe what’s happening with guardians is not what was anticipated.” Their introduction might, in other words, prove to be a more fundamental reform than even Sir Robert Francis had envisaged.

The prospect of guardians intervening in strategic decision-making may concern some managers. But Hughes urges NHS leaders to welcome their input, which is borne of the frontline workers’ hands-on expertise: this isn’t about “pointing the finger of blame”, she says, but building a “common enterprise where we’re trying to do things better”.

She stresses too that guardians are there for managers as well as more junior staff: “If you as a manager feel that you’re not able to escalate an issue, talk to your guardian,” she says. And Hughes adds that the system may improve the handling of staff complaints against line managers. Unlike complainants who call the whistleblowing helpline, she explains, those who approach a guardian are drawn into a detailed conversation: “The guardian is able to find out what has gone before: have there been other factors which might suggest that people are not raising concerns for the right reasons?”

For the system to work, it’s essential that both managers and more junior staff who approach guardians are confident that they’ll be protected. All are offered confidentiality, and guardians provide ongoing support to those raising concerns. NHS Improvement’s policy states that “if somebody is victimised after speaking up, the person who victimises them should be subject to the full disciplinary process”, she says. “I’m looking to see that actions are taken; that people are using that policy.”

As yet, it’s not clear that they are: Hughes’s information suggests that about 5% of those raising concerns

The impact of guardians can be “really dramatic in terms of fixing the root cause, rather than trying to patch things up as we go along,” she says. “Maybe what’s happening with guardians is not what was anticipated.”

– about 300 people – fear they’ve suffered detriment, but only one trust has told her they’ve disciplined somebody for victimising a complainant.

The guardians themselves, of course, also need protecting – and here, the picture is clearer. Hughes conducts exit interviews with guardians leaving the role, and says no one has told her they’re quitting because they’ve “had a bad experience”. Her office organises regional networks where guardians can support one another, and provides direct support when “guardians have felt quite vulnerable in their role as the messenger” carrying bad news. She regularly publishes case reviews examining NHS bodies’ handling of guardians’ management and casework: these are bluntly-written and would, she suggests, provide a way to call out any trust failing to protect its guardian.

Looking to the future, Hughes says the programme is rolling out into primary care; her office is working out how to expand coverage to the sector’s 50,000 organisations. Meanwhile, the arm’s length bodies – including NHS England, NHS Improvement and the NGO’s host organisation, the CQC – “have all appointed guardians, because they recognise their own speaking up cultures aren’t right”. And social care? “I’ve certainly had people coming to me saying that they’d like to have them in social care,” she replies. “That’s well outside my area.” In the newly renamed Department for Health and Social Care, though, it may not remain outside her area indefinitely.

Henrietta Hughes seems a gentle, caring person; even in an interview, her GP’s bedside manner comes through. How can people be confident that she’ll be robust in their defence? “When it comes to protecting my patients, I’ve always been very robust about ensuring they get the care they need. And in this role I’m more than happy to challenge the system – whether that means trusts, regulators or government departments,” she replies. In one of her appraisals, she adds, a former chief inspector of hospitals called her “both the nicest and the toughest person in the NHS”.

If so, she should fit the bill; for she’ll need both characteristics. Protecting guardians and those speaking out, and pushing intransigent organisations into developing strong guardians systems, demands steel and leverage. But fostering the collegiate working on which success will depend, and encouraging organisations to embrace the flow of critiques built into the guardians system, calls for a gentler line.

Senior leaders, says Hughes, must take the long view – embracing constructive challenge in the short term to avert destructive criticism in the future. “Do the right thing, and your reputation will follow,” she concludes. “My call to the leadership of inadequate trusts and those that require improvement is to be genuinely interested in the views of all your staff, patients and carers. They’re bringing gifts of information that will help you fix and improve your systems. And the more you can listen, learn and make those changes, the better chance you have of becoming an outstanding organisation.” ■

As the pressure on NHS services grows, assaults and abuse against NHS staff are again on the rise. **Emma Dent** explores the reasons why – and what employers can do to protect people at work.

Not 'part of the job'

That violence and aggression is perpetuated against NHS staff is nothing new. But recent research has shown such attacks are on the rise. Public concern about the issue is now such that the Government has supported Chris Bryant's private member's bill seeking to double sentences for assault against emergency workers (see page 16).

Research by Unison and the Health Service Journal, published earlier this year, found the number of attacks on staff is increasing, and shows a marked correlation with the NHS's declining financial and waiting time performance.

The research found an average increase of 9.7% in assaults across the NHS since 2015-16, the last year for which national figures were collected (see opposite). But in trusts reporting deficits of over £20m, reported assaults were up 23.1%, while those reporting financial surpluses saw attacks rise by just 1.5%.

