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healthcare manager

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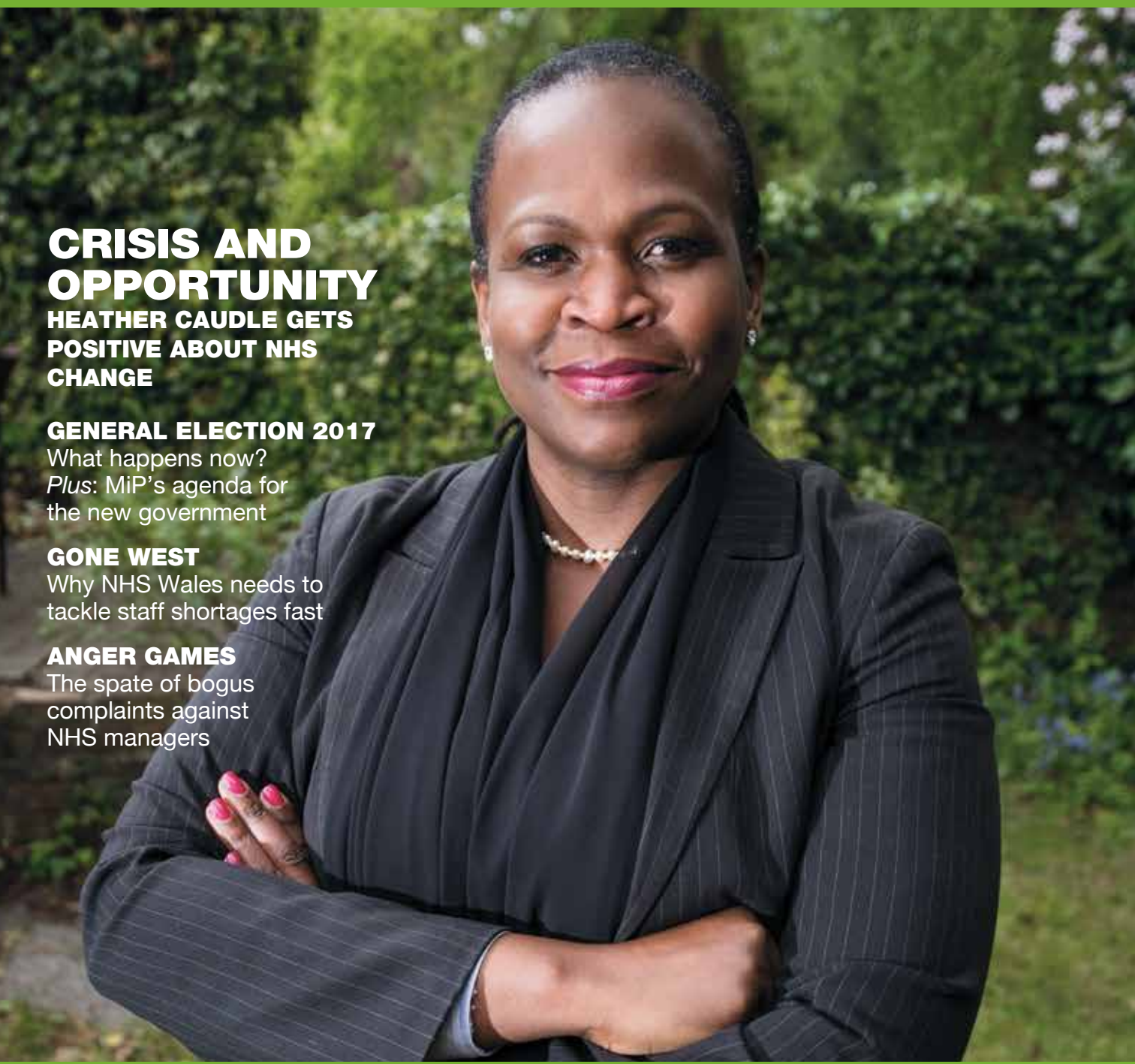

CRISIS AND OPPORTUNITY
HEATHER CAUDLE GETS POSITIVE ABOUT NHS CHANGE

GENERAL ELECTION 2017
What happens now?
Plus: MiP's agenda for the new government

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Why NHS Wales needs to tackle staff shortages fast

ANGER GAMES
The spate of bogus complaints against NHS managers

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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

The unexpected result of the snap election leaves the NHS in an interesting position. Without a majority and consumed by Brexit worries, ministers are unable to give much political direction to the NHS. The funding position is as clear as mud, and the fate of government initiatives such as STPs, devolution and integration is anyone's guess.

It will be a bumpy ride. But it's also an opportunity. After a relatively quiet campaign, the NHS is right back in the political battleground. On NHS pay, funding, reform, the internal market and a host of other issues, the door is ajar and the government is in listening mode – it has no choice but to be.

This is why MiP will continue its campaign to get politicians to listen to managers and other staff about what needs to be done in the NHS. In the coming months, we will take every opportunity to influence the new government and the backbench MPs on whom its life depends.

Away for the political spotlight, I'm particularly pleased to have an extensive interview in this issue with Heather Caudle, NHS England's new director of nursing in charge of improvement. Heather is one of the few black women leaders in the NHS and will have a huge role to play in planning the future of the largest component of the NHS workforce.

Enjoy the summer – who knows where we'll be come the autumn?

heads up

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

UNISON health conference

What kind of manager do we want in the NHS?

STEVE FORREST/WORKERS' PHOTOS

Delegates from UNISON's health conference in Liverpool took part in a lively fringe meeting hosted by MiP on 24 April, where MiP chair Sam Crane and chief executive Jon Restell led an informal discussion on the theme of 'what kind of managers do we want in the NHS?'

Restell talked about the responses to a survey carried out by MiP on the union's conference stand, which asked delegates about their best and worst experiences of management in the NHS.

"Poor communication, not listening and a 'my way or the highway' attitude were the most common complaints about poor management. The qualities that made the best managers were, according to delegates, being a good listener and someone who motivates staff," said Restell.

Issues raised by delegates in the discussion included:

- Informal resolution of problems had become harder with the shift to foundation trust status, which some delegates saw as heralding a more remote style of management
- There were too many interim managers – especially in service management jobs – leading to a loss of corporate memory and a lack of interest in the long-term future of the organisation
- Partnership working between management and unions was under threat, especially as a result of high turnover among managers
- Many managers felt insecure in their jobs, which made them vulnerable to pressure and overly-defensive; and managers felt pushed around by regulators and sernior managers within the system
- MiP has a big role to play in advising managers, employers and UNISON branches on tackling difficult problems, promoting good management standards and instilling confidence in managers about the value of partnership working.

Anne Speed, UNISON's regional head of health for Northern Ireland, said MiP had an important role "engaging in public discourse about public services and forging an alliance with the rest of staff side to defend the NHS and make a stand against privatisation."

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leading**edge**

Jon Restell, chief executive, MiP

Only the self-deluded would claim a commanding understanding of our current politics. Such self-delusion in public life has always existed but the extraordinary developments of recent years, here and overseas, make it easier to spot and ridicule. Certainty seems a suspicious quality. The best we can do is feel our way, plan and reflect, and assume pretty much nothing.

The latest extraordinary political event was June's UK general election. The fall-out includes a deal with the DUP and, as I write, growing pressure for an end to the public sector pay cap.

The DUP deal smacks of the pork barrel politics more often associated with America than the UK. That said, in her shoes, I'd probably have done the same as Arlene Foster.

By protecting the pensions triple lock and universal winter fuel payments, the DUP deal ties down some big chunks of money – money that would've been available for other things such as health and social care.

