managers in partnership

healthcare manager

Issue 42
Summer 2019

Julie Ogley

Politicians haven't got the message about social care

NATION TO NATION
Learning from collaborative working in Scotland and Wales

THE GET OUT CLAUSE
Defending managers against arbitrary dismissal in the NHS

ALL POINTS NORTH
Report from MiP's North Summit in Leeds

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inside

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Managers in Partnership

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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.

The word 'crisis' is perhaps used too easily to describe any service, organisation or policy going through difficulties (and who isn't right now?) but, as Julie Ogley, president of the Association of Directors of Adult Social Services tells us in an exclusive interview (*see page 12*), the "absolute crisis" in social care is both real and already upon us.

We know how the social care crisis hits the NHS through bed blocking, unnecessary admissions and a general decline in public health. In public service, the welfare of our most vulnerable people is everybody's business. Our members and colleagues in social care deserve and need our full support as they struggle to keep services going against almost impossible odds.

By the time you read this, we may already have a new prime minister. However preoccupied he may be with Brexit, both health and care workers will want the new government to think imaginatively and bravely about how we can resolve this crisis. Social care has, for once, been reasonably prominent in this Tory leadership campaign, although the warm words and piecemeal policies offered so far by Jeremy Hunt and Boris Johnson fail to get anywhere near matching the scale of the crisis Ogley describes.

Johnson has at least spoken – fairly casually, it has to be said – about finding a cross-party consensus on the future of social care. That needs to happen fast. Whichever man gets into Downing Street this summer, we must hold him to account for the promises he's made to sort out this most neglected area of public service.

Craig Ryan
Editor

heads up

News you might have missed and what to look out for

Staff Wellbeing

Review disciplinary policies to protect staff, trusts told

NHS Improvement (NHSI) has told all English NHS trusts to review their disciplinary and investigation procedures and ensure staff health and wellbeing are given top priority, following a highly critical independent report into the circumstances surrounding the death of London nurse Amin Abdullah.

Abdullah committed suicide In February 2016, while waiting for his appeal against dismissal by Imperial Healthcare Trust to be heard. A independent inquiry by Verita Consulting found serious procedural errors in the handling of Abdullah's case and described the trust's disciplinary and investigation procedures as "weak and unfair".

In a letter to trust chairs and chief executives, NHSI chair Dido Harding reported that a multi-disciplinary advisory group, set up to consider the wider lessons of the Abdullah case, had recommended key areas for improvement in the handling of investigations and disciplinary cases in English NHS trusts. They included:

- poor framing of concerns and allegations
- inconsistency in the fair and effective application of local policies and procedures
- lack of adherence to best practice guidance
- variation in the quality of investigations
- shortcomings in managing conflicts of interest
- insufficient consideration of the health and wellbeing of individuals
- failure to adequately consider alternatives to formal procedures

The joint NHSI-NHS England people committee has produced new guidance for trusts, based on the advisory group's recommendations, against which HR teams and trust boards should review their current procedures in order to bring them into line with best practice, Harding said.

She added: "The committee recognised that, sadly, Amin's experiences are far from unique and acknowledged there needs to be greater consistency in the demonstration of an inclusive, compassionate and person-centred approach, underpinned by an overriding concern to safeguard people's health and wellbeing, whatever the circumstances."

Read NHSI's new guidance online at: bit.ly/hcm42-nhsi. If you think your organisation's disciplinary procedures aren't up to scratch, contact your MiP rep or national officer.

MiP have moved home

MiP have now moved into the new FDA head office building near London Bridge.
Our new address is: Managers in Partnership, Ebbark House, 93-95 Borough High St, London SE1 1NL
Tube: Borough or London Bridge. Buses 21, 35, 133 & 343. Phone numbers and email addresses are unchanged.

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leading**edge**

Jon Restell, chief executive, MiP

"I don't want to eat animals, Daddy; the trouble is they're just so tasty." Thus my daughter, oozing sincerity, laid out the the ethical meat-eater's dilemma. I'm often reminded of her words when I hear well-meaning ministers and system leaders talking about doing right by NHS managers.

We've heard that "it's time to reset the rhetoric", "we must value great leadership" or "I want to give leaders time, space and air cover". More recently, Dido Harding and others have proposed – rightly and helpfully – a new compact for senior leaders. Dido has also attacked "trial by *HSJ*". But these positive intentions tend to evaporate when the pressure is on and the finger of blame needs pointing away from oneself: "I don't want to bash managers; the trouble is it's just so easy."

Managers and their many allies need to make it less easy. It's a fearsome challenge when the public and – to some extent – the government don't believe fundamentally that managers have a role in health and care. Doctors and nurses don't need to explain their values or why they do what they do. Their caring image is imprinted on the public's imagination. But managers have no such imprint. They must explain. Many fail or stop trying, adopting an outlook of noble masochism.

As I've written before, the perennial failure to value senior managers undermines their morale and effectiveness, and deters many talented managers and clinicians from aspiring to the board. By ignoring heaps of evidence that good leadership is vital, we risk negligently damaging patient care.

The narrative should be so different. As the NHS Confed's recent report on first-time chief executives says, the question shouldn't be 'who would be an NHS chief executive?', but 'why wouldn't you want to be a chief executive in the NHS?'

The new chief executives were an amazing bunch – reflective, responsible and determined to put their people at the heart of things. I felt that even those hostile to management would have been as inspired, convinced and reassured as I was.

I recently listened to a panel discussion between four participants held as part of the research. They were an amazing bunch. Reflective, responsible and determined to put their people at the heart of things, they demonstrated in spades the value of NHS chief executives. I felt that even people hostile to management would have been as inspired, convinced and reassured as I was.

I took three important lessons from this. First, chief executives need to talk about the big stuff. At our recent North Summit, Julian Hartley, chief executive of Leeds Teaching Hospitals, talked powerfully about his own background and why education and healthcare are the twin pillars of civilisation. I felt the hairs rise on the back of my neck – Julian had tapped straight into that stream of progress that started with the great Victorian social reformers.

Second, managers need to shape their own professional values and standards, not sit back and let someone else do it – however well meaning they are. The new chief executives were compelling on the key components of their professional practice: mentorship, handling setbacks and emotional reactions, visibility, equality and inclusion, curiosity and using a positive, realistic tone. They clearly see confidential peer support as vital for themselves to thrive: self-help – another Victorian classic.

Thirdly, managers themselves have the answers to the systemic and cultural problems of NHS leadership, especially the burning issue of high staff turnover. The new chief executives saw greater leadership stability as a priority: we need to appoint the right people to the right job, with the most challenged organisations needing the most experienced chief executives. This points us to managing careers, rather than filling jobs, having better career discussions and encouraging people to move around – for the right reasons – and not to stay in safe corners. We also need to be honest with the public and regulators: change takes time and won't always lead to steady progress, relationships take three to four years to mature, and - perhaps most difficult - healthcare is complex and there is always the likelihood of things going wrong.

As the NHS in England engages on its final People Plan, I encourage all managers to talk big and Victorian – shape your own values and standards, and give honest answers. With many routes into management, many different perspectives and lots of separate disciplines, our diversity is a great strength. This summer, let the voices of NHS managers be heard.

Read the NHS Confederation's report, *The best job in the world?* at: bit.ly/hcm42-confed

Pensions

Government wrong to exclude managers from pensions tax fix

HARLI MARTEN ON UNSPLASH

Government plans to restrict new flexibilities in NHS pensions to senior clinicians are "wrong and unfair", and undermine the Department of Health and Social Care's pledge to develop HR policies to serve the whole workforce, MiP chief executive Jon Restell has said.

The DHSC announced on 3 June that it would consult on proposals to offer senior clinicians the option to build their pension pot more steadily throughout their career – and avoid the unexpected tax bills currently hitting many clinical and non-clinical NHS leaders. MiP explored this problem in an article in the last issue of *Healthcare Manager* (*HCM42, page 15*), which revealed that some senior leaders are having to remortgage their homes and others are leaving the NHS pension scheme completely.

"We strongly oppose what the DHSC is planning," Restell said. "It must include all staff in any future flexibility. Excluding senior managers, support staff and junior clinical staff is wrong, unfair and undermines the new positive focus on the whole NHS workforce. We will press hard for the equalities impact assessment of any proposals."

Restell warned it was doubtful whether the government's proposed "50-50 option" – under which staff would be able to pay pensions contributions on only half their salary in exchange for reduced benefits – would resolve the problem. "I doubt senior doctors will see it as the answer to annual allowance charges," he said.

"The proposed new compact with senior leaders in the interim NHS People Plan is off to a very bad start," he added. "The plan has a heavy emphasis on improving the diversity of senior leadership in the NHS, and this is also likely to be impacted by these measures."

Restell demanded that the DHSC show evidence that taxes on pensions doesn't affect the recruitment and retention of managers. "The board vacancy rate in the trusts most in need of permanent leaders is well-documented," he said. "These recruitment problems are a major threat to patient care. It would be helpful for NHS Improvement to say what it thinks."

"This focus on retention issues is far too narrow," he added. "Pension flexibilities are more about the long-term sustainability of the NHS pension scheme. Ultimately the Treasury could sort this out by changing the tax policy that penalises employees in defined benefit pension schemes."

Pensions

Government appeal against age discrimination ruling fails

The government has been refused permission to appeal against a landmark court ruling that its reforms to pension arrangements for firefighters and judges unlawfully discriminated against younger workers.