In acute trusts failing to meet the elective care target of treating 90% of patients within 18 weeks of referral, there was a massive 36.2% increase in attacks on staff. But the number of attacks in mental health trusts, notorious for high levels of violence, has levelled off, perhaps reflecting efforts across the sector to tackle the issue.

Stressed staff, stressed patients

MiP national officer Claire Puller says the data makes it clear that putting trusts under pressure results in increased pressure on staff. "Where the trust is in debt, the staff will be stressed and the patients will be stressed," she explains. "We also forget what an abnormal, stressful experience being in hospital can be for patients."

While working as an NHS occupational therapist, Puller experienced violence from patients on three separate occasions, but she believes support for staff experiencing aggression and violence at work has improved.

"The first time, I was made to sit down and go through what I had done to provoke the patient to assault me. By the third time, it was just seen as unacceptable. The NHS now understands that if something has happened to staff, they need to be taken care of. A lot can be accepted when people are unwell but there has to be a line drawn in the sand."

Lesley Lashmar is restrictive intervention team leader at Lincolnshire Partnership NHS Foundation Trust, which has seen an overall 30% fall in incidents of violence and abuse. She agrees that the

NHS TURNS SPOTLIGHT ON VIOLENCE AGAINST STAFF

The NHS is to resume collecting statistics on assaults against staff, two years after the practice was discontinued in England, while the Care Quality Commission (CQC) is to extend its inspection regime to include hospital security arrangements, *Healthcare Manager* has learned.

NHS Protect ceased collecting data on assaults against staff when the organisation was subsumed into NHS Counter Fraud Authority in 2016 – a move described by UNISON national officer for health Celestine Laporte as "a very strange, ill-judged decision."

The Department of Health and Social Care (DHSC) told *Healthcare Manager* that officials are now working with NHS Improvement on collecting new data on assaults and abuse suffered by NHS staff in England.

A DHSC spokesman said the department is also working with NHS England and NHS Improvement to "agree leadership for the central security management functions required to support trusts", and with the CQC to ensure that security management is tested as part of the inspection regime.

He added: "NHS staff work incredibly hard in a high-pressure environment, so it's completely unacceptable for them to be subject to aggression or violence." NHS Improvement declined to comment.

attitude that violence is 'part of the job' is dying out.

"This is not a risk-free environment," she says. "There is no let up, no down time anymore. Patients often come in with nothing, when they used to come with their bags ready packed. But admissions are now very risk aversion-led and staff know that if something is reported it will be responded to."

The trust employs full time instructors who train staff in de-escalation techniques, which start as soon as a patient is becoming agitated, and restraint techniques, which should be a last resort. On wards for older people, a new shift has been instigated to improve cover at peak times for incidents.

"Boredom is often an issue in triggering incidents, so occupational therapy and activity co-ordinators play key roles in looking at ways to engage people," says Lashmar.

The trust also works with police liaison officers, who routinely spend time on the wards, Lashmar explains, so they can respond quickly when an incident cannot be contained by staff.

Lincolnshire's relatively low levels of agency staffing may also have contributed to its success in reducing violence, although Ms Lashmar admits incident levels may rise following the opening of a psychiatric intensive care unit last year.

Culture of acceptance

The Health Foundation recently funded a project aimed at reducing violence by up to 80% at two NHS trusts – South London and the Maudsley (SLAM) and Devon Partnership – which highlighted the need to improve clinical leadership at ward level. SLAM medical director Dr Michael Holland describes how violence levels on some wards were so high that staff were afraid to come to work – but also how a culture of acceptance had grown up around violence.

> "These are challenging places to work, there is unrelenting demand on staff, with no breaks in demand. There needs to be capacity to allow them to become therapeutic places."
>
> **DR MICHAEL HOLLAND, SLAM medical director Improvement**

"You need process changes and environmental changes, but also a cultural change – and you need the leaders to unlock that," says Holland. "We put in a process called 'intentional rounding', though the staff prefer the term 'intentional engagement': basically, going round and asking every patient how they are, how are they feeling, do they need anything?

"We also tracked flash points, which were found to come down to things like frustration, such as when a patient has leave [clinical authorisation to leave the ward] but has to wait two or three hours to get it," he continues. "On one ward meal times were a flashpoint – we realised there were more patients than chairs. Anyone would get frustrated with that."

Holland echoes Lashmar's observations that in-patients are more unwell than they used to be. "The patients have to get out of the wards sooner, to free up beds," he explains. "These are challenging places to work and there is also unrelenting demand on staff, with no breaks in demand. There needs to be capacity in the system to allow them to become therapeutic places."