A hung parliament also means more power for backbench MPs across the political spectrum. This consigns controversial domestic legislation to the 'too difficult' box, where it's likely to be joined by the radical elements of the STP programme in England.

Backbenchers will find it hard to resist the temptation to use their newly acquired leverage to intervene in planning and funding decisions. If this undermines fair funding and evidence-based decision making, it won't be good for the NHS in the long run.

> "With the economy growing at less than half the rate of healthcare demand, the government will have to find more money to maintain services and end the pay cap."

It's been particularly startling to see Conservative cabinet ministers publicly calling time on the public sector pay cap. Michael Gove, for example, talks about honouring the integrity of the pay review body process as if he's a union press officer.

Not before time. The pay cap is often described as a recruitment issue. But it's just as much a matter of retention. Staff, whose real earnings have fallen by 15%, are voting with their feet. High turnover and the loss of experienced staff hurts patient care.

But a hung parliament doesn't touch demand for health and care, which is stubbornly rising at a long-term trend rate of 4% a year. With the economy growing at less than half that rate, the government will need to find more money for the NHS if services and quality are not to be cut and the pay cap is to end.

For MiP and health campaigners, funding must be the priority in the run up to the autumn budget.

Simon Stevens and other NHS leaders are right to say that the NHS must show that it's as efficient as possible and can effectively shift resources within the care system. But we need to be realistic about how much more can be done. Also rightly, Stevens points out that the NHS is leanly managed, with running costs significantly lower than comparable healthcare systems. Eyewatering savings, particularly in providers, will be hard to repeat. There's little gold left in those particular hills.

There's also a belief in targeting savings at the back office. The superb response of the NHS team to the recent terrorist attacks in Manchester and London shows how much we need effective systems and infrastructure. And after the WannaCry cyber attack, who would now claim that that the back office has no part to play in keeping patients safe? Leadership and management is key to meeting a whole of range of challenges from efficiency to staff wellbeing. We treat managers as second class employees at our peril.

Finally, it's become tempting to see ditching the pay cap as an end, not as the means to an end. Yes, it removes the shackles from bargaining committees or review bodies, so they can look at the needs of public services and the aspirations of public servants to pay their bills and protect their standard of living. But it does not automatically mean we will be able to fund long-overdue pay reform or guarantee decent pay rises. That will only be achieved with a wider political commitment to stop hollowing out the public realm and fund public services properly.

Campaigning

Tell us your stories – help us get the government to listen to NHS managers

SPOTMATIK

Following the general election, MiP's campaign to make the voices of NHS and social care managers heard in the corridors of power will switch towards influencing the new government and parliament.

The new government must decide how much money to give health and social care. With a spending review more than likely in the autumn, our campaign priority in the next few months will be funding.

But we need your help. The personal stories of senior managers carry punch with politicians and the media. Detailed analysis and information from managers on the ground can make the case for more funding. Making a powerful case to politicians now is particularly important, because a hung parliament gives individual MPs much more influence over the government.

Tell us how inadequate funding affects – or will affect – the patients you care for, your service, your staff and your working life. Your stories will be completely anonymised and used to illustrate our campaign themes. We will raise your concerns with MPs, as well as publish your stories in Healthcare Manager and on our website.

We'd like to thank everyone who used our general election toolkit in order to make the voice of health and care managers heard during the election campaign, and all those who shared our blogposts setting out the commitments we expected from politicians to the NHS and the people who work for it.

We're also reviewing how our campaign has gone so far. If you have any feedback or suggestions then please send them into Dylan Underhill at mip@connectpa.co.uk.

For more on our campaign themes, see 'A new deal from the new government' on p18.

Pensions

Major review of NHS scheme begins

Actuaries have started work on a new valuation of the NHS Pension Scheme, which will assess the costs of the scheme and could lead to changes in benefits or contribution rates.

The latest four-yearly valuation, carried out by the Government Actuaries Department (GAD) on behalf of the Department of Health, covers the 1995 and 2008 sections and the 2015 version of the scheme. GAD's report will set the employers' pension contribution from April 2019 and also determine whether the costs of providing benefits fall within the government's cost cap.

"If the costs of the scheme fall outside the cost cap then either employees would need to pay higher contributions or the value of benefits would need to be reduced – or there would need to be a combination of both," said MiP chief executive Jon Restell.

The Scheme Advisory Board (SAB), on which MiP has a seat, will be consulted throughout the valuation process on methodology, data and, crucially, on the actuarial assumptions used in the review. If the cost cap is breached then the SAB will also make recommendations on further action to the Secretary of State.

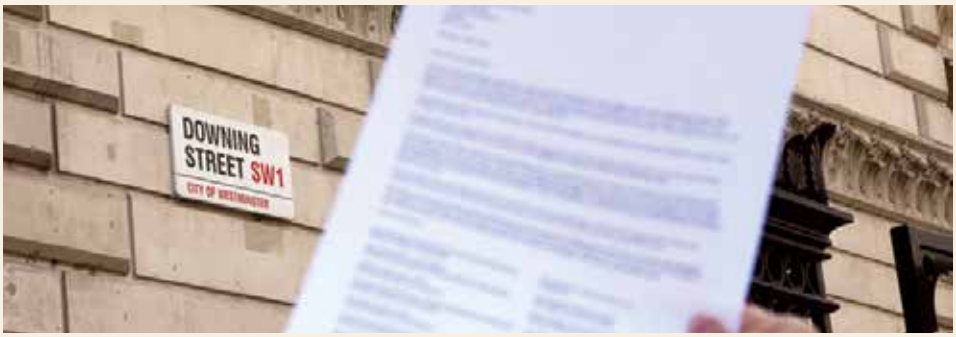
While some of the assumptions are set by the Treasury for all public sector pension schemes, others are specifically agreed for the NHS scheme. Assumptions on things like pensioner mortality, retirement ages, ill-health retirement, death in service, lump sum payments and future pay increases may determine whether the scheme saves money or incurs further liabilities.

Agreement on assumptions is expected by late summer 2017 with the final valuation results by March 2018.

A related review of how employee contributions are assessed will be equally important for MiP members. "Recommendations might look at the current tiers and rates and specifically whether a flatter structure should be used as the balance in the NHS shifts from final salary to career average schemes," added Restell.

Pay

Unions join forces to press for end to NHS pay freeze



MiP and 15 other NHS unions have joined forces to urge the prime minister to put an end to the public sector pay freeze and signal a change of direction in her government's attitude to the NHS.

In the unprecedented joint letter, sent on 19 June, leaders of unions representing all types of NHS staff pointed out that Theresa May has herself admitted that the pay freeze and a lack of public sector investment in the public sector was a significant factor in the government's general election setback.

On the day the Brexit negotiations finally kicked off in Brussels, the unions also pressed the prime minister to end the uncertainty hanging over NHS staff from other EU countries and to prioritise patient safety by guaranteeing safe staffing across the NHS.

"People who are working in the NHS are delivering care to the best of their ability but we are very worried that care is becoming unsafe. Our services are struggling to make do without the staff they need," said the letter.

It continued: "The Public Sector Pay Cap has forced professionals out of jobs they love. Those who stay are overstretched and under pressure to do ever more with less. The longstanding cap stands in the way of recruiting and retaining the best in health care. It is having a profound and detrimental effect on standards of care for people at a time when the NHS is short of staff across every discipline."

The union's joint plea was reported by the *Guardian, the Daily Express, Sky News, Personnel Today* and *PoliticsHome*, among others, and was widely discussed on social media using the hashtags #NHSPay and #scrapthecap. A Labour amendment to the Queen's Speech calling for an end to the pay cap across the public sector was narrowly defeated in the Commons on 28 June.