On 27 June, the Supreme Court ruled that the government had no grounds for appeal against the Appeal Court's ruling in the so-called 'McCloud case' that 'transitional protection' for existing members of the schemes amounted unlawful discrimination against younger staff. The government is now obliged to begin talks on how to compensate firefighters and judges who have lost out under the arrangements.

Although the British Medical Association has said it intends to pursue similar claims on behalf of some doctors, MiP said the implications of the ruling for NHS staff remain unclear. Unlike the two schemes at the centre of the McCloud case, reforms to the NHS pension scheme underwent an equality impact assessment when they were introduced in 2015.

"The impact of the case needs to be considered scheme by scheme, rather than as a blanket public sector policy. It's not a given that all schemes are in the same boat," said MiP chief executive Jon Restell.

He urged all the healthcare unions to work together on the legal issues and the impact on the scheme. "The sustainability of the NHS pensions scheme is an important consideration," he said.

Restell also called on the government to restart talks on possible changes to NHS pensions following the recent revaluation, which found that the scheme was overfunded. The government paused the negotiations earlier this year, claiming it needed to consider the possible implications of the McCloud case.

"Our members have been overpaying contributions and deserve improved benefits and a cut in their contribution rate as a result," he said.

HPMA Awards

Hillingdon scoops top partnership award

An innovative project to involve staff in developing an organisation-wide people strategy has been named as the top partnership initiative of 2019 at the Healthcare People Management Association awards in June.

Hillingdon Hospitals NHS Foundation Trust won the partnership working prize, sponsored by the National Social Partnership Forum and presented by HPMA president Dean Royles, for their 'Developing a People Strategy in Partnership' initiative. The judges said the project showed "a combination of positive mindsets, effective working relationships and full scale staff engagement", with management and unions working together to tackle a range of workforce issues including staff shortages, high turnover rates and heavy reliance on bank and agency staff.

The initiative has already led to the introduction of a new learning management system, a successful overseas recruitment campaign, and the streamlining of recruitment processes, resulting in a reduction in Hillingdon's vacancy rate, agency spending and recruitment timescales.

"We were really impressed by the clear and demonstrable partnership working from the outset at the core of this initiative," the judges wrote. "The achievements were clearly demonstrated and were backed by strong evidence of outcomes including tangible savings and improvements. The initiative shows that partnership working from the outset, developing solutions through collaboration and focusing on real strategic issues delivers substantial benefits for staff and patients."

The other shortlisted initiatives were:

- The "We, not them and us" project at Birmingham and Solihull Mental Health Trust, which aimed to overcome a historical culture of mistrust between management and unions at the organisation
- The 'Negative to Positive' project at the Christie NHS Trust, which aimed to reduce bullying and harassment complaints through greater use of mediation and staff listening events.

For further information on the HPMA partnership working awards and the three shortlisted initiatives, visit: bit.ly/hcm42-hpma

Pay

Overtime counts towards holiday pay, court rules

Paramedics, nurses and other shift workers employed by the NHS could receive a boost to their pay following a court ruling that overtime payments must be taken into account in calculating holiday pay.

On 10 June, the Court of Appeal ruled in favour of 13 UNISON members working for the East of England Ambulance Service (EEAS) who had argued that their holiday pay should reflect the hours they actually worked rather than solely their contracted hours. The ruling, which upholds an April 2018 decision by the Employment Appeals Tribunal, affects only staff who regularly work paid overtime, so is unlikely to apply to most NHS managers.

The court said clause 13.9 of the Agenda for Change pay agreement – which states that holiday pay should be based on what an individual would have received if they had been at work – should be honoured, and dismissed the trust's claim that work beyond the end of a shift was "voluntary" and should not count towards calculating holiday pay.

It was not known at the time of going to press whether the EEAS planned to appeal against the ruling.

Congratulating UNISON's legal team on "another huge success", general secretary Dave Prentis said: "Before today's judgment NHS workers who did regular overtime or often worked well beyond their shifts saw a drop in their pay whenever they took a well-deserved break. This is a victory for all those health service workers who regularly go the extra mile to make sure we receive the best care possible at all times of the day and night."

Devolution

Managers could be "agents of devolution", says MiP

Devolution of health and social care will not succeed unless managers are given a major role and recognised as experts in the systems they manage, MiP has argued in a new essay collection.

The essay, written by MiP chief executive Jon Restell and communications and officer Mercedes Broadbent, forms part of the collection *Is devolution the future of health and social care*, published in July with a foreword by Greater Manchester Mayor Andy Burnham *(pictured above left)*.

MiP's essay argues that health and social care managers work at "the coalface of health devolution" and that, if properly supported, could become "the agents of health devolution, creating positive changes in the lives of millions of people". MiP members are fully aware of the pitfalls and advantages of the current framework, MIP argues, and have a good overview of workforce plans, which are an integral aspect of devolution and important for the long-term success of any system.

MiP argues that health and care devolution will not succeed unless managers are fully engaged. They need to be treated not merely as part of the system but as "experts on their systems, who want nothing more than to see their systems excel", the essay argues.

The essay collection was launched in the Houses of Parliament on 2 July, with a keynote address by Lord Peter Smith, chair of the Greater Manchester Health and Social Care Partnership *(pictured above right)*.

In a speech, Smith argued that the Long Term Plan for the NHS focused too much on healthcare services and should also have addressed the social and economic factors that determine health outcomes. He emphasised the need to find a solution to the crisis in social care in the UK, warning that without one lack of access to social care would cause "the NHS to grind to a halt."

You can download and read the collection *Is devolution the future of health and social care*, including MiP's essay, on the MiP website at: bit.ly/hcm42-essay.

Workforce

People Plan promises "new offer" for NHS staff

The government is to set out a "new offer" to NHS staff later this year as part of its long-term plans to tackle staff shortages and ensure the future supply of skilled workers needed to deliver the NHS Long Term Plan.

Although the interim NHS People Plan, published on 3 June, includes some proposals to tackle immediate staff shortages, key components of workforce strategy – including overseas recruitment, CPD training and the professional regulation of managers – have been delayed until the final five-year plan is published after the government's spending review this autumn.

The proposals outlined in June included:

- More workforce planning to be devolved to local Integrated Care Systems
- All NHS organisations to set out their own plans to make the NHS a better place to work
- A new compact between national bodies and senior leaders along with 360-degree feedback on regional and national teams by local organisations.
- An increased emphasis on leadership and workplace culture in the regulation of local organisations by NHSE/I and the Care Quality Commission
- New targets to increase the nursing workforce by 40,000 within five years and cut nursing vacancy rates to 5% by 2028
- An independent review of HR policies in the NHS later this year
- 'Passports' to allow NHS staff to move between employers without having to repeat training
- A new offer to NHS staff to be developed over summer 2019, including possible changes to the NHS Constitution

MiP welcomed the interim People Plan and the willingness of the the NHS leadership to engage with trade unions in drawing up detailed proposals later this year.

"We'll be talking about the importance of line managers and middle managers in supporting staff as part of that engagement, and we'll also work with the system on the devolution of powers and a new compact for senior leaders," said MiP chief executive Jon Restell. "But we need to be realistic. Government needs to find a lot more money if we are going to be able to recruit and train the new staff that services need. So the spending review needs to find that money later in the year."

Read the interim NHS People Plan, including the plans for different workforce sectors, at: longtermplan.nhs.uk/interim-nhs-people-plan/.

Professional regulation

Harding promises to end "trial by *HSJ*" for managers

PA ARCHIVE/PA IMAGES

The NHS needs a "fair and just" process to deal with failures at senior management level and an end to the current "trial by *HSJ* process", according to NHS Improvement chair Baroness Dido Harding.

Speaking at the NHS Confederation annual conference on 20 June, Harding also called for a "proper debate across the NHS" on the issues raised by the Kark review, which earlier this year proposed an extension of the fit and proper person test and the introduction of professional competencies for senior managers.

"We need to build a just and fair culture – but that's not the same as saying there are no consequences ever for senior managers, or that we should never move senior managers on from one role to another," she told delegates. "What I do think we need to have is a much more of transparent and overtly fair way of doing so."

> "When it is the right time for a senior leader to move on from an NHS organisation? The NHS needs to make sure that judgement is made fairly and that we support them to learn and then to move on to whatever the next step is in their careers."

Harding promised to "build a consensus" on how failures in leadership should be tackled and "when it is the right time for a senior leader to move on from an NHS organisation". But the NHS needed "to make sure that judgement is made fairly and that we support them to learn and then to move on to whatever the next step is in their careers," she said.

She added: "We have to be brave enough to have those discussions, rather than just immediately assume that this is another stick to beat senior folk – it isn't, it's an attempt to find a just and fair approach to managing."

MiP chief executive Jon Restell welcomed Harding's remarks and her previous calls for a new "compact" for NHS managers. But writing in this issue of *Healthcare Manager* (*see page 3*) he warns that it's still "too easy to bash managers" when things go wrong in the NHS. "These positive intentions tend to evaporate when the pressure is on and the finger of blame needs pointing away from oneself," he writes.