Although around a third of SLAM's wards are now close to zero violent incidents, the trust still has some way to go to match the performance of Devon Partnership, which has achieved the aimed-for 80% per cent reduction in incidents – a success which Holland attributes to strong leadership at both ward and management level. "You can tell the difference there, you can feel it," he says.

'We want it now'

While mental health trusts routinely treat violence and aggression as a clinical issue, acute trusts are more likely to deal

TOUGHER PENALTIES FOR ASSAULTS ON NHS WORKERS

The Assaults on Emergency Workers Bill, which would double the maximum sentence for common assault from six months to a year for offences committed against emergency workers on duty, is likely to become law later this year.

The bill was brought before Parliament by the Labour MP for Rhondda, Chris Bryant, who says the move was triggered by an incident in his constituency.

"Five years ago, when the fire bridge attended some fires in the [Rhondda] valleys which had been set deliberately by kids, they were pelted with bricks by the same kids, who thought they could get away with it," he explained.

Mr Bryant tabled the bill after conducting polls on which of six issues he should seek to table a private members bill on. Stronger penalties for attacks against emergency workers came top of the list.

"When Holly Lynch MP tried to earlier table a similar bill [then home secretary] Amber Rudd said there was no need for it," adds Bryant. "But now there is support across the House. The public can see that attacks on all emergency workers are on the rise and offenders get pathetic sentences."

The bill's definition of an 'emergency worker' includes most NHS workers. Bryant stresses that higher penalties would apply whenever an emergency worker is attacked while performing emergency duties, even if they are not on shift at the time.

The bill, passed by the Commons at the end of April, received its second reading in the House of Lords on 29 June. Bryant is confident it could become law by the end of September, with higher tariffs being enforced by the end of the year.

with it through operational and security management teams. But the message is the same.

"We needed a cultural shift to make it clear these incidents are not part of the job," says Jayne King, head of security at Guys and St Thomas' NHS Foundation Trust. The trust launched its 'Keep our staff safe' campaign in 2016 after its chief nurse realised violent incidents were on the rise.

"Some people will always act out because of their illness or treatment, and staff will always make allowances. But we have clear expectations about behaviour and what is unacceptable," King adds.

She says the trust's definition of violence includes both physical and non-physical contact. "It doesn't have to be a punch in the face. A quiet voice can be more intimidating. And that type of intimidation can be more challenging for staff; it can be very wearying," King explains.

King thinks increasing rates of violence in acute trusts may be down to what she calls a 'we want it now' culture. "You can see frustration on the rise in all aspects of life," she says. "As a security colleague of mine says, the genie is out of the bottle about this; the issue now is how we handle it."

While half of all violent incidents across the trust happen in accident and emergency, King says other 'hot spots' include the maternity and children's services at the trust's specialist children's hospital.

"At the children's hospital emotions are at full pelt," she explains. "Lone working in the community in care of the elderly is another hot spot, largely because of the behaviour that can result from dementia and delirium. Lone workers need a 360° view of risk assessment – before they leave the office, when on the visit and afterwards. In accident and emergency, it's more about early intervention to de-escalate a situation."

All violent incidents at Guy's are subject to a post-incident review. And if an assault on staff merits police involvement the trust facilitates what is needed, with police interviews carried out in work time and staff being accompanied to court if necessary.

As well as the courts, offenders also face a range of sanctions from the trust, of which the ultimate is exclusion. NHS guidelines say exclusions must be reviewed after a year, during which time arrangements are made for offenders to be treated at another trust.

"Sometimes relationships between the clinicians and the patient have completely broken down and such measures can be an opportunity for the patient to start afresh," King says. ■

After struggling to meet people's needs in its busy outpatient clinic, the gastroenterology department at St Mark's Hospital worked with patients and quality improvement managers to deliver dramatic results. **Matthew Limb** reports.

Unblocking the system

The challenges for healthcare organisations in managing inflammatory bowel disease (IBD) have long been recognised. IBD encompasses ulcerative colitis and Crohn's disease, both chronic diseases of the gastrointestinal tract without identified causes.

"Compared with other chronic conditions, like diabetes and hypertension, it happens at a younger age more often than not," explains consultant gastroenterologist Naila Arebi. "It doesn't really kill people, so mortality is low, which means this cohort have to live a long time with the disease."

Many IBD patients have vague, non-specific symptoms that pose challenges for GPs. "It comes in acute attacks and then goes quiet, so there are relapses and remissions," says Arebi. "Sometimes people have very mild disease and don't really need specialist input, but they do still need to be monitored, as they could develop complications either from drug treatments or from the condition."