MiP chief executive Jon Restell, one of the signatories of the letter, said: "When unions, employers, think tanks and even some Tory MPs say that NHS staff need a pay rise, the government really needs to see what everyone else can – that its pay policy is at a dead end."

Senior Managers

MiP calls for scrapping of managers' salary cap

MiP has called for the policy of capping senior NHS pay at the level of the prime minister's salary to be scrapped after Treasury documents revealed more than 90% of requests to exceed the cap have been approved.

Under rules laid down in 2015, all trusts and CCGs wanting pay senior staff more than Theresa May's £142,500 salary must seek prior approval from the Treasury. But information obtained by the *Health Service Journal* under the Freedom of information Act showed that 54 out of 59 requests to exceed the cap had been approved in 2016-17.

"The figures for salaries above £142,500 strongly suggest that the policy of using the Prime Minister's salary as a benchmark has run its course," said MiP chief executive Jon Restell. "The burning priority must be recruiting and retaining board level people, especially in the most challenged providers."

"While we need a consistent and open senior pay framework, the NHS needs to be quicker to make offers, and it must bite the bullet and pay competitive salaries," he added. "The current approach smacks too much of political massaging. NHS Improvement and the Department of Health should be much more positive and upfront. It would help to attract candidates to these demanding jobs."

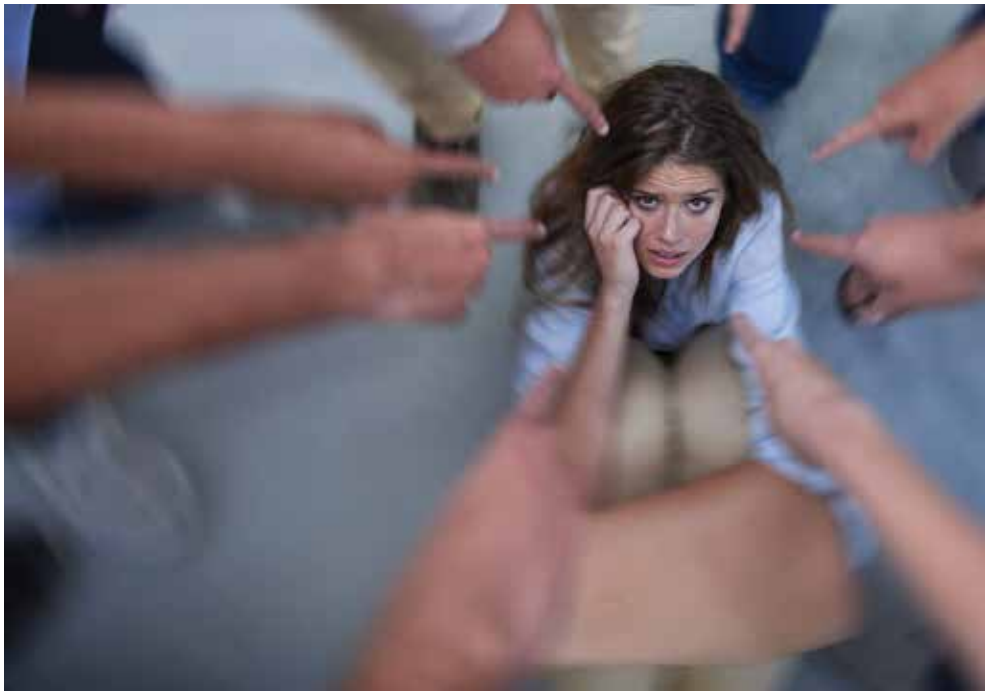
Restell has also warned that the NHS risks losing further valuable management talent in the latest round of reorganisation if it doesn't find a better way to manage redeployment across the system.

Commenting on revelations that NHS Improvement's leadership committee had approved nine compulsory redundancies at board level, he said: "Hospital and CCG mergers will create more compulsory redundancies at board level. MiP believes national leadership bodies should become better at structured redeployment across the system."

He added: "Many members, particularly younger chief executives and directors, want to continue with careers in the NHS but find system attitudes have not moved on from earlier reorganisations. A more proactive, supportive approach would save money and retain skills in an area of staff shortage."

NHS Scotland

Scapegoating and bullying rife in the NHS, MSPs told



PEOPLEIMAGES

The NHS in Scotland suffers from a "blame culture" where scapegoating and bullying behaviour are too common and staff feel unable to raise problems informally, according to MiP evidence to a Scottish parliamentary inquiry.

In written evidence drawn from members' comments and surveys, the union told the Scottish Parliament's health and sport committee that NHS Scotland "is blame-orientated with a culture of formal grievances to resolve matters which should be discussed informally first". This often leads to unnecessary and lengthy investigations, and a failure to "nip problems in the bud", the report said.

MiP's evidence also pointed to a widespread perception that managers trying to performance manage staff under NHS Scotland's capability policy were often unfairly accused of bullying and harassment – and could suffer suspension for up to 18 months as a result.

Giving evidence before the committee on 30 May, MiP national officer Claire Pullar said people making complaints were rarely asked what they wanted out of the process. "Often they say, 'I'd like an apology, I'd like it not to happen again, but I don't want the manager suspended for 18 months while someone does an investigation that all my colleagues will have to go through as witnesses."

She added: "How do we reintroduce certain skills that we have lost, such as talking to each other rather than putting in a grievance when people feel ticked off with with one of their managers?"

The union also highlighted how forms of bullying behaviour against managers such as 'mobbing' and 'gaslighting', which often go unrecognised, could lead to managers taking sick leave from work or needing mental health support.

"Unacceptable behaviour is sometimes used to bring a senior manager down. Senior managers experience 'mobbing' actions that can lead to them being removed from their roles," said the report. It said 'gaslighting', a form of psychological manipulation involving deliberate distorting or denying of the truth, was an increasingly serious problem and should be recognised as a form of bullying behaviour.

MiP also criticised both the Scottish and UK governments for scapegoating NHS managers and treating them with disdain. "They are referred to a 'bureaucrats' and not as they should be seen – as skilled, essential managers deliver patient-centric health services," said the union's report. "Our members are entitled to dignity in their workplace as the guardians of staff who report to them – clinical and administrative."

In response to questions from the committee about whistleblowing policies in the NHS in Scotland, Pullar warned that, although vital, many managers saw whistleblowing as another "blame-orientated" process.

She told the committee: "I have evidence from senior managers here who say they have never seen someone raise concerns through whistleblowing and not seen it have a devastating impact on them personally – whether it's on their career or their relationships with colleagues.

"It's still a very blame-orientated process... It's a very undignified way of doing it, but we need whistleblowing and we need people to feel safe whistleblowing – and at the moment I don't think they do."

Read MiP's full evidence to the Health and Sport committee's inquiry into NHS culture and governance, and evidence from other unions and professional bodies, at: bit.ly/hcm3402.

Leadership

Successful launch for Women into Leadership Healthcare

TOM HAMPSON/VISUAL EYE CREATIVE

Former MiP chair Zoeta Manning chaired the first Women into Leadership Healthcare event in London on 22 March. The conference, sponsored by MiP, brought together women from all parts of the NHS to explore the role of women in healthcare leadership and offer practical advice and coaching to women on how to develop their careers in times of change.

In her opening speech, Manning told delegates: "women leaders in the NHS have come a long way but still have miles to go… Just because women face barriers doesn't mean they don't have fire in their bellies to reach the top."

Ruth Passman, head of equality and health inequalities at NHS England, told delegates that women made up a large majority of the NHS workforce but only a small minority of NHS chief executives and trust chairs. Women were particularly under-represented in CCGs, and were disproportionately affected by NHS restructuring, particularly the abolition of Primary Care Trusts and Strategic Health Authorities.