Analysis

A global take on the workforce crisis

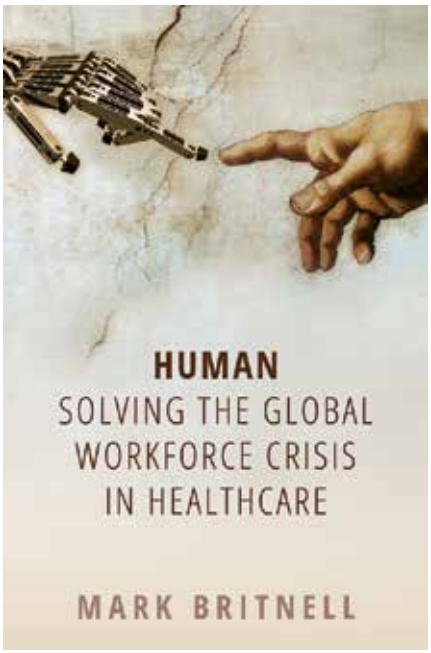
A new book by global healthcare expert Mark Britnell, proposing radical solutions to the NHS workforce crisis, is attracting attention from NHS leaders and some politicians. **Mercedes Broadbent** reports.

Policymakers and healthcare leaders need to bring a global perspective to tackling the NHS workforce crisis and reframe the debate to focus on productivity, health, and national wealth creation. This is the central message of Mark Britnell's new book, *Human: solving the global workforce crisis in healthcare*.

In March, Britnell, head of global health practice at KPMG and a former NHS chief executive, discussed his proposals for tackling the NHS's workforce shortages with shadow health secretary Jon Ashworth at a meeting organised by the centre-left think tank, the Institute of Public Policy Research.

Britnell said he was partly motivated to write *Human* by his experience of surviving prostate cancer, which he believes made him more optimistic and taught him much about the changes to global health systems needed to improve health for everyone. One aspect of his argument that will be music to the ears of NHS managers is that governments must make health systems excellent places to work that prioritise keeping staff happy.

With over 100,000 vacancies across the NHS, everyone working in healthcare knows that urgent action is needed to solve the workforce crisis, but Britnell suggests novel solutions by looking at both the problem and the solution from a global perspective. Citing important health experiments in Israel, Australia and the Netherlands, it's particularly vital, he suggests, that the NHS learns from best practice around the world.



The NHS makes a major contribution to productivity in the UK, Britnell argues, and acts as a wealth creator by putting money back into the economy through its spending on equipment, services and staff pay. By framing the NHS debate in this way, he says, governments can be encouraged to become more entrepreneurial in their approach to health spending and to stimulate the health labour market through measures such as relaxing limits on the number of workers being trained for health and care professions.

> "Britnell argues that it's not fair for wealthier countries to consistently recruit the best healthcare staff from poorer countries. Eventually this will lead to severe deficiencies in those countries, which deserve to have excellent health systems too."

Britnell argues for health technology to be used to complement the workforce, rather than to challenge it, and for patients to be given active ownership of their own care and more control over managing long-term conditions. Britnell's approach also involves integrating the wider community into healthcare services on a much larger scale, including providing significantly more support for families and carers, who

already provide most care in society.

While tech can also be used to improve workplaces, Britnell believes that workloads, pay, flexible working and getting the culture right are just as important – arguments that MiP has been making for some time. Overhauling our approaches to healthcare leadership and management development, and finding better methods of coaching individuals and teams to maximise both motivation and performance, will also increase the capacity and happiness of staff, especially managers, Britnell suggests.

In addition, *Human* makes a moral argument: that it's not fair for wealthier countries to consistently recruit the best healthcare staff from poorer countries in order to keep their health systems operational. Eventually, Britnell argues, this will lead to severe deficiencies in those countries, which deserve to have excellent health systems too. A similar pattern can be seen at national level, he says, with more powerful organisations ensuring their supply of staff to the detriment of others. Yet even the richest and most powerful countries and organisations don't have enough staff. It's clear, Britnell writes, that the global healthcare system cannot sustain current models of workforce planning indefinitely.

At the IPPR, Britnell told his audience that the challenges facing health systems are not unsolvable, but have very real solutions which could radically transform global health within ten years. He argued that it's entirely possible to increase capacity in healthcare by a staggering 20% over the next decade, but only if those in power begin looking at workforce issues as a problem that will be solved fundamentally by human collaboration, rather than by competition for resources. Solving this problem, he argued, will require co-operation from healthcare leaders, politicians, communities, and individuals – as well as between countries. If such a coalition could be built around Britnell's agenda, the NHS could soon feel the benefits. ■

***Human: solving the global workforce crisis in healthcare,* published by Oxford University Press, is available now.**

Comment: **Derek Mowbray**

Why the NHS needs a new kind of leader

Jon Restell's column in the spring edition of *Healthcare Manager* (HCM41) alerts us to the focus placed on leadership in the government's Workforce Plan.

The main challenge, I believe, is the continued ambiguity about what leaders are supposed to do. My mantra is that processes need managers and management; people need leaders and leadership. People frequently become managers having done something else completely different – often something that has a large technical component. They translate this experience into being project managers, measuring everything that goes on, and forming judgements based on these measures. This isn't what is needed.

Instead, we need people who understand that the principal skill of leaders is conversation and the ability to persuade. Too often I come across leaders without this skill, and who revert to using their authority and power to influence the way things happen. The result is a workforce that under-performs because of extraordinary high levels of 'psychopresenteeism' – people being at work in body but not in mind – which costs the NHS huge sums of money. The recent staff survey confirms the trend of several years, showing that over 60% of the NHS workforce comes to work unable to perform their duties over a three month period. The number of suicides amongst junior doctors is alarming. How any organisation tolerates this is bewildering.

The task of leaders is to create and sustain a psychologically healthy organisation in order to guarantee a successful business. Unless the workforce feel they own their organisation

> "The task of leaders is to create and sustain a psychologically healthy organisation in order to guarantee a successful business."

and are able to contribute openly to its future success without feeling fear, the organisation will not attain its full potential. The Wellbeing and Performance Agenda, which I advocate, places leaders and leadership at its centre. Leaders need to be bold and focus on the behaviours that persuade and reduce the risk of stress, as well as delivering psychologically healthy organisations.

Adaptive leadership, a style of leadership based on the principle of sharing responsibility for the future success of the organisation amongst the entire workforce, requires a psychologically safe environment. This approach rests on the simple premise that the combined intelligence of the workforce is far greater that that of its leaders; therefore, its leaders need to gather that intelligence and apply it to ensure tomorrow is better than today.

Given that the European Commission is investing heavily in work to create healthy organisations, the NHS could become a model for how this is done. From what I observe so far, it continues down the wrong path. Hopefully, Jon will be able to change this. ■

Derek Mowbray is a chartered psychologist, director of the Management Advisory Service and a former NHS manager. Find out more about the Wellbeing and Performance Agenda at: mas.org.uk/wellbeing-performance-agenda

MiP held its first North Summit on 12 June in Leeds, bringing together members and stakeholders for a focused discussion with NHS leaders in the north of England. **Mercedes Broadbent** reports.

Northern exposure

"The care we deliver for our patients is only as good as the teamwork we have," said MiP member Julian Hartley, chief executive of Leeds Teaching Hospitals NHS Trust. Setting out his vision for the future of the NHS, Hartley – who led the development of the NHS People Plan with NHS Improvement chair Dido Harding – emphasised that NHS staff were at the centre of the new challenges and opportunities facing the NHS.

In his keynote speech to MiP's Nprth Summit, Hartley thanked Jon Restell, chief executive of MiP, for his advice and support during the development of the interim People Plan. Involving managers in improving workforce conditions was vitally important, he said, because "only the people doing the work can improve the work". He suggested that workforce improvement would take time – probably 15 years – and that after just three to four years, the NHS is in "only in the foothills" of what needs to be done.

Hartley identified five priorities for the NHS People Plan: improving the experience of all staff, especially those from BAME backgrounds; providing better support for leaders and making the NHS the best place to work in the UK; managing the crisis in nurse staffing; using digital technology to improve the NHS as a workplace; and 'improving everything the NHS does'. Workplace planning can no longer be done in a silo or on a purely national level, he warned, suggesting that devolution could help boost local workforce planning.

ALL PHOTOS: LINDSEY PARNABY

Julian Hartley, Peter Homa, Sophia Christie and Jon Restell at the MiPNorthern Summit in Leeds.

Hartley's speech was followed by a panel discussion on reconfiguring local services in the NHS, chaired by Jon Restell, and featuring Hartley, Sophia Christie, former head of the Devon STP, and Peter Homa, chair of the NHS Leadership Academy.

Homa said it was important to concentrate on supporting people at all stages of their career, including times when they excel as well as when they fail. "We should be concerned with the entire arc of a person's working life, other than just the situation where they struggle," he added.

Christie focused on how the constant shift between local and national approaches to reform "makes genuine change and improvement very difficult", and emphasised the need to identify what should be genuinely local. She defined a 'local community' as around 20,000 people, and argued that the natural way to integrate care into a community of that size is to interface with local authorities – something on which the NHS has plenty of room to improve (see interview on p12).

She warned that integrating health and care would not be easy, because "all of the things which keep us well" – social care provision, parks and libraries, and other local council services – "have been decimated in order to protect our response to acute conditions".

The panel was followed by networking discussions on a variety of topics: organisational development; NHS pensions

"Only the people doing the work can improve the work. The NHS is in only in the foothills of what needs to be done."

JULIAN HARTLEY

and senior managers; the Workforce Disability Equality Employment Programme; diversity and equality in the workplace; and men as allies for women in leadership. Each networking discussion table was asked to produce three concrete suggestions for MiP members to take back to their organisations to work on (see panel below).