St Mark's Hospital, part of London North West University Healthcare NHS Trust, was facing an increasing need to monitor outpatients with IBD. In 2016, a service evaluation showed there was a clear "mismatch" between need and access. Up to two-thirds of patients were in remission, but those with acute symptoms were having trouble accessing help when they needed it. There were long waits in clinics, and seemingly-well patients were in effect "displacing" people with active disease or those being referred for suspected cancer.

Naila Arebi, Consultant gastroenterologist, St Mark's Hospital.

"We came up with the idea of trying to stratify the patients who are 'well', or have a low risk of developing complications, and offering them out-of-hospital follow-up with a telephone clinic," says Arebi.

Improvement science manager Susan Barber from the North West London Collaboration for Leadership in Applied Health Research and Care (CLAHRC) worked on the project from the beginning alongside the clinical team from St Mark's. She describes how they discussed with patients and other stakeholders what needed to be changed, and how this could be implemented step-by-step, with "everybody on the same page".

Barber acted as mentor and coach for staff who were unfamiliar with quality improvement (QI) methodology. "You make plans, you enact them, and in those plans you predict what you think what you're going to achieve and [measure] whether you do. Then, if you don't, you can think again and make another cycle," she explains.

A key early job was to decide on criteria for identifying "low-risk" patients in remission who could be offered an alternative to an outpatients appointment with a consultant. "We tested and tried several elements," says Barber. "The first thing was the stratification of the database itself. We then had to figure out ways and means of offering patients the option, getting their response to it and going the next step and maybe booking them in for the next appointment in a different way – the telephone clinic."

The team also planned to set up new "rapid assessment" clinics to deliver urgent specialist access within one week for patients with acute symptoms, hopefully reducing attendances at the emergency department.

At the outset there was some "clinician resistance", says Arebi, to the idea of out-of-hospital or telephone clinics for monitoring low-risk patients. "A few people were anxious and felt it was the health service trying to save money," she explains. "Consultants were a bit apprehensive that they wouldn't have enough work and might be made

Members of the gastroenterology department who worked on the outpatients project at St Mark's Hospital.

redundant… We realised that raising awareness about the project and quality improvement methodology would be a challenge."

The team organised multidisciplinary meetings to discuss ideas, problems and possible solutions, and held regular sessions for staff to learn about QI methods and discuss the results. They also worked with the trust's IT department to identify the data they needed to understand the wider impact of their decisions.

"Consultants could see the benefits, they could see how many patients didn't have to come to clinic and they could focus on the difficult cases – which they've been trained to do," Arebi adds.

Patient involvement throughout was key. Before the project, outpatients were asked to complete service questionnaires independently, and showed little interest in telephone clinics. But once clinicians began talking patients through the process, and were booking follow-up appointments on the spot, there was a "dramatic" improvement, says Barber: the proportion of patients choosing telephone clinics more than doubled from 6% to more than 15% in the first 16 weeks.

Susan Bailey-Fee, who suffers from IBD, was one of two patients on the project team. "The main advantage is, if you're long-term stable, it isn't really necessary to go into hospital and see a consultant – you're losing a day off work and cost of travel just to be told 'you're fine, come back in six months'," she explains. "All that could be done over the phone because you've already had your blood tests done. It frees up time for the patient as well as the hospital. So it's a good idea."

The new system has reduced waiting times for new gastroenterology patients, with average referral times down from 12.5 weeks in January 2017 to 7.6 weeks by October. 86 patients with acute symptoms used the new rapid access clinics between June and December 2017, with no admissions to hospital; a survey found that that 55% of these patients had reduced their emergency department attendance as a result, while 90% were extremely satisfied with the standard of care they received.

Barber says the team are already involved in the plans to expand the number of hospital doctors working in scheme beyond the current three consultants and three registrars. And, with funding from Brent and Harrow CCG, they plan to recruit an IBD nurse to work through GP practices. Eligible patients in remission will have the option of being monitored by the nurse through regular telephone clinic appointments or other community services.

Consultant Naila Arebi says the "transformed" IBD outpatient service is now much more responsive to patients' needs. "We couldn't have done it without the managers at CLAHRC," she adds. "They have the time to think about what we're doing and reflect a bit more – while we're running the clinical service."

She believes the model could be replicated for other long-term conditions. "I think overall it's been a really positive experience – it's been challenging but an eye-opener on getting a different perspective on a problem," she says. "I'm confident we've created a recipe for other people to adopt this approach."

"It's still relatively early days," says CLAHRC's Susan Barber, who praises the St Mark's team for making good progress up a steep learning curve. "If they keep that up, they believe they will make this 'business as usual' within the next year," she adds.