She said women thrived in an "open and supportive culture" and needed clear career paths and opportunities for promotion into middle and senior mangement roles. "We need to shine a light on the traditionally female roles which don't get the recognition that they deserve… Women need a glass lift to get them through the glass ceiling," she told delegates.

Gill Morgan of NHS Providers spoke about building a culture of inclusion and respect to help female leaders succeed. She said evidence clearly showed that organisations with diverse leaderships and women on boards performed better. "This is a moral and bottom-line issue," she said.

MiP national officer Jo Spear and Sheree Axon, NHS England's director of organisational change, led a session on 'parent leaders' – looking at what unions and employers could do to help parents and their 'balancing act' between work and family responsibilities so the NHS could make the most of this valuable and talented workforce.

The next Women into Leadership Healthcare event will be held in Manchester on 10 October 2017. For details, visit healthcare.womenintoleadership.co.uk

MiP National Committee elections 2017

MiP will be holding elections this autumn for a new national committee to take office for two years from 1 January 2018.

The national committee formulates MiP policies on healthcare, the NHS and workplace relations – including negotiations, and the representation, recruitment and organisation of MiP members. Committee members are ambassadors of MiP, representing the union on public platforms and talking up issues that matter to you, upholding MiP's values and maintaining our political neutrality.

The national committee is made up of elected representatives from each geographical area of the UK with co-optees for any areas of healthcare not represented. There are two seats for Scotland, Wales and London, and one seat for each of the other English regions and for Northern Ireland.

Nominations open on 25 August and an election will be held in any constituency where there are more nominations than seats. The new committee will elect a chair and vice chairs at its first meeting early in 2018.

The full timetable for the elections is shown below. Nomination forms and further details will be available on the MiP website at bit.ly/mip-national-committee.

You can also find out more about the committee's work by downloading the terms of reference, available from: bit.ly/committee-terms-of-ref.

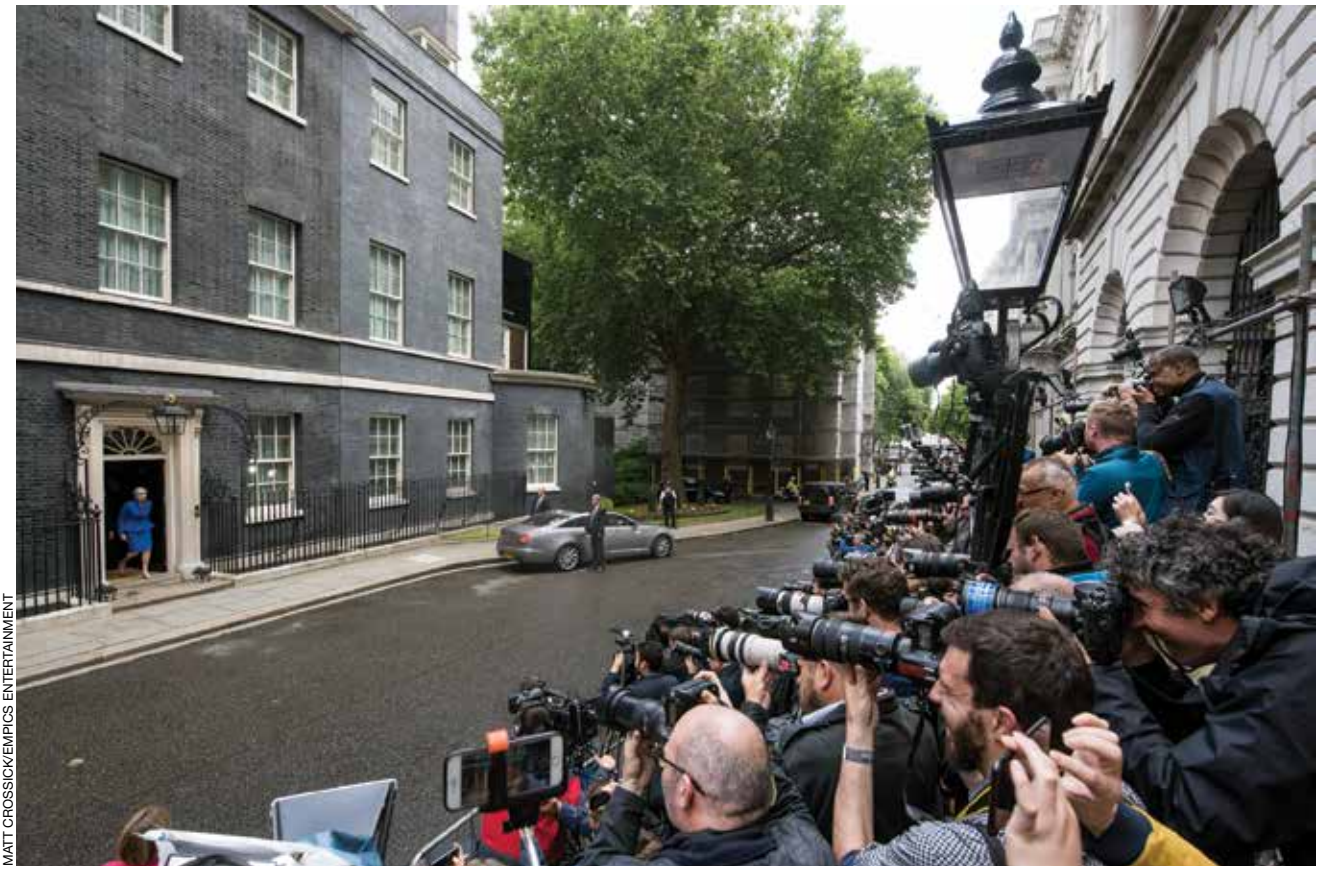
ELECTION TIMETABLE

Nominations open:	25 August 2017
Nominations closed:	25 September
Elections open:	13 October
Elections close:	13 November
Results announced:	24 November
New committee takes office:	1 January 2018

Analysis

The shock election result has left the NHS in the thick of the political battleground but without a clear direction from government. Anything could happen, says **Craig Ryan** – but here's ten things worth looking out for.

So, what happens now?



MATT CROSSICK/EMPICS ENTERTAINMENT

1. Simon Stevens has a stronger hand

Voters' anger at perceived NHS cuts was a significant factor in a number of Conservative losses, most notably in Canterbury. So, preoccupied by Brexit and the possibility of another election, ministers may be inclined to let the NHS England chief get on with it. "The weakness of the minority government will strengthen the hand of NHS England in implementing the Five Year Forward View and continuing its work to achieve financial stability and improvements in performance," says King's Fund chief executive Chris Ham.

2. STPs will get harder

Unpopular reconfigurations of services

"The government's 1% cap on NHS pay rises was already under severe pressure, with unions, employers and just about everyone else calling for it to be scrapped."

may prove impossible to get through. Local opposition will be emboldened by the election result and Tory MPs sitting on small majorities will try to block them – and the government's parliamentary weakness gives them the clout to do so. That said, if this leads to more engagement with local people, it could strengthen the plans in the long run.

The Tory manifesto was lukewarm on STPs, promising only to support those that were "clinically led and locally supported". Jeremy Hunt's job is to neutralise the NHS as an election issue, so some sort of review or delay seems likely, and Hunt may also want to get some sort of national grip on the whole STP process.

3. There might be (a bit) more money

One of the few numbers in the Tory manifesto was £8bn extra for the NHS over the next five years. They're unlikely to go back on that. But it's unclear how the money will be found – and it's unlikely to come all at once. Expect the centre to continue bearing down on deficits using mechanisms like the capped expenditure process.