The North Summit is part of MiP's commitment to expand its programme of events outside London, which includes an event for members in Manchester in October and MiP's annual Summit, which takes place in Birmingham on 7 November. ■

NORTHERN HIGHLIGHTS

Each networking table was asked to produce three concrete ideas to take back to their workplaces. Here's what they came up with.

Organisational development group

Be clear on the direction of travel for organisational change

Always respond to consultations

Remember your rights – particularly that you have the right to be consulted about all changes affecting your job

Diversity and equality group

It's important both to remove discriminatory barriers and help people to overcome those that remain

Equality reps can have an impact on recruitment panels

Identify why more BAME staff face disciplinary action and take steps to remedy the reasons

Men as allies group

Men need to educate themselves to understand gender socialisation

Tackle 'micro-aggressions' and stereotyping

Learn how to support female colleagues

Workforce Disability Equality Employment Programme group

Organisations can proactively support and train managers to understand how to provide reasonable adjustments

Increase monitoring of discrimination

MiP to raise challenging disability discrimination at the National Social Partnership Forum

The social care system is in "absolute crisis", says Julie Ogley, the head of the body representing England's adult social care chiefs. Given chronic staff shortages, underfunding and a lack of national leadership, health and care managers must work together to map a way forward, she tells **Matt Ross**.

Worlds apart?

"We're so caught up with Brexit that it seems impossible nationally to think about anything else," says Julie Ogley. "Yet we've got an absolute crisis emerging in social care. If I can't pay sufficient fee levels to keep an active domiciliary care market or care homes in operation, people will go into hospital and won't be able to leave.

"Our NHS colleagues understand that locally – and I think they probably do nationally," she adds. "But somehow we haven't managed to get that message across to our national politicians."

The director of social care, health and housing at Central Bedfordshire Council, Ogley has just begun a one-year term as President of the Association of Directors of Adult Social Services (ADASS), representing social care chiefs across England. And her message is clear: the perfect storm battering social care is powerful enough to drag down both health and care provision.

The media debate on social care tends to focus on growing demand among older people but, as Ogley points out, many elderly people can fund their own care. And rising life expectancy also increases the pressure on services for people of working age, far fewer of whom have assets: people with Down's Syndrome, she explains, have an increased risk of contracting Alzheimer's in their 40s, "and those are very complex and costly care packages".

"Language like the 'dementia tax' and the 'death tax' isn't helpful when we've got a social care system that's on its knees. People take up positions, rather than having a dialogue."

As a result, a growing proportion of social care funds are spent on people with mental and physical disabilities. "Ten years ago, the majority of my funding was around older people; now it's equal with funding for services for people of working age," she says. "We're focusing on those with the most complex needs, and serving fewer people."

Meanwhile, wage costs are rising – yet councils and care providers still struggle to recruit and retain workers. Turnover among care staff averages 30% a year, and the staffing problem is "absolutely chronic", says Ogley. "We can't recruit into our reablement service; we can't recruit social workers."

"People's expectations and the money in the system don't match," she concludes. And while rising NHS contributions to social care have helped to keep services afloat, the government's tendency to fill the remaining gaps via last-minute Budget allocations leaves Ogley and her colleagues unable to plan ahead. "I can't invest those funds in anything that's continuing – to increase fee levels in care homes, for example – because I can't leave the council having to find that additional money the following year," she says.

There's an urgent need, Ogley believes, for a national conversation about social care funding – but that demands a more mature, cross-party dialogue between politicians. "Language like the 'dementia tax' and the 'death tax' isn't helpful when we've got a social care system that's on its knees", she says. "People take up positions, rather than having a dialogue about what we expect the state to provide and what families should pay for."

In social care, she notes, people who have the money to fund their own care are expected to spend it. "There's a part of me that wonders why we don't have a tiered approach in the NHS, as we do in council care."

While Ogley well understands the financial pressures on NHS bodies, she points out that the Five Year Forward View and the £20bn funding boost announced last year at least give health services some ability to plan ahead. Social care managers must, however, operate in a national policy vacuum: the

PAUL HEARTFIELD

long-promised green paper has now been postponed five times, while social care has been stripped out of the workforce plan. "But you need to look at the health and social care workforce together," she says. "If we're not careful, the NHS could see the answer to its problems as taking the care workforce. It's already a more attractive employer because it pays more. I'm really worried that hospitals might take the nurses out of nursing homes.

"It's frustrating that we're not seeing the national leadership around social care in the same way that we see it around the NHS," she comments. Government's failure to tackle the barriers to collaborative working across health and social care is, she believes, hampering frontline professionals' ability to rebuild services for the modern world.

In Central Bedfordshire, Ogley's team is doing what it can. The council is planning five integrated health and care hubs, and has allocated capital investment for the first. Integrated into – and part funded by – a new housing development, the hub will house five GP practices, an NHS diagnostics team, a pharmacy, and community, mental health, social care and housing staff.

But such collaborative projects struggle in a complex regulatory and organisational landscape, where administrative boundaries rarely align. In Ogley's area, a single Clinical Commissioning Group covers two councils with very different political complexions, whilst her population is served by seven hospital trusts. "The footprints in the NHS are really quite interesting, aren't they?" she says innocently.

With NHS and social care bodies operating to very different performance metrics, incentive structures too are often misaligned. Ogley's council is building a 168-unit 'Extra Care' housing development with an on-site, 24-hour care team, which she says will generate savings for the NHS via reduced rates of domestic accidents, fewer GP call-outs, and the capacity to take test samples. Council-backed projects such as 'Village Care' and 'Good Neighbour' also help relieve the burden on NHS services. But NHS financial frameworks task acute trusts with delivering treatments rather than averting them, whilst the benefits of such preventive work are hard to quantify: "When I talk to the chief executives in hospitals, they glaze over a bit, because that's not the performance information they're used to seeing," says Ogley.

To help overcome such obstacles, Central Bedfordshire has been working with primary, mental and community health providers to improve use of resources across the system – building care around patient journeys rather than individual services. "And I was staggered, because people didn't know one another," she comments. "How can we all be working in a local area, and not know the district nurses or the mental health team?"

This work, she adds, was nearly derailed when the Department for Health and Social Care threw its weight behind the Primary Care Home and Primary Care

Network initiatives. "People wanted to stop what we were doing and start something else," she recalls. "Sometimes, people feel that they've got to follow national initiatives to the letter without thinking: 'Actually, we're already doing this.'"

But Ogley does understand that the government's tendency to constantly push initiatives down through the NHS can make life difficult for her health service colleagues. "Councils don't quite appreciate the level of direction that comes through the NHS," she says.

Equally, NHS staff often seem mystified by councils' decision-making processes, she adds. "In public meetings with elected members, officers do not speak unless asked," she explains. "We have lots of informal meetings with politicians where we can speak freely, but in those set pieces we have to remember our place. Sometimes people think I'm crazy when I say this is how it is."

Yet Ogley argues that council decision-making often generates longer-term perspectives on the future of service delivery than those taken by NHS bodies, which must pursue the medium-term strategies passed down from Whitehall. "The council has a generation-long time horizon, whereas the health system works on a five-year plan," she comments. "So when we're going for approvals within the NHS, people are still thinking about the current model [of service delivery] rather than what it will be like in five, ten or 15 years."

For example, she says, rules designed to ensure that everyone has a local GP mitigate against centralising primary care in Central Bedfordshire's integrated health and care hubs. Yet emerging technologies and working practices would permit hubs to provide better services for patients – increasing the use of remote consultations, for example, and reducing the need for patient referrals.

New technologies are transforming the provision of social care, she adds, allowing more people them to live at home without a care worker on site. But, she argues, two changes are required in the way these new technologies are being developed.

"New systems focus on cutting existing costs rather than supporting entirely new models. Why can I book a weekend break from my sofa, but not respite care for my mum?"

First, they should make the leap from medical to consumer technology – becoming more accessible and intuitive. "I don't think that the specialist technology people around social care are really linking with the big providers that produce iPhones and what have you," she says. "There's a bit of distance there, and we really ought to try and bring them together."

Second, she says that many new systems focus on cutting the cost of existing service delivery models, rather than supporting entirely new models. "I can book a weekend break from my sofa, but not respite care for my mum," she comments. "We've just tried to procure a new customer database and financial management system with an e-market and a self-service portal, and we've not been able to find that. We should be! If you can do your shopping online, why can't you look at what support is available, what it might cost, and who you might choose to provide it?"

Likewise, Ogley says, people developing new ways of collaborating across health and social care must keep their eyes on two risks. First, integrating health and social care delivery must not lead to the separation of social care activities from other council operations: the goals of social care professionals are best realised in partnership with those managing housing, libraries, leisure centres and other services, she argues. In Central Bedfordshire, she points out, her control of both housing and social care much improves services for the borough's ageing population – enabling her to develop the Extra Care scheme, for example, and to build apartments that tempt older people out of under-occupied family homes.

Second, she warns that councils must be given a full say in the emerging partnerships with NHS bodies. "We'll find it really hard if we don't include local authorities properly, coming together as equals," she says, pointing out that councils "have different populations and challenges. And decisions made years ago about levels of council tax have an impact. There are some areas in which councils need to keep their autonomy, and council tax is the big one."

The "current model of social care is not fit for the future," says Ogley. And in the absence of national leadership or secure funding, she urges social care directors to seize the initiative and map out a path forward: "We're going to have to stand in that space."