Patient representative Susan Bailey-Fee describes the scheme as "a massive change for the stable patient" and argues that involving patients from the start was crucial to its success.

"As a patient you don't realise all the intricacies of the NHS, and how long it takes to achi something that you think is quite simple – that small piece of the puzzle," she says. "I think if more patients could be encouraged to get involved, a lot more projects and issues could be solved really quickly with more of a patient voice." ▪

The St Marks IBD project won the 2018 Brian Turley award for working with patients, service users, carers, families and communities. For further details visit bit.ly/hcm3801.

legal**eye**

Doug Christie argues that the Civil Liability Bill will deny injury compensation to thousands of workers and cost the NHS millions – just to feed fat cats in the insurance industry.

At the end of June, the government's Civil Liability Bill, introduced into the House of Lords in March, began its passage through the Commons. If passed, the bill could limit the rights of hundreds of thousands of people injured at work through no fault of their own.

Currently, anyone who is injured in a workplace accident can claim from the employer the cost of getting legal advice on a possible claim if their injuries would entitle them to more than £1,000. Whether the claim falls under the 'small claims limit' is determined by the value of the injured person's compensation for pain and suffering. If this is £999 or less, the case is dealt with in the small claims court, where legal expenses cannot be claimed.

The bill purports to be about limiting whiplash claims made against car insurers, but the government are also proposing to increase the small claims limit from £1,000 to £2,000 for all cases, including accidents at work, and to £5,000 for road traffic accidents, which includes injuries to cyclists and pedestrians.

£2,000 is a lot of money for most workers, including many working in the NHS. Left to the small claims court, the injured party would either have to take on employers or insurers on their own, or pay for a lawyer to help them – using money that was meant to be compensation for their injuries and losses.

The bill will also have a big impact on the NHS. At the moment, the NHS can recover the cost of treating people injured in road traffic accidents from the insurer of the driver who was at fault. If the bill goes ahead as planned, the

cost to the public purse will be around £150m a year, while insurers will see their annual profits boosted by £1.3bn. These are the government's own estimates, laid out in their impact assessment of the bill.

It is estimated that at least half a million people every year would be left on their own while trade union legal services will be undermined if the bill goes ahead as currently drafted. The government is intending to abandon a principle that has stood for generations: that the person who caused the injury should pick up the bill to ensure the injured get legal help and proper compensation.

The government claims the bill will reduce so-called 'fraudulent' claims. However, its figures for fraud come entirely from the insurance companies and are in no way independent. Not even the insurers are suggesting people injured at work are making fraudulent claims. The government is using a 'crisis' about the number of whiplash claims ramped up by the insurance industry to take away rights from everyone.

The government claims the bill will reduce insurance premiums but we have been here before. In 2011, the government made huge changes to the rights of injured people which the Association of British Insurers estimates have saved insurance firms an astonishing £11 billion in the years since – yet premiums are higher now than ever.

The truth is that the government's cries of "compensation culture" and "fraud" are actually a fig leaf to distract people from the government's true intentions: to attack access to justice for all injured people, including workers, and to pass billions to those in the insurance industry.

As they enter the House of Commons, these insurer-backed proposals can still be stopped. Help us to put pressure on the government to think again by writing to your MP. For further information and a pre-drafted letter, visit the campaign website at feedingfatcats.co.uk. Or follow @FeedingFatCats on Twitter and support our campaign. ▪

Doug Christie is union and client director at Thompsons Solicitors.

Legaleye does not offer legal advice on individual cases. MiP members in need of personal advice should immediately contact their MiP rep.

Managing a successful return to work

If you've been off sick long-term, you need to plan your return carefully – especially if workplace pressures contributed to your ill-health. MiP national officers **Steve Smith** and **George Shepherd** give their tips for a successful comeback.

1. KEEP IN TOUCH

If you're off work for a while, it's easy to lose touch with workplace developments. So make sure you agree "keep in touch" arrangements with your employer. This might involve regular phone calls and emails or, if your health allows, meetings on site. It's best to have a named person responsible for doing this: your line manager, if you have a good relationship, or someone from HR. But make sure you're not cajoled into working in between your catching up sessions.

2. TAKE ADVICE

Everyone's circumstances are different, so you need to plan a return to work that suits you. Take advice from your GP or other health professionals, and consult with your MiP national officer before agreeing anything with your employer. If workplace problems contributed to your ill-health, you need assurances that these will be tackled before you go back.