The Conservative manifesto promised "the most ambitious programme of investment in buildings and technology the NHS has ever seen". Mystery still surrounds the funding for this, but the Government is likely to rely heavily on the £10bn-worth of asset sales identified by the Naylor review. They will have to tread carefully – a fire sale of NHS stuff to private property developers would not be a good look at the moment.

4. Forget about new laws

There won't be time. With no majority, Brexit will consume even more parliamentary time than expected.

Promises, promises

What the Conservative manifesto offered... and what we might get

Funding

"Increase NHS spending by a minimum £8bn over the next five years"
It will be hard to back down on one of the few goodies in the manifesto. But experts agree it's nowhere near enough and the DUP want £1bn to go to the NHS in Northern Ireland.

"The most ambitious programme of investment in buildings and technology the NHS has ever seen"
It's not clear where the money's coming from, but ministers are probably eyeing up the £10bn of potential property sales identified in the Naylor report. How many sell-offs of NHS assets will get past jittery Tory MPs sitting on small majorities remains to be seen.

Workforce

"Make it a priority... that the 140,000 staff from EU countries can carry on making their vital contribution to our health and care system"
Not exactly a guarantee, but with the balance of opinion in the Commons shifting towards a softer Brexit, there's a good chance of an early deal.

"Ensure that the NHS and social care system have the nurses, midwives, doctors, carers and other health professionals that it needs"
A vague (and grammatically-challenged) promise that the Government is unlikely to have time to meet – and certainly not without abandoning its pay cap and investing a lot more than the promised £8bn.

"We will act to reduce bullying rates in the NHS, which are far too high"
Health minister Philip Dunne made a strong personal commitment to this at last year's MiP conference. Dunne kept his job, and as this requires neither much money nor legislation, some progress should be possible.

"We will introduce a new GP contract... we will reform the contract for hospital consultants"
Highly unlikely. An unstable government won't want to provoke another damaging dispute with doctors.

"We will recruit up to 10,000 more mental health professionals"
There is strong cross-party support for action on mental health, so some movement is possible. Funding and recruitment will prove difficult.

Reform

"We will legislate to reform and rationalise the current outdated system of professional regulation of healthcare professions"

This has been trailed as a merger of the NMC, the GMC and other professional regulators. It's hard to see this government having the head space or the legislative time for this.

"We will back the implementation of... Sustainability and Transformation Plans, providing they are clinically led and locally supported"
This could be more of a get-out clause than a commitment to genuine local involvement. Political support for STPs is likely to stay patchy, and significant local opposition could easily kill off unpopular plans.

"If the current legislative landscape is either slowing implementation [of STPs] or preventing clear national or local accountability, we will... make the necessary legislative changes"
With no majority and Brexit hogging the timetable, new NHS legislation is highly unlikely during this parliament. The Government may concentrate on promised "non-legislative changes" to limit the operation of the internal market.

Two new faces at the department

While Secretary of State Jeremy Hunt, and health ministers Philip Dunne and Lord O'Shaughnessy kept their jobs, two new junior health ministers were appointed to replace Nicola Blackwood and David Mowatt, who both lost their seats in the general election.

Jackie Doyle-Price

Doyle-Price, 47, becomes a junior health minister after serving two years as an assistant government whip. The MP for Thurrock in Essex has a wafer-thin majority of 345, so won't want to make herself any more unpopular than necessary.

She will have to tread carefully with GPs, whom she has criticised in the past. On her website, Doyle-Price blamed GP shortages on GPs "not delivering enough" and has said that practices should "take responsibility" for matching staffing levels to patient demand – provided "they get the money to so so".

During her 2017 campaign Doyle-Price backed the controversial closure of la local minor injuries unit and sale of land at nearby Orsett Hospital. "NHS trusts should be free to sell land if they want – that's exactly what's going to happen with regard to Orsett Hospital," she told a hustings meeting in the constituency.

Steve Brine

Unlike other recent appointments at the DH, Brine, 43, has some experience of the health brief: he served as Jeremy Hunt's PPS (unpaid assistant) for a year after the 2015 election. A former radio journalist and business consultant, the Spurs-supporting MP for Winchester enjoys a comfortable 10,000 majority over the Liberal Democrats.

Locally, he is known for being heavily involved in the NHS, chairing a number of public meetings and taking part in 'Ask the NHS' sessions. He has also taken an usually close interest in his local STP – Hampshire and the Isle of Wight – and has been vocal in calling for wider public involvement.

In 2015, Brine warned his constituents that "consumerism" posed a significant threat to the NHS. "We are raising expectations so much around the National Health Service and our health professionals are buckling under the pressure of that expectation," he said.

Ministers are unlikely to find time for new health legislation, especially as it could simply hand the opposition a stick with which to beat the government.

The Conservative manifesto pledged new laws to remove impediments to the 5YFV, restrict the internal market, replace the Mental Health Act and rationalise the regulatory regime for doctors, nurses and other clinicians. They're all probably off the agenda unless non-legislative solutions can be found.

5. Expect more tinkering

Unable to legislate, ministers and NHS England will rely on evolutionary changes. Expect more CCG mergers, and piecemeal and cautious progress on integrating and reconfiguring services. The government has promised some non-legislative moves to roll back the internal market, and accountable care organisations may get a boost – especially as the DUP is keen on them in Northern Ireland.

6. Get a tin hat and a thick skin

There was mercifully little manager-bashing during the 2017 campaign, but the NHS is right back in the middle of the political battleground and the temptation may be too much for some politicians. With little room for policy changes and little money to spend, old chestnuts about "more managers than nurses", "fat cat NHS bosses" and "faceless bureaucrats" could make an unwelcome comeback.

7. Pay restraint may be relaxed

The government's 1% cap on NHS pay rises was already under severe pressure, with unions, employers and just about everyone else calling for it to be scrapped. After the election, the prime minister's new chief of staff, former housing minister Gavin Barwell, partly blamed his defeat in Croydon Central on the policy. Asking for pay restraint to go on for 10 years was "too much", he said. Health secretary Jeremy Hunt also dropped a hint, saying he would "relay" concerns about NHS pay to Chancellor Phillip Hammond. Although the government defeated Labour's attempt to end the pay cap in an amendment to the Queen's Speech, there's a good chance that Hammond will relax the cap in his autumn Budget..

8. A short-term fix for social care

Hammond will also come under severe pressure to find more money for England's collapsing social care system. But after the "dementia tax" fiasco, a long term solution looks further away than ever. Finding a way to reform and fund social care is probably impossible without cross-party agreement, something to which the current febrile "pre-election" atmosphere at Westminster is hardly conducive.