In doing that, she knows that social care chiefs will have to work hand-in-hand with NHS leaders – overcoming the many fractures between their professional worlds, and building services that meet the needs of patients rather than organisations. "We need to bring together a system where we make decisions in the same time frame; where we consider our population as it's going to be, as well as it is now; and where we look at all of a person's needs – whether it's housing, or prevention, or treatments and care," she concludes. "And we need to find a way of doing that together."■

With the English NHS in a hurry to integrate health and social care services and dismantle competitive structures that discourage collaborative working, **Alison Moore** examines the lessons from the well-established partnerships in Scotland and Wales.

Nation to nation

The NHS in England is at last developing a more integrated and collaborative approach to health and social care, through initiatives such as integrated care systems and the Primary Care Home model. But while collaborative working remains the holy grail in much of England, Scotland and Wales have taken advantage of devolution to develop sophisticated approaches to integration that leave their larger neighbour in the shade. For England, its neighbours' advances offer the chance to learn from their experiences and avoid some of the pitfalls.

The first lesson is the need to be realistic about the timescale: both Scotland and Wales took a considerable time to develop their approaches even once the political commitment to integration was there. In contrast to the hurried development of plans in England, Scotland's commitment to integrated services dates back to the 1999 devolution settlement, explains Alex Baylis, assistant director of policy at the King's Fund. Backed by long-term commitment from politicians – first minister Nicola Sturgeon has said she wants her legacy to be the quality of relationships between the people and public sector organisations – Scotland has been able to develop clarity on its values and take the time to design services with the public.

In both Scotland and Wales, the infrastructure behind integration has a legislative basis – in stark contrast to England, where integration initiatives are still tiptoeing around seemingly immovable legal restrictions.

Scotland's health bodies and single-tier councils are more coterminous than their counterparts in England, which may make it easier to draw in housing and leisure services, both of which can have a significant impact on the long-term health of the population. Many English ICS areas and even some CCGs have to deal with several top tier authorities, which may not make integration impossible but certainly adds an extra level of complexity.

Developing relationships

In both Scotland and Wales, the infrastructure behind integration has a legislative basis – in stark contrast to England, where integration initiatives are still tiptoeing around seemingly immovable legal restrictions. While no one thinks legislation is the answer to integration, it does give a framework within which relationships can develop.

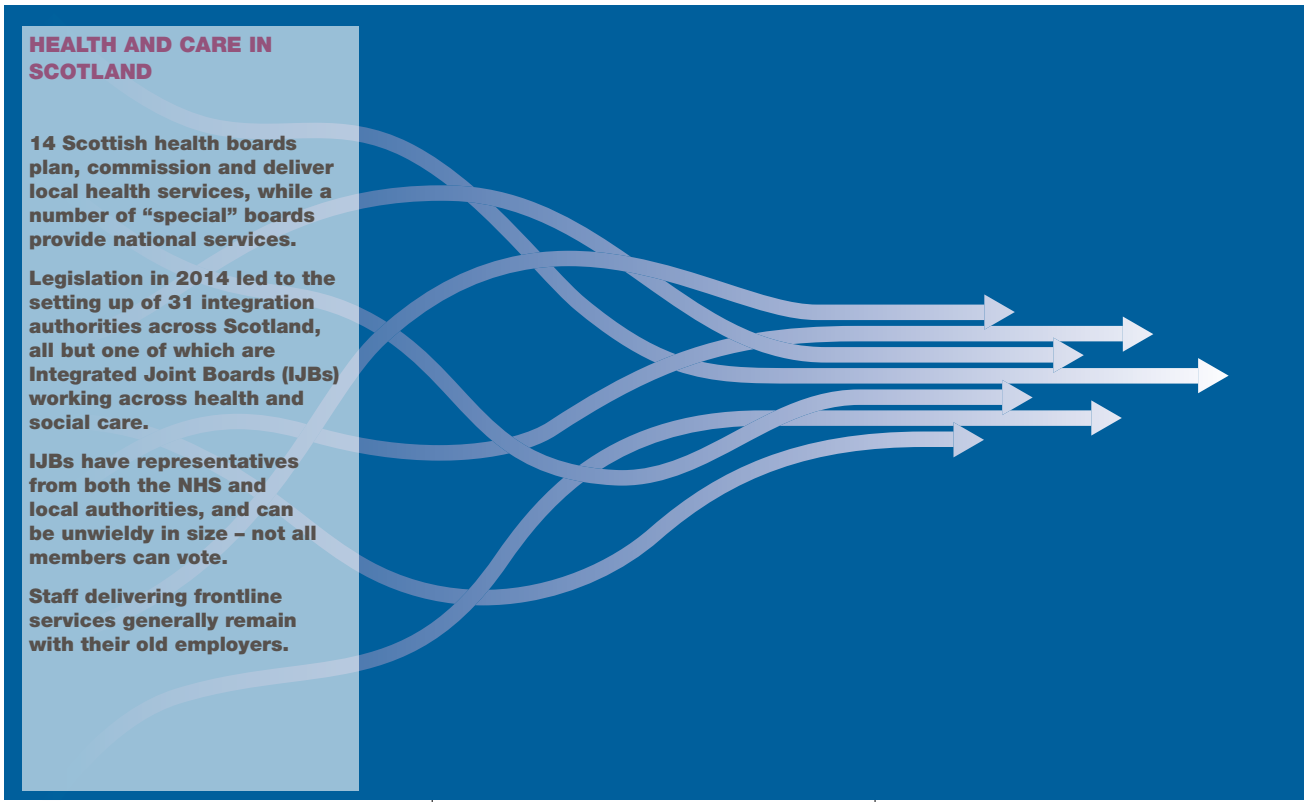
"Trust, shared purposes, shared objectives, and a common understanding" are all important in health and care relationships, says Professor Mark Llewellyn, director of the Welsh Institute for Health and Social Care at the University of South Wales. The relative stability of Welsh NHS structures over the last decade has allowed collaborative relationships to flourish, he explains, while the abolition of the purchaser/provider split in 2009 means Welsh managers are not having to unlearn ingrained competitive behaviours: collaboration is now in the DNA of NHS managers in Wales.

And that collaboration has deepened since the setting up in 2016 of regional partnership boards, which aim to secure partnership working between local authorities and health boards. These often work very closely with charities and community organisations, with some chairs coming from the not-for-profit sector.

Llewellyn sees the regional partnership boards as having a potentially powerful role in deciding spending priorities and, while originally they were primarily concerned with health and social care, some boards have started taking a wider view – for example, by looking at the role of housing in promoting health and social wellbeing.

Opening up structures

MiP chair Sam Crane – who spent many years working in the Welsh NHS – says



the Welsh approach to local integration "is all about collaborative transformation and new ways of working". Key to this at local level are the Neighbourhood Care Networks, which build on the GP clusters seen in England by pulling in a wide range of local services, including district nurses, health visitors, dentists, optometrists and pharmacists, as well as social care services and housing associations. The networks help to plan local services with GPs, look at public health issues like smoking cessation, and have a remit to "sweat" local assets and funding.

It's a highly inclusive model which contrasts to the approach in England, where CCGs and primary care networks remain dominated by GPs and managers from the existing NHS structure. Likewise, bodies which are meant to drive integration in England, such as STPs, have been slow to include lay members – and in many cases have had up-and-down relationships with local councils.

"England still has a long way to go", Crane suggests, in harnessing some of the transformational opportunities at local level – especially those involving organisations outside the existing NHS system – and in enabling networks to work on their own local priorities as well as national themes and targets. "I think England is about five years behind in terms of the structure and collaboration," she says.

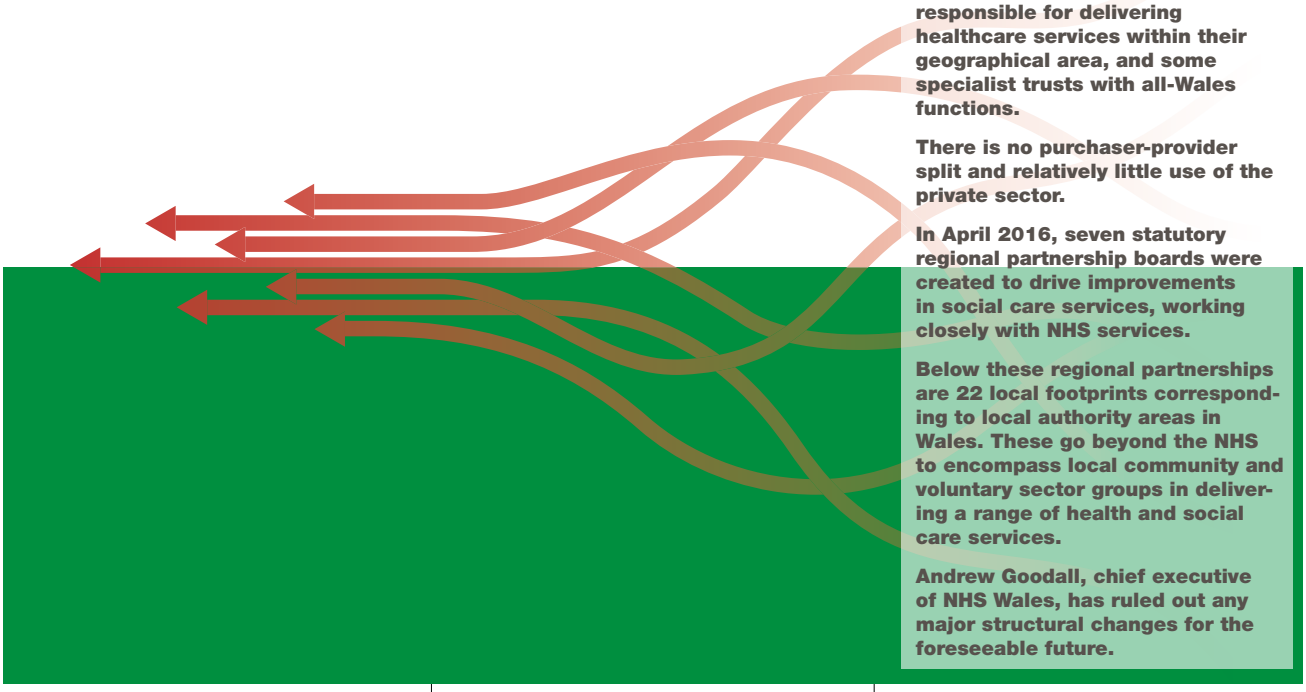
In Scotland, the relatively new joint boards for each area – effectively single commissioners for health and care services – have developed new models of care and taken control of significant budgets, allowing them to shift resources around the system – a freedom often used to move funds towards community-based services.