3. ONLY GO BACK WHEN YOU'RE READY

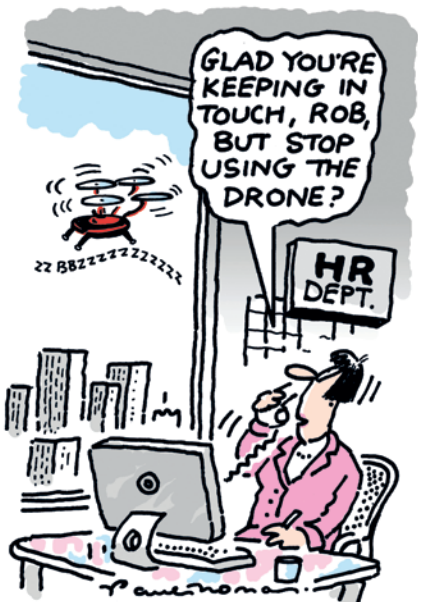
Remember, you will probably only get one shot at this, so don't go back until you're 100% ready. If you go off sick again, you may face a capability review or pressure to take ill-health early retirement. Don't work while you're off sick – if you're ready for light duties, consider a phased return.

4. NEGOTIATE A PHASED RETURN

This might involve working one or two days a week at first and gradually building up to your "normal" hours. It's important that your workload is realistic and that you have enough time to catch up with developments while you were off – your employer should make sure that the rest of your job is covered by an interim or other staff.

5. DON'T GET BITTEN TWICE

Too often, members return to work to find themselves under the same pressures that caused them to become ill in the first place – stress, excessive workloads, bullying, toxic relationships or poor working practices. Your MiP national officer will help you to identify these causes and agree remedies with your employer before you go back.



6. AGREE REASONABLE ADJUSTMENTS

Most employers are willing to make reasonable adjustments to get experienced permanent staff back to work. They may include changes to your workload, job description, place or hours of work, line manager – or arrangements that allow you to take medication or manage chronic pain. They don't need to be expensive – they just need to work.

7. KNOW YOUR RIGHTS AND CHECK YOUR POLICIES

There are no national policies on managing sickness absence, so check your employer's policy on how and when your sickness absence will be reviewed. But you also have contractual rights to sick pay under Agenda for Change and legal rights under health and safety legislation. Your MiP national officer will advise you on these rights, and whether your employers' policies meet their legal obligations.

8. DON'T BE AFRAID OF THE "DISABILITY" LABEL

Admitting that you have a disability doesn't mean admitting that you can't do your job. If your illness has left you with a recognised disability, there is a robust legal framework of protection: your employer has a positive duty to make reasonable adjustments to help you overcome barriers – and that includes the impact of treatment for long-term conditions such as cancer and HIV.

9. USE YOUR OCCUPATIONAL HEALTH DEPARTMENT

It's a common misconception that OH's job is to pressure people back to work as soon as possible, but we find they are often much more objective than people expect. Usually, OH will arrange a home visit or workplace meeting to discuss reasonable adjustments and when it's realistic for you to return to work. In rare cases where they won't acknowledge the problem that damaged your health, you can ask for a formal risk assessment. Your national officer will advise you on this.

10. SICK LEAVE ISN'T FOREVER

Eventually, if your employer is willing to make reasonable adjustments and you still feel unable to return to your job, they can terminate your employment on health grounds. You may be able to take ill-health early retirement, which allows you to retire without any reduction in the value of your pension. In very rare cases where you are unlikely to work again in any job, your employer may top-up your pension. You can discuss all your options with your MiP national officer. ▪

COMMUNICATIONS

Look out for MiP's new website!

The digital world moves fast – and it's left our current website behind. So we've built a brand new site, designed to reach new audiences and give you a stronger voice in the public debate.

Like many of our members, you read *Healthcare Manager*; but the chances are that, these days, you get most of your news and information online. And we know that our current website is not up to scratch. So in early autumn, we'll be launching a brand new site – redesigned from scratch to meet your needs and help us achieve the union's aims.

Some time ago, as part of a wide-ranging review of our communications, we ran an online survey of members – asking where you want us to focus our communications work, and how you'd like us to communicate with you. The results were pretty clear.

When asked to name your priorities in our comms work, your top three answers were: working in government to get your views across to politicians and civil servants; raising MiP's media profile; and marketing to recruit new members. While you still value dMiP's magazine, you said you preferred to receive most information – especially news – via the digital route.

We already knew that our website needed updating. But your views were crucial in shaping our new site – and we've spent many months working with our web and database supplier, a design firm, the editor of *Healthcare Manager*, a communications consultant and a digital project manager to create a site that enables us to meet your goals.