9. A reprieve for EU staff

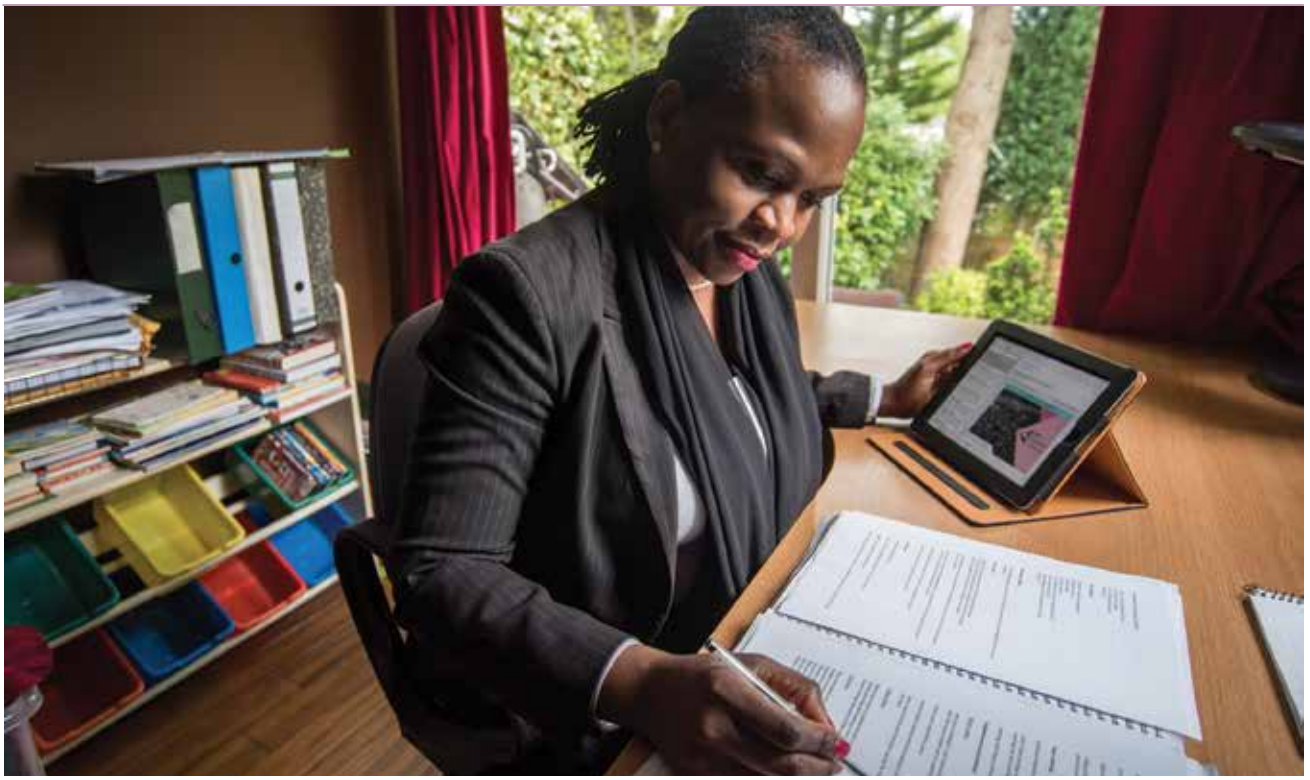
NHS leaders have been rattled by recent figures showing a 96% drop in applications to work in the UK by nurses from other EU countries. With the new parliament thought to be leaning towards a softer Brexit, an early deal that would allow EU staff already working in the NHS to remain indefinitely looks very possible.

10. More money for the NHS in Northern Ireland

The cheque's already in the post. Theresa May's deal with the DUP means an extra £1bn for Northern Ireland, and most commentators expect the DUP to come back for more sooner or later. ■

Heather Caudle is a pioneer of partnership working and one of just a handful of black leaders in UK nursing. As she prepares to join NHS England, she talks to **Alison Moore** about her career and her positive take on the problems facing the NHS.

Crisis and opportunity



DANIEL DEME

Heather Caudle is driven by a relentless positivity which permeates everything she does and translates into incredible energy – even her Twitter profile urges people to "dream, decide, do".

Now her energy and positivity are transferring to the national stage as she moves from being chief nurse at Ashford and St Peter's Hospitals Foundation Trust to NHS England, where she will be director of nursing for improvement. Her areas of responsibility include safeguarding, continuing healthcare, maternity, and children's and young people's care.

It's not her first major career change. "I have not gone up the traditional route in nursing, but was a mental health nurse who made the crossover into safety

and quality in the acute general sector and was able to effect some change at strategic level," she explains. She says her philosophy has always been "in partnership you can make things better".

"I'm looking forward to working on a national basis," she adds. "My remit will be much wider and the impact of my work will be far reaching. This can be daunting, but I'm looking forward to the challenges and opportunities to help strengthen and improve nursing."

She has always been keen on using data and evidence to drive change and improve services. "When you are running an eating disorder service, you know when the clinician is successful by identifying changes to what patients weigh or by the number of times they engage in purging behaviour. It's driven by the data," she says.

"In project management there are always milestones, and there's a data side you always need to refer to to see if you're successful. When I came to Ashford and St Peter's I tried to implement the same ethos. In my own thinking, this is what I will be driving and supporting nationally.

"The new job requires someone who can both understand change and improve methodology, surpassing divisions between different professional groups [and] encouraging people to work together," she explains.

Another challenge will be working at a national scale, where Caudle will have to work collaboratively alongside other senior nursing colleagues. "This will mean, no matter what organisation we work for, senior leaders have shared goals and objectives, to drive improvement consistently across the country," she says. She also wants to develop messages that resonate with NHS staff who are not clinicians – a skill she admits she needs to work on.

Caudle acknowledges that many of the changes required in NHS organisations are cultural. "A lot of listening is going on in [NHS England] and it's really championed. It's not a tick box exercise, it's a real cultural thing," she says.

"I will continue to work in partnership with others. It's about being able to describe the purpose, listen to the constraints people have and empower local leaders to address the issues."

Caudle will have to get used to a lot of travel. While based mainly at Skipton House in London, she will make weekly trips to Leeds as well as visits around the country.

As an acute trust chief nurse, she is acutely aware of the pressing workforce issues that will be the backdrop to her strategic work on improvement. Not only is the NHS failing to recruit the nurses it needs, but she acknowledges issues with morale – which she describes as "up and down" – and continuing pay restraint.

While not underplaying any of these challenges, she cites her experience as part of a leadership team at Ashford and St Peter's which managed to buck the negative trends in the NHS staff survey. The trust has improved its performance on relationships with line managers and with people feeling their feedback was taken seriously when reporting serious incidents, using methods such as raising the profile of 'speak up for safety' guardians.

"The issues highlighted [in previous surveys] were leadership and the organisation learning from mistakes and incidents," she says. "We have focused on these issues specifically and have seen a significant improvement in our staff survey results. It was very much in partnership with the board, with the director of workforce and organisational development taking the lead," she says.

In NHS England, she says, "I will continue to work in partnership with others. It's about being able to describe the purpose, listen to the constraints people have and empower local leaders to address the issues. The role is also about being able to look at the data and respond."

She urges managers on the ground to take steps to boost morale and make changes that matter to staff. Managers need to listen to what staff say are the barriers they face – and then be open and honest about what real change is within their gift.

She sees looking at ways to make NHS resources go further as one the key aspects of Leading Change, Adding Value – the national framework for nursing, midwifery and care staff. "Working sustainably is key. We need to focus on working more efficiently and working differently, perhaps more in partnership with others," she says.

More generally, Caudle thinks the NHS may now be at a tipping point where problems become opportunities, but stresses that the NHS has to manage that change successfully. She points to opportunities she sees to use the untapped potential of BME staff to help meet some of the current challenges, and is also keen to get a deeper understanding of what's going on with the nursing workforce. Why are nurses rushing to do agency work, for example? What is needed to retain more staff and bring people back into the service?

She suggests the current problems may echo some of those from the early 2000s, but the answers may be different because there is less money to spend. Back then, the NHS could devise solutions, such as term-time or school-hours working, which are harder to afford in times of continuing austerity.

Caudle's path to the top was a circuitous one. She was brought up in a large family in Trinidad where she initially worked as an assistant teacher in a seaside village.

A turning point came when one of her students developed drug-induced psychosis and had to be looked after in a monastery. Visiting and supporting patients made her realise both how much her efforts were valued and that this made her feel good in return. "They

were ever so grateful for what I did and my acceptance of them – there was stigma in both drug use and mental health. At that point I decided to go into the caring professions."

The experience led her to apply to train as a nurse in the UK at the North London Joint College of Health Studies. After qualifying she worked as a mental health nurse and then started to specialise in eating disorders. She also trained and qualified as a family psychotherapist.