Positive outcomes

Given the different geographical, public health and political challenges facing each country, it's very difficult to assess the performance of the different models of integration across the UK. But the King's Fund's Alex Baylis certainly sees some positive outcomes in Scotland. "In general, Scotland has improved resilience, leading to fewer admissions, delays in discharge and crises for patients needing urgent care in winter – we found this was pretty much across the board the winter before last when we did our research," he says. "More specifically, we found Glasgow was not only reducing hospital admissions but also reducing commissioned care home places, which appeared to be because their home care was so effective."

But Baylis also points to examples of initiatives in England which are being quickly scaled up – such as the care home vanguard in Fylde, Lancashire – and raises the possibility that the environment south of the border may be more conducive to rapid change. "In general, some Scots look on with a bit of envy – although they should be careful what they wish for – at the way NHS England has created a burning platform and a sense of urgency, leading to more consensus and a faster pace of change," he says.

In Wales, Crane believes the new collaborative structures have improved the way people and NHS organisations work together – and sees parallels with the new structures emerging in Greater



HEALTH AND CARE IN WALES

Wales has had a relatively stable structure for the last decade, with seven local health boards responsible for delivering healthcare services within their geographical area, and some specialist trusts with all-Wales functions.

There is no purchaser-provider split and relatively little use of the private sector.

In April 2016, seven statutory regional partnership boards were created to drive improvements in social care services, working closely with NHS services.

Below these regional partnerships are 22 local footprints corresponding to local authority areas in Wales. These go beyond the NHS to encompass local community and voluntary sector groups in delivering a range of health and social care services.

Andrew Goodall, chief executive of NHS Wales, has ruled out any major structural changes for the foreseeable future.

Manchester. "But in Wales, everyone is part of the same organisation which does makes things easier," she says.

Llewellyn agrees there is evidence that Welsh patients have benefited from more seamless care but warns against simplistically attributing outcome improvements to system change: "These benefits may have happened anyway", he points out.

A key role for managers

Service integration can place an additional burden on managers, who must take on extra responsibilities at the same time as learning new ways of working. In Scotland, the chief officers of Integrated Joint Boards (IJBs) are in a powerful position sitting between health and social services, but have enormous expectations placed on them which they may struggle to fulfil. At least, unlike their counterparts in England – where many STP or ICS leaders still have a "day job" running a trust or CCG – IJB chief officers can focus solely on driving forward integration.

Claire Pullar, MiP's national officer for Scotland, suggests the IJBs have allowed managers to foster a degree of innovative working. "IJBs put people in a place which is protected from health policy and from local authority policy," she says. "People who work in them talk about being open to different ways of working and finding a non-traditional route or solution."

But Unison's head of bargaining for health in Scotland, Willie Duffy, is more sceptical. He argues IJBs have not delivered the closer working practices, better staff engagement and reduced duplication of effort that was promised, and warns that confusion has been created by staff working together while having different terms and conditions and operating under different management structures.

While managers in Scotland and Wales have benefitted from relatively stable structures, that is not the case in England, where the last six years alone have seen the introduction of CCGs, ICSs and STPs, the abolition of Strategic Health Authorities, and big changes to national structures – all at a time when management budgets have been cut. "The thing about England is that people don't ever let the structures bed in – there is constant churn," says Pullar.

On the other hand, managers in Wales may have escaped the uncertainty generated by a major reconfigurations – compulsory redundancies are almost unknown – but they can find it difficult to find time for some of the transformational work they would like to do. In particular, Crane suggests, collaborative working demands very different skills, which managers need more support to develop. "We need leadership at the top to say, this is how we are going to work, this is how we will support you, and these are the skills you need," she says.

This is also a looming issue for the English NHS, where managers and boards are swiftly having to lose the competitive habits of decades to find win-win solutions across their health economies. As integration moves forward, it's just one of the many lessons the English NHS has to learn from its neighbours. ■

Threats of dismissal for an unspecified "substantial reason" are increasingly being used to get rid of NHS managers whose faces don't fit. **Craig Ryan** spoke to two MiP national officers about recent cases and how they defend members from unfair treatment.

The get out clause

We all expect the law to protect us from arbitrary dismissal, but it's increasingly common for senior managers in the NHS to be sacked or forced out for vague or unfair reasons – and with little chance to fight back.

Under the 1996 Employment Rights Act, "some other substantial reason" (SOSR) is one of the five legal grounds for a fair dismissal. It's something of a catch-all, covering dismissals that fall outside the scope of the other four reasons – conduct, capability, redundancy and breaching a statutory restriction. But there's no clear legal definition of what constitutes a "substantial reason", which gives employers wide scope to pressure people into leaving without going through formal disciplinary, capability or redundancy procedures.

If brought before a tribunal, employers must show that their reasons are not "wholly frivolous or insignificant" and that they followed a "fair procedure". But, as there are no set procedures for an SOSR dismissal, this can amount to little more than a discussion or consultation with the employee concerned. In reality, very few SOSR dismissals are tested in the courts.

SOSR "is certainly being threatened a lot more than it used to be in the NHS", says Claire Pullar, the MiP national officer for Scotland and Northern Ireland. "We're seeing a rise in a number of poor employment practices [deployed] in order to show people the door."

> "People will be told if they don't sign a settlement agreement, they're going to be unemployable or get bad references and so on, so it's a form of bullying tactic."

This could be a perverse side-effect of Scotland's 'no redundancies' rule, under which managers can spend years on the redeployment register doing work usually done by staff in lower bands. Pullar explains: "At some point your employer says, 'You've been on the redeployment register for a while now, we're going to dismiss you for some other substantial reason'. And, of course, SOSR comes without a payment, when they would have been entitled to one if they'd been made redundant at the time.

"Employers will argue that you've had your redundancy payment through doing a non-job, but they've actually made it harder for you to move on and get a job elsewhere," she adds.

According to George Shepherd, MiP's national officer for the East of England, by far the most common excuse for an SOSR dismissal in England is that the board or chief executive has "lost confidence" in the manager concerned. But in most cases, he explains, the "no confidence" excuse is just "spin" to cover a clash or personalities or a desire to bring in different people.

Shepherd sees Very Senior Managers (VSMs) and Band 9 staff as being most vulnerable to SOSR, particularly following a change in leadership at their employer. "There might be a new chief executive or chair, and they want their own team on board," he says. "And what we often find then is scapegoating, individuals being blamed for things they don't necessarily have responsibility for.

"I've had cases where the chair has phoned up the chief executive, or invited them to a fancy restaurant, and just said, 'The board has lost confidence in you and it's time for you to go'," he recalls. "In one case, we contacted board members and found that wasn't true. We went to one of the national bodies and were able to get the decision reversed."

Pullar says the "loss of confidence" excuse is less common in Scotland, although managers whose "faces don't fit" – especially following organisational change – can find themselves "in a non-job" on protected pay, and vulnerable to SOSR dismissal further down the line.

SOSR dismissals can be very hard to fight in the courts, especially when many senior managers have a clause in their contract which requires them to maintain the confidence of the board. "If it's really vexatious, or you've had really good appraisals and can prove beyond a shadow of a doubt that you weren't responsible for any identified failings,

these dismissals can be fought against," says Shepherd. "We have had some successes but even in those cases it can prove very difficult."

Pullar described one tribunal case where a member due to retire in 18 months was "very badly treated" by the employer, and dismissed under SOSR with just three months notice. Supported by MiP, he won his case at the Employment Tribunal but received only the legal minimum redundancy payment – less than a third of what he would have been entitled to if he'd been made redundant under Agenda for Change.