The result is a site built to:

- Provide a strong digital platform for publishing news, features and opinion, with easy social media sharing to drive up visitor numbers, reach new audiences among potential members and beyond, and strengthen MiP's voice in the public debate

- Explain clearly what MiP does, demonstrate its value to potential members and provide a modern, streamlined online joining process
- Draw visitors further into the site by presenting them with relevant content and useful information – and to convert interest into actions such as joining or signing up for email bulletins
- Show members how the union works for them and champions their interests, and boost members' participation in MiP activities such as volunteering and events
- Showcase MiP's work within each geographical area and each health and care topic, making clear to potential members that MiP is relevant to them
- Develop our external mailing list by encouraging people to sign up for email bulletins
- Provide health and care managers with advice on problems at work – saving them time and helping to improving outcomes
- Update the website's look and feel, and upgrade its functionality so that it's easily explored on all types of devices

We're currently testing the new site, and aim to go live soon. So do please keep an eye on our website, and when the new one (pictured above) goes live, have a good look around. You can help us raise MiP's profile and get our messages out by sharing content via social media. And we're looking forward to hearing your views on the new site.

We do hope you like it. The new site will give us the tools to reach a far wider audience, improve recruitment, and boost your voices in the public debate – strengthening our ability to protect and support health and care managers across the UK. ■

Please send any comments about the site to our new communications officer, Mercedes Broadbent: m.broadbent@miphealth.org.uk

CASEWORK

Finding the right way out

When the threat of redundancy looms, everyone's situation is different. **Craig Ryan** talks to one MiP member about how the union worked to get the outcome that suited him.

With restructuring a fact of daily life in today's NHS, MiP always works to avoid compulsory redundancies and maximise opportunities for redeployment. But sometimes it's also your union's job to negotiate with your employer to make sure you can leave the organisation in a way that works for you.

"The first thing I ask the member is what they want to achieve out of the situation," says MiP national officer George Shepherd, who looks after members in East London and the East of England. "Before I talk to the employer, we talk through all the options, go through the pluses and minuses, and I help them to come to a clear decision."

Martin (not his real name), a director working for a large NHS trust, faced years of uncertainty over his future following the appointment of a new chief executive in 2015. "Any new chief executive wants to put their own stamp on an organisation, and he identified changes which didn't fit with the existing structure," Martin explains. "So individuals were asked to be flexible and make some – supposedly temporary – changes to move towards the plan the chief exec desired."

It was clear there would be fewer posts at Martin's level, but the trust initially promised that no one would be made redundant. "I knew something was going to happen, and I clearly wasn't going to remain in my substantive post," says Martin. "So, I've been doing all sorts of projects and God knows what else in between, which isn't exactly great for one's mental health."

George supported Martin and several other members through the two and a half years it took the trust to implement its new structure. "The management

group at the trust has been continually hacked over, with restructures, regrading and titles being taken away," George explains. "So I've been fire-fighting on their behalf… and we've had some good results though negotiation."

In the spring of this year, the trust formally notified Martin that he was "at risk" of redundancy. He was placed in a pool of staff to be made redundant by September if suitable alternative employment could not be found.

The timing presented a big problem for Martin. "In the worst case scenario – if I didn't find another permanent job – I wanted to be able to take the redundancy and maintain some sort of income by accessing my pension," says Martin. But under the rules of the 1995 pension scheme, that wouldn't be possible until his 50th birthday – four months after the redundancies were due to take place.

George saw an opportunity to strike a bargain. As well as unfairly keeping staff in limbo before going back on its promise of no redundancies, the trust also appeared to have breached its own procedures in several ways – not least by including seconded staff in the redundancy pool, making it less likely that suitable posts could be found for permanent staff like Martin.

In talks with the trust, George and Martin were able to use this as leverage to negotiate a deferment of Martin's redundancy for four months. "I told the trust they were going to have a fierce legal battle on their hands if they didn't come to an amicable resolution," George explains. "And we felt we had a very strong moral case because of how unfairly Martin and the other staff had been treated."

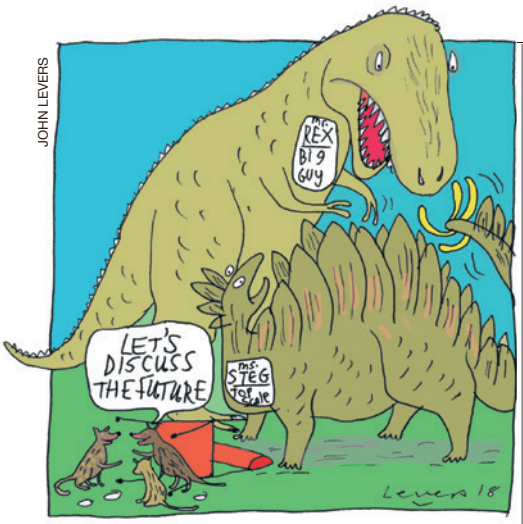
Martin adds: "We were aware that the organisation was being heavily scrutinised externally and wanted the restructure to go through without much challenge or difficulty." "George was very good at saying to them, 'You've got someone here with an exemplary record for 30 years, why wouldn't you want to do this the easy way and afford them an extra few months?'"