One of the breakthrough moments in Caudle's career was redesigning an eating disorder service which was under threat, and developing an innovative model by working in partnership with a nearby trust. "It was the first time I had a real conversation with a director. We were successful – the service is still going and is still one of the best in England," she says.

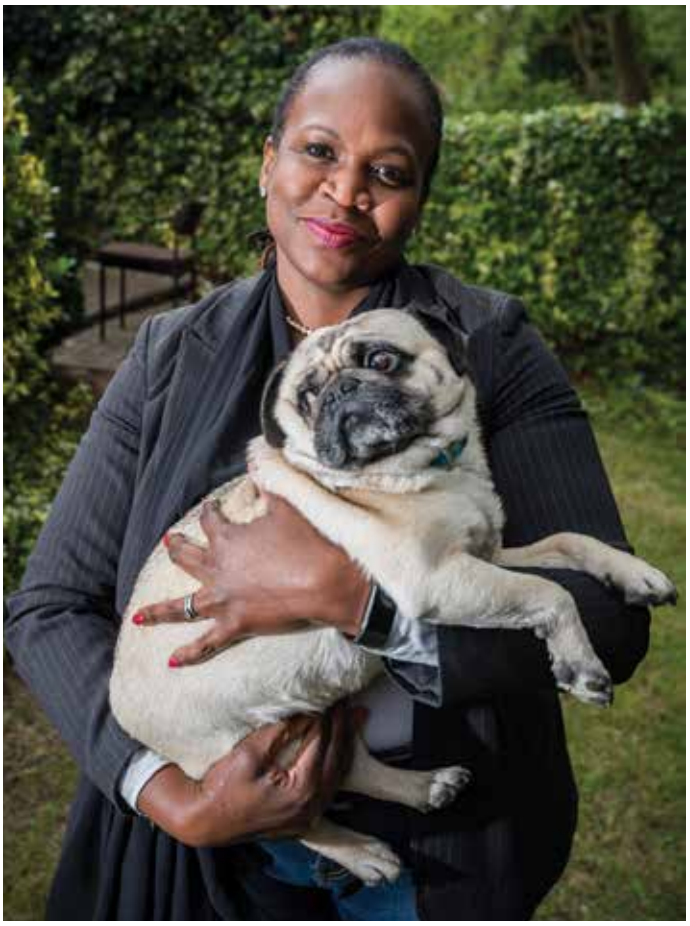
Off the back of this, she was approached to help release £2m of savings for an aspirant foundation trust while ensuring patient quality did not slip – a job that involved the contentious merger of two psychiatric intensive care units.

With a husband and two small children, a move out of London was on the cards. She was approached about a role in patient safety at Ashford and St Peter's and accepted it. Husband Jez now works from home, enabling him to take on some childcare duties.

Caudle's career progression has not always been smooth. She has been turned down for jobs she felt she was ready for and admits she has questioned whether her own ethnic background was a factor.

"What might have indirectly protected me was just not knowing what the rules were," she says. "I didn't know that these opportunities were not open to me. I didn't know the rules about the BME glass ceiling."

Visiting trusts, she has sometimes been shocked by the poor opportunities for progression available to BME staff. "I just didn't realise that there are hospitals where a nurse of a certain colour or ethnicity just did not move beyond band 7," she says. "Even if BME candidates manage to get through to some roles, their fight may not be over as there can be problems with culture and environment in the workplace."



DANIEL DEME

She supports the Workplace Race Equality Standard (WRES) but warns that it can only do so much. "It's a leadership challenge," she says. "The WRES is a measure. As someone who understands and appreciates data I can see it being helpful. However, we will not change the culture of the NHS by mandate. If you manage to create organisations focused purely on achieving the right culture and providing the highest quality compassionate care, that is when the BME issue will be resolved."

She adds: "We must work together to remove any opportunity for bias and unfairness, and challenge stereotypes about the characteristics of others – remembering that sometimes what we have always known and done might not be the appropriate course of action for current, future and even more complex problems."

The Breaking Through course – run by the NHS Leadership Academy – influenced her to look at other demanding jobs and led her into the world of safety and quality improvement.

Caudle says her working life has influences by a strong "moral compass about helping others" and very much inspired by her strong Catholic faith. She is keen to carry her focus on helping and communicating with everyone regardless of status into her job at NHS England. But she's clear that she will miss life at Ashford and St Peter's: "One of the porters said to me, 'We will be sad to lose you – you're a legend, you're smiley and we can talk to you.' I hope I can continue to be recognised in this way when working in my new national role!" ■

With its population and NHS workforce ageing fast, Wales needs urgent action to boost skills and recruitment across health and social care. **Jenny Sims** asks if a host of local and national initiatives add up to a coherent strategy for the future.

Welsh work in progress?

The health and social care system in Wales faces a crisis. Although many local and national initiatives are being tried, experts warns there is still no comprehensive vision for the NHS workforce in Wales.

Professor Sir Mansel Aylward, chair of Public Health Wales says "it's going to be difficult to plan effectively, authoritatively and strategically for recruitment, training and retention until we have a vision." And he wants that vision to be both "disruptive" and "prudent".

Technological advances are happening so fast, Aylward says, that it's difficult to predict delivery models for ten to 15 years ahead. Instead, he suggests planning for the next five to ten years around three core principles:

- Caring for those with the greatest need first, using skills and resources accordingly
- Doing only what is needed and doing no harm – no more, no less
- Reducing unnecessary variation by using evidence-based practice consistently and transparently.

"What's evident to me is that at the present time we do not have a workforce that meets the needs required for the proper application of a prudent health model," Aylward adds.

As a nation, Wales is ageing fast. The number of over 65s is expected to rise from around 75,000 to 183,000 over the next two decades and, by 2039, for every 100 working age adults there will be 48 people aged over 65. A third of the adult population has at least one chronic health condition and nearly two-thirds of adults and one third of children are overweight or obese.

"What's evident to me is that at the present time we do not have a workforce that meets the needs required for the proper application of a prudent health model."

SIR MANSEL AYLWARD
CHAIR OF PUBLIC HEALTH WALES

At the same time, NHS Wales has an ageing workforce. A quarter of GPs are aged 55 or over, as are one in four midwives and 15% of nurses. The Welsh Assembly's health, social care and sport commitee recently heard that some GPs routinely see more than 100 patients during a consultation session, and that 400 GP posts and 40% of hospital consultant posts in Wales are vacant.

"Clearly this situation is unsustainable" says Caroline Jones, Welsh Assembly Member for South Wales West, who sits on the committee. She points to the committee's recent inquiry into medical recruitment, which found that staff who train in Wales were much more likely to stay working in Wales.

"We need to train more of our doctors and nurses right here in Wales," says Jones. "We cannot allow ourselves to become reliant on overseas workers. We need innovative solutions to how we can encourage, train and retain a homegrown workforce."

Nurses, doctors, and social care leaders are singing from the same song-sheet. Some cautiously suggest attaching strings to the "golden handshake" recruitment incentives used to attract GPs to rural areas, binding them to working in Wales for a fixed period.

Recent figures suggest that there are around 1,200 nursing vacancies in NHS Wales, with a further 1,700 across

the not-for-profit and private sectors. In 2015-16, NHS Wales spent more than £48m on agency nurses – enough to pay for 2,000 newly-qualified nurses.

But there is cause for some optimism. The bold campaign by the RCN in Wales for legislation to link nursing staff levels to patient numbers resulted in the Nurse Staffing Levels Act (Wales) becoming law last year.