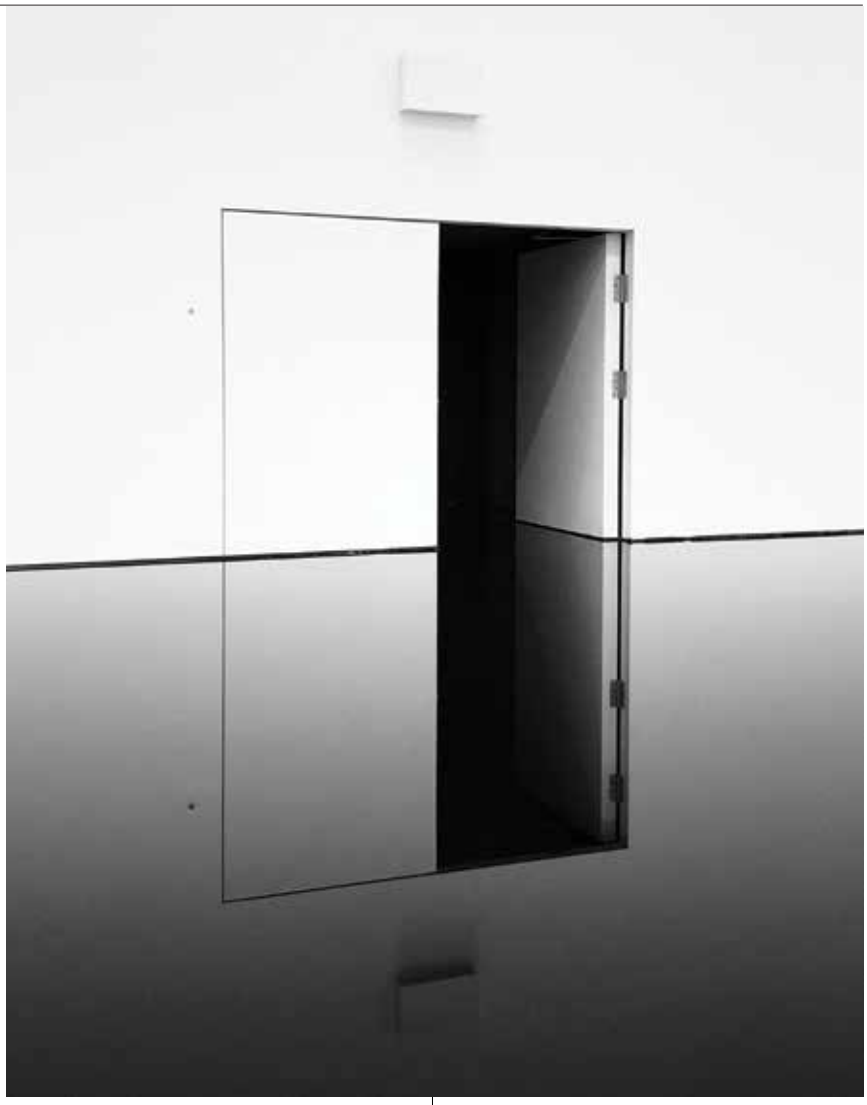
Faced with such legal obstacles, MiP negotiators generally take a pragmatic approach – taking legal advice and using any available leverage to keep the member's job where possible, or negotiating the best way out if not.

"You have to ask members if they really want to stay in an organisation that doesn't want them," explains Shepherd. Most members in this situation "really know the writing is on the wall", he says, and prefer to negotiate a settlement agreement so they can leave at an agreed date and on fair terms, which usually include a financial settlement.

But such agreements do mean forfeiting any right to challenge the dismissal at an employment tribunal, he warns, and the threat of an SOSR dismissal is sometimes used to pressure a manager into signing an agreement to leave. "People will be told if they don't sign, they're going to be unemployable or get bad references and so on, so it's a form of bullying tactic really," Shepherd adds.

He notes that it's increasingly common for members to be offered a 'secondment' – a temporary or interim post at another NHS organisation, often a national body – as part of the settlement agreement. "But I don't like the use of the word 'secondment', because with a secondment you have a right of return to your substantive post, but in these situations they've no intention of doing that," says Shepherd. "In my view, they're a fixed term contract."

The Government's clampdown on public sector exit payments is making it harder to negotiate satisfactory settlement agreements for managers threatened with SOSR. "Employers often claim they can't pay any compensation beyond the contractual period of notice – generally three months," explains Shepherd. "In those situations, I will usually say, 'Well, you don't have to give the notice now, do you? You can give that in another three months'. This gives the member more time – up to six months – to find a new job," he says.



Pullar and Shepherd agree that a negotiated settlement is usually better all round than going to the courts. Pullar cites one recent case, which resulted in a £32,000 settlement for an MiP member, but a legal bill of over £100,000 for the health board. "All they had to show for all that money was a poorer relationship with staff and a lack of trust from the Central Legal Office because they'd sent them to a tribunal where they were clearly in the wrong," she explains.

"I ask employers to think about how they want to spend their money. What will be the impact on all the stakeholders, on recruitment and retention, on how the board members feel?" she adds. "If you really want someone to go, if you're certain that's best for the business, fair enough. But think about the best way to do that without wasting money, energy and reputation." ▪

For an excellent summary of the legal position on SOSR by Lewis Silkin Global HR Lawyers visit: bit.ly/hcm-sosr. If you have been threatened with an SOSR dismissal, contact your MiP national officer immediately.

legal**eye**

Jo Seery explains a new ruling by the Employment Appeal Tribunal, which may extend protection against discrimination to people *perceived* to have a disability.

The Equality Act states that treating someone less favourably than someone else because of a protected characteristic, such as disability, amounts to direct discrimination. However, in the case of Chief Constable of Norfolk v Coffey, the Employment Appeal Tribunal (EAT) held that it is also direct discrimination to treat someone less favourably because they are *perceived* to have a disability.

The Coffey case

When Lisa Coffey applied to become a police constable with the Wiltshire Constabulary, her hearing was found to be below the recommended medical standard. Candidates who did not meet the medical standard were assessed individually for their ability based on the role, functions and activities of an operational constable. Wiltshire arranged a practical functionality test which Coffey passed.

Coffey worked as a constable from 2011 onwards with no adverse effects. When she applied for a transfer to Norfolk in 2013, she disclosed her hearing impairment and enclosed the functionality test report. The Norfolk force's medical advisor recommended an "at-work" assessment of her effectiveness in an operational environment. Norfolk rejected that recommendation and asked for clarification from another medical advisor, who confirmed that Coffey's hearing had not deteriorated since 2011 and she would pass a practical test.

Despite these opinions, Norfolk refused Coffey's application on the basis that her hearing was below the medical standard. Coffey brought a claim of direct disability discrimination on the basis that she had been treated less favourably because she was perceived to have a disability.

The Equality Act

Disability is one of the protected characteristics specified by the Equality Act 2010. The Act defines a disability as a physical or mental impairment which has, or in the case of a progressive condition is likely to have, a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities.

Section 13 of the Act provides that direct discrimination occurs when a person A treats another person B less favourably than A treats or would treat others because of a protected characteristic.

Tribunal decision

In its statement to the tribunal, the force claimed that as a "non-disabled permanently restricted officer", Coffey's appointment might put financial constraints on the pool of officers who were operationally deployable. It claimed that to recruit her would have knowingly risked increasing the pool of restricted officers, an outcome that "was not consistent with service delivery".

The tribunal held that the acting chief inspector who took the decision perceived that Coffey had a disability which would require adjustments in the future despite the position she held at Wiltshire. As such, it held that Norfolk Constabulary had directly discriminated against Coffey and recommended that her rejection be expunged from the employer's record.

The EAT agreed with the decision. In upholding Coffey's claim, the EAT clarified that the appropriate comparator was a person who was not perceived to have a disability, i.e. someone who did not have a condition that was likely to deteriorate and who had the same abilities as the claimant.

This is the first appeal decision to find that a worker has been discriminated against because they are perceived to have a disability. The EAT accepted that it will not always be easy to determine whether a worker is perceived to be disabled. The key is whether the worker is perceived to have the features of a disability. In this case, the EAT took into account the fact that a person is defined as disabled if they have a progressive condition – namely an impairment which has an effect on their ability to carry out day-to-day activities, which, while not substantial now, is likely to result in a substantial adverse effect in the future.

The EAT rejected an argument that it would be difficult to apply a performance standard to a claim of direct discrimination on the basis of the worker's perceived disability. Although the Equality Act 2010 states that a claim for direct discrimination does not apply where a disabled person lacks a relevant ability, that does not protect an employer who wrongly perceives that a disabled person lacks an ability which they actually have.

The employer appealed to the Court of Appeal, which heard the case on 20 February 2019. Judgment is still awaited at the time of going to press. ▪

Jo Seery is an employment law specialist with Thompsons Solicitors.

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

Men can play a big part in supporting women leaders and the push for a more gender-balanced NHS. **Samantha Allen**, chair of the Health & Care Women Leaders Network, explains how.

How men can support women leaders

PAUL THOMAS

1. MEN CAN MAKE A DIFFERENCE

Men play a crucial role in ensuring women are represented and supported in leadership positions. Data shows that where men are actively involved in equality issues, 96% of their organisations report progress, compared to only 30% where men are not actively involved.

2. SISTERS SHOULDN'T DO IT ALL FOR THEMSELVES

We need men, as leaders and colleagues, to understand the workplace barriers women face and be prepared to ask women how they can support them. We all have a role in ensuring the NHS working environment supports everyone to achieve their potential and that our leadership represents the communities we serve.

3. THE SYSTEM NEEDS FIXING – NOT THE WOMEN

It's easy to characterise the drive for equality as political correctness, or to see the moral case but not the urgency. Greater awareness of the business benefits of a diverse leadership team can help leaders to make the case for diversity in their organisations. And we need a greater sense of urgency because, in areas such as the gender pay gap, we're actually slipping back.

4. ENCOURAGE DIFFERENT MODELS OF WORKING

Women, who historically have often shouldered the burden of caring responsibilities, may not want to work in the way previous leaders have. Contributors to our *Men as Allies* report, published earlier this year, picked out accepting and supporting different models of work as something that would benefit both women and the growing number of men with caring responsibilities. But we all need to work hard to make this happen, as senior roles are often not constructed to enable flexible working.