Martin says support from MiP not only helped him to get the outcome he wanted, but helped him to decide what the right outcome was. "You'll have an honest conversation with George – he'll help you determine what the reality is, and then he'll go into bat for you… So you can manage your situation in a much more balanced and coherent way than if you were unrepresented."■

If you have any concerns about your redundancy entitlement, contact your MiP national officer for advice.

Integration has the potential to transform our health and care services, argues one social care manager, but time is pressing and demand is constantly growing.

Social care needs to evolve to collaborate



JOHN LEVERS

I've worked in social care commissioning for decades, and every year now the challenges grow. But here in Scotland, the integration of health and social care gives me hope that – even as demand continues to rise – we'll be able to improve at least some of our services.

Scotland's creation of integration authorities to bridge the gap between NHS boards and council social care is forging new relationships between professionals from different backgrounds. And the residents of the urban area I serve are already seeing results: we're sharing the cost of commissioning more 'intermediate care' places, for example, so elderly people can leave hospital more quickly – freeing up NHS beds.

But big cultural shifts need nurturing. Both NHS and social care staff have strong identities, and sometimes we argue without good reason; we need to park that. Many managers on both sides are willing to reach out, and we try to make things work. But some traditionalists remain. Too many people seem to view their NHS or council badge as a mark of their identity, dividing neatly into two opposing groups to back their own 'side' in any dispute or decision.

Time is pressing: massive demographic change, rising costs and constrained budgets are squeezing the system. At a national level, we need a debate about sustainably meeting rising demand; we should stop pretending we can satisfy everyone's health and care needs in a low tax economy. We've seen more cash for the NHS recently, and the Scottish Government is transparent about the problem. But I don't think the debate goes deep enough, or reaches across party lines in the way that's required.

Some Scottish Government policy aspirations ratchet up the pressure. The Scottish living wage – about £1 an hour higher than the English minimum wage – drives up providers' costs. Deciding that the field is no longer profitable, some providers have exited the marketplace.

Meanwhile, an English employment tribunal appeal ruling has barred the practice of paying care staff a fixed fee for overnight care: we now have to pay the hourly living wage – tripling the cost. As a result, night-time support services are undergoing a radical redesign. Both the living wage and the employment ruling are laudable attempts to increase the wages of care staff – but in reality, some will see changes to their shift patterns that actually drive down their incomes.

At the same time, 'hands on' care work is becoming more demanding. Most authorities now focus resources on people with 'substantial' and 'critical' needs, leaving those with 'moderate' needs to organise and fund their own care. When our workers spend so much of their time supporting people with incontinence issues or very challenging needs, retaining staff becomes problematic. Staff recruitment in social care is a national risk.

The result is challenges in our supply chain. Sometimes we ring round 15 or 20 providers before we find one with enough staff to offer a care package. Staff shortages and high turnover undermine the personalisation agenda, which presumes a surplus of supply to give people a choice of care staff. And given how tight things are already, Brexit's impact on recruitment is a big concern.

Better technology can offer solutions. It can improve efficiencies: why send a care worker to someone's house three times a day to prompt them to take their medication, when we can achieve the same outcome remotely using an iPad? And it can offer people more privacy: we can monitor their safety and wellbeing remotely, rather than having someone live with them. In the pilots we've run, clients speak favourably of their new reality. People are understandably nervous about new technology, but the 'old ways' are financially unsustainable.

Given time, I believe health and care integration will give us more answers. Some governance and business processes have actually become more burdensome, as we navigate our way through the mix of NHS, council and Integrated Joint Board approval processes. But on the other hand, we're pursuing sensible ideas previously caught up in the tensions between the two sides. As one example, we can devise better options for the adults with severe needs who've spent long periods living in hospitals. Integration is allowing different solutions to be proposed.

I remain positive about the future of health and social care in Scotland. As money gets tighter, managers on both sides are being pushed into working together. Real collaboration is happening – sharing procurement expertise; taking a wider world view; cohabiting in unified workplaces; considering how each system input affects the whole system. In time, maybe, we'll all put our badges aside and work as one unified system – serving our communities together. ■

The Sharp End is your chance to tell politicians and civil servants how their policies affect your work and your organisation. Most stories are also published in the *Guardian*. To work with a reporter on your own story, email thesharpend@healthcare-manager.co.uk. When requested, anonymity is guaranteed.

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