5. CHALLENGE ASSUMPTIONS

Women often have to battle assumptions about their leadership style and their ability both to do and commit to senior jobs. Male leaders need to be aware of the assumptions made about women in recruitment and promotion processes or the everyday working environment – and challenge their own assumptions too. Supported conversations that actively explore how such assumptions can be avoided could yield more women candidates for senior roles.

6. SUPPORT PERSONAL DEVELOPMENT

Coaching or mentoring can make a real difference for women who want to progress to new roles or challenges. As one interviewee for our report suggested, women sometimes have the insight to make changes as a leader but might need support to grow the courage or confidence to take risks and make changes happen.

7. OFFER CHALLENGE

Refusing to accept all-male shortlists for senior jobs is one way to make a clear commitment to gender balance – but it's important to avoid tokenism with this approach. Talking about diversity, challenging a 'macho' culture and role-modelling behaviours are other important ways men can help.

8. SUPPORT FROM LEADERS

Support for the aim of achieving gender balance on NHS boards by 2020 needs to be backed up by pressure from above. Holding the chair and chief executive to account for progress is one way forward. Organisations can also publish data about gender balance and progression, as they have done with the Workforce Race Equality Standard. More data will help us to identify the actions we need to take to achieve gender parity in the future.

9. BEING AN ALLY IS MORE THAN JUST SAYING YOU'RE ONE

Not all men will necessarily embrace or even understand the drive for gender balance. Some will feel threatened by it. One contributor to *Men as Allies* said: "Men sometimes held themselves back from getting involved in debates around gender equality because they fear being viewed as patronising or 'getting it wrong.'" Dealing with the fear of losing power, being supplanted or seen as patronising may be difficult, but doing so constructively will boost the chance of meaningful change.

10. GET COMFORTABLE FEELING UNCOMFORTABLE

Challenging norms, assumptions and ingrained patterns of behaviour is uncomfortable. Giving space and time to other people in a competitive environment is an act of generosity. Speaking out and following your words with actions is brave. Women leaders do this on a daily basis. They already have brilliant male allies who are challenging, generous and brave, and are willing to get comfortable with being uncomfortable – but we want to see this as the norm. If you are not uncomfortable sometimes, then you won't be making progress. ■

Samantha Allen is chief executive of the Sussex Partnership NHS Foundation Trust. The report *Men as Allies*, compiled by the Health & Care Women Leaders Network, is available from bit.ly/hcm4201. For further information email women.leaders@nhsemployers.org or follow the network on Twitter: @hcwomenleaders

Unfair redundancy cap discriminates against managers

A survey of MiP members found widespread fear and confusion about Treasury plans to cap and claw back exit payments for NHS staff. That's why MiP is asking the government to think again, explains **Mercedes Broadbent.**

MiP members "feel targeted, undervalued, and discriminated against" by the government's proposals for a cap of £95,000 on public sector exit payments, MiP has warned in its response to the Treasury's consultation exercise. The cap will affect most staff working in the public sector – including all NHS organisations – who receive an exit, redundancy or early retirement settlement.

As part of its response, MiP surveyed its members in order to get a clear picture of their views, and used the results to ask the government to consider some important aspects which the union believes the consultation has ignored. The law introducing the cap has already passed, but consultations on the draft regulations for implementing the cap in practice offer MiP an opportunity to try to mitigate some of the worst aspects of the proposals.

MiP has criticised the omission from the consultation process of the government's separate proposals for the recovery of exit payments from staff who return to work in the public sector within 12 months. These so-called 'clawback' proposals have not yet been legislated for, and fall outside of the scope of the Treasury's consultation. But MiP believes the exit payment cap legislation cannot be adequately considered without also taking the clawback proposals into account.

When asked if they were already aware of the proposed cap, 64% of MiP members said no. When asked if they were concerned about the impact of the cap on them as an NHS employee, 81% said yes, and 63% said they were concerned about the impact on staff they manage. These findings unequivocally demonstrate that MiP members feel that there could be a significant negative impact from the cap not only upon them, but upon the staff they manage – with the clear implication that the ripple effects of the cap could affect virtually all NHS staff.

When asked about the impact on them personally, 74% said the cap could affect their plans to retire, and 70% said the proposals could affect their career plans within the NHS.

84% of MiP members were also previously unaware of government proposals that some or all of the exit payment could be reclaimed if they found work elsewhere in public service within 12 months. 80% said the possibility of clawback may affect whether or not they remain working within the NHS.

These results show both fear and confusion around this issue, as well as a marked lack of communication from government with the staff these proposals are likely to affect. In the midst of a workforce crisis, capping and clawing back of exit payments could lead to senior staff turning down promotions, bringing forward their retirement, or even leaving the NHS altogether.

Some public servants – including the fire service and judiciary – may be excluded from the cap: 80% of MiP members said that this would be unfair. During the consultation period, MiP plans to raise the real possibility that the government's proposal may be discriminatory, and to ask if an equality impact assessment has been carried out by the Treasury into the potential outcomes of the cap – if not, we would request that an assessment be carried out immediately.

MiP members were also very uncomfortable with the proposal that ministers would decide on any exceptions to the cap. 93% of respondents did not feel comfortable with ministers making such decisions, the strongest response in the survey. This discomfort is understandable – NHS managers are all too used to being made scapegoats by politicians, and the cap would give senior politicians a lever with which to exert control over MiP members – which would necessarily lead to their jobs being politicised.

"I believe that the existence of this cap represents a failure of public policy and is, in practice, an attack on public servants during a time of increased pressures and media attention," said MiP chief executive Jon Restell. "This cap is likely to make our members feel targeted, undervalued, and discriminated against by these proposals. The real solution to any perceived problem with the number and size of redundancy payments is to reduce the number of redundancies in the first place and retain valuable managerial and other skills in the public sector."

He added: "The survey results are clear that these proposals will be instrumental for some of our members when taking the decision whether or not to remain within the NHS workforce at a time of recruitment crisis." ▪

Mercedes Broadbent is MiP's communications and policy officer. For more on the exit payments cap, visit the MiP website at miphealth.org.uk.

WHY THE CAP DOESN'T FIT

A selection of responses from MiP's survey of members on the government proposals for a public sector exit payment cap.

The cap will put people off public service jobs

"There have been several changes which have resulted in worse terms for public sector employees. A further deterioration is not warranted and is likely to prevent younger colleagues and future employees from entering public services."

"Whilst exit payments easily fail the Daily Mail test, these changes feel like a significant change to my contract and may well impact on the level of risk I'm prepared to take in terms of very senior roles."

The cap is a waste of skills and talent

"It will deter people from using their transferable skills in other public sector positions. What a waste of skill. The public sector is not going to be a place people will work as even at the end there will be precious little benefit to the employee."

The cap makes redundancy an easy option

"I have already had discussions about the ease of making people redundant now that this cap is due to come into place. The decision to accept lower grade alternative [jobs] to prevent any gap in service is likely to force staff to accept poor alternatives to their post being made redundant."

The cap betrays people's loyalty

"It feels like a betrayal of my contract after decades of service."

"I have worked for years in the public sector and this is part of the package I've worked for. It's like reneging on my contract of employment."

The cap discriminates against some public servants

"Certain sectors of the NHS undergo regular change processes often involving non-voluntary redundancy. Both these proposed regulations appear unfair when people may be subject to redundancy not at their choice, and when in many professional roles it is difficult to secure another appointment outside the public sector. It would be doubly unfair should these regulations apply to only some public servants."

The cap is unfair to managers in the North

"Given the high proportion of public sector jobs compared to private sector jobs in he North (where I live), such a proposal would be discriminatory against those of us who do not have access to the larger number of private sector jobs in the South East. In effect, for a northern based public sector employee, the recovery of an exit package is tantamount to a ban on future working for a year."

The cap discriminates against managers

"This is unreasonable, unfair and introduces a two-tier system of protections of staff, unfairly discriminating against dedicated NHS staff who have dedicated their career to public service."

"This would present a tiered system which penalises higher earners with no clear rationale. It will make some staff more vulnerable in organisational restructures and affect their chances of being able to find work if they do leave a 12 month gap after leaving a post. It will make it much easier to eliminate senior staff who may find themselves really compromised with limited options ahead of them."

MiP Members' Summit 2019

Managing Change Well

7/11/2019

Your Members Summit

7 November 2019, Austin Court, Birmingham B1 2NP

Book your place now for MiP's Members Summit, which takes place this year in Birmingham on 7 November. The Summit is our annual event for members – a full day of interactive training and practical workshops, debate about the union's work, and networking with other members from across the UK. The Summit gives you personal support and a voice, both as an employee and as a professional healthcare manager.

The Summit is CIPD-accredited and free to all MiP members.

Details of the programme and speakers for this year's Summit will be confirmed soon, but the day will include:

- Group discussions on organisational change
- Practical tools and information for you as both employee and manager
- Debate and decisions about your union's policy and priorities
- Informal networking with your colleagues from health and care across the UK, including a drinks reception at the end of the day
- Opportunities to address key challenges and take home practical solutions
- Learning from positive experiences to take back to your workplace

To book your place, visit the Summit website: connectpa.co.uk/events/mip-members-summit-2019

You can also read reports from last year's Summit on the MiP website: miphealth.org.uk/home/our-services/members-summit.aspx

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