A first in Europe, the law now gives Welsh Health Boards the duty to ensure appropriate and safe levels of nursing on acute medical and surgical wards. The RCN is currently in discussions about how it could be implemented in the other three UK nations.

Social care faces different but no less severe pressures. 96% of care in Wales is provided by unpaid carers or family members, and 70% of the Welsh population are expected to need some form of social care in the future. There is already significant strain on the 80,000-strong social care workforce.

It costs at least £3,000 to recruit and provide initial training to a care worker, and high turnover and recruitment costs are a significant problem. Turnover rates vary between 5% for qualified social workers to 30% for domiciliary care workers. In rural Powys, 46% of staff in 2016 had been recruited within the last year.

Unsurprisingly, new solutions are being sought, such as developing care qualifications for unpaid or family carers – an idea put forward by the Swansea Carers Centre. But Sarah McCarty, director of improvement and development for Social Care Wales, says a "cultural shift" is needed in how social care services are organised and developed.

"Integration is a hot topic and there are many challenges – one of them is differences in terms and conditions," she explains. Social care employers complain that they spend a lot of time and money upskilling and training workers, only for them to leave as soon as an NHS vacancy arises, she says.

Andy Hardy, MiP's national officer for Wales and South West England, says jobs in NHS Wales are more attractive than those in social care. "Pay rates are relatively good and health boards have decent all-Wales policies. The NHS is safe, works jointly with trade unions, and there's no Private Finance Initiative.

"Integration is a hot topic and there are many challenges – one of them is differences in terms and conditions."

SARAH McCARTY
SOCIAL CARE WALES

"In contrast, across the border in England, care companies have a high blame and 'churn and burn' culture, with low pay levels and unforgiving targets," he adds. "I'm sure if Wales can step up to the social care challenge with co-operation from all interested parties – trade unions and Welsh inspectorate bodies included – then they'll make it a success."

Hardy believes the Welsh Government's commitment to retain bursaries for nurse training – recently abolished in England – may prove significant. "A commitment to working in Wales for a period after qualification in my view is fair and will help with retention and loyalty of staff," he says.

"I have a lot of members in England who ask me about any vacancies in Wales," he adds. "Due to larger health boards, terms and conditions are a lot easier to manage with regard to negotiating machinery and forums, and I see genuine pride in NHS Wales – staff want the health service to succeed and thrive, from Band 1 and 2 workers right up to the Chief Executive."

Health and social care has been made a priority in the sector reviews of vocational qualifications being carried out by Qualifications Wales – the body set up in 2015 to make sure the qualification system in Wales meets learners' and employers' needs.

This ties in with moves to register all home care workers in Wales from 2020, and all care home staff from 2022. The aim is to boost professional standards and reassure the public that care staff are fit to practice. A three-year development programme for home care workers started in April, and the register opens in April 2018.

Another pioneering scheme is the new curriculum at Cardiff University Medical School, which offers interdisciplinary training so that medical students, nurses, midwives and physiotherapists can work together and understand each other's jobs. GP clustering in Wales offers another opportunity for inter-disciplinary training and collaborative working, with Caerphilly Social Services, for example, basing some social workers at one of the town's GP practices.

The most significant workforce initiative from the Welsh Government is the launch, in November 2016, of Health Education Wales (HEW). Overseen by an impartial board, the new body aims to "deliver a national co-ordinated approach to delivering workforce education and training to meet the specific geographical needs of Wales".

Health minister Vaughan Gething says it will "create an environment in Wales which builds a culture that supports learning in the working environment, attracting and retaining the best people possible, on a cross Wales basis."

It's far from clear whether this patchwork of initiatives and pilot schemes will crystallise into the "vision" Aylward is calling for. But it hard to see a coherent strategy emerging without some harmonisation of terms and conditions across the health and social care sectors. ■

Managers are increasingly becoming victims of spurious allegations, which damage their careers and cost the NHS dear. And, too often, sloppy investigations and poor HR support make things worse. **Craig Ryan** reports on MiP's efforts to tackle the scourge of vexatious complaints.

Accused and abandoned

Managing a new team is hard at the best of times. It's harder still when standards have slipped and colleagues are reluctant to change. And it can become impossible when those colleagues collude to undermine you – and your employer doesn't give you the support you need.

MiP national officer Claire Pullar spent six years supporting one MiP member – let's call her Jill – who faced a sustained campaign of vexatious allegations after moving from another part of the UK to take up a senior management job.

"Jill witnessed behaviour that was unprofessional and contrary to contractual requirements," explains Pullar. When Jill tried to change things, one member of staff raised a spurious grievance and other staff joined in. "I needed to make sure the employer recognised the term 'mobbing'," says Claire, "and the intent of this behaviour and the risks it poses to the manager who is the focus of it."

The grievance was dismissed with no case to answer but Jill's colleagues appealed. A second investigation also ruled there was no case to answer and found evidence of deliberate collusion to stop Jill from managing her team.

But Jill's nightmare didn't end there because her employer failed to give her the support they had promised. "Without the coaching, mentoring and support required and agreed to, the complainants reassumed previous unmanageable behaviours," says Pullar. "I agreed that our member should be moved to a role elsewhere that utilised her strengths and put a barrier between her and the complainants."

MiP national officers report a steep rise in vexatious complaints against NHS managers in the last two years. These complaints are often directed against managers trying to implement change or tackle unacceptable behaviour at work, but they can also be driven by personal dislike, jealousy or frustration with other problems in the workplace.

Vexatious complaints show that workplace bullying isn't always something inflicted by managers on subordinates – it can strike out in all directions. And while there is something of the playground about this behaviour, the impact on a manager's career and personal life is anything but child's play.

Jill's six-year ordeal is unusual, but cases often drag on for months or years, with the same or similar allegations being investigated several times over. Too often, complaints are taken at face value, and employers don't even check if there is any substance to them before suspending or moving managers.

The standard of investigations is often poor. MiP member Antonia was removed from managing her team and relocated as soon as complaints were made against her. "The investigation itself was long and cumbersome, with some element of bias," says MiP national officer Corrado Valle, who supported Antonia. "It wasn't even clear what the allegations were until the date of the interview with the investigator."

Valle helped Antonia secure a second, better-run investigation, which absolved her from any wrongdoing and put her back in charge of her team. But by this time she had been absent for nearly a year.

"The longer it takes to complete an investigation, the higher is the reputational risk for the member, especially if they are suspended or moved from their post," says Valle. "A thorough initial investigation would have highlighted the lack of evidence and would have stopped the proceedings at that point."

George Shepherd, MiP's national officer for the east of England, says groundless discrimination claims are also becoming increasingly common in the NHS. "There's a culture growing where individuals who are being performance managed will stick in a discrimination claim in an attempt to frighten off their manager," he explains. With no cap on discrimination awards, and employers reluctant to take action against people who make vexatious claims, some staff see this as "a no-risk strategy", Shepherd warns.

Shepherd recently supported Richard, a finance director and MiP member, accused of race discrimination on the basis of several largely trivial complaints. The employer appointed an expert, who had previously been asked to look proactively

for evidence of discrimination in the workplace, to investigate Richard's case. "We raised significant concerns that this process looked like a witch hunt as, in my view, the investigator had already concluded there was active discrimination in the workplace," George explains.

"We were easily able to combat the allegations by proving they were vexatious, and we lined up a number of character witnesses to confirm that Richard does not display the behaviour outlined in the grievance," adds George. "When I asked the employer what evidence they had to support the allegations, they admitted there was none."

MiP national officer Steve Smith supported a group of MiP members who were the subject of a 14-point anonymous whistleblowing complaint. After a lengthy investigation, in which more than a dozen staff were interviewed, none of the 14 points was found to have any substance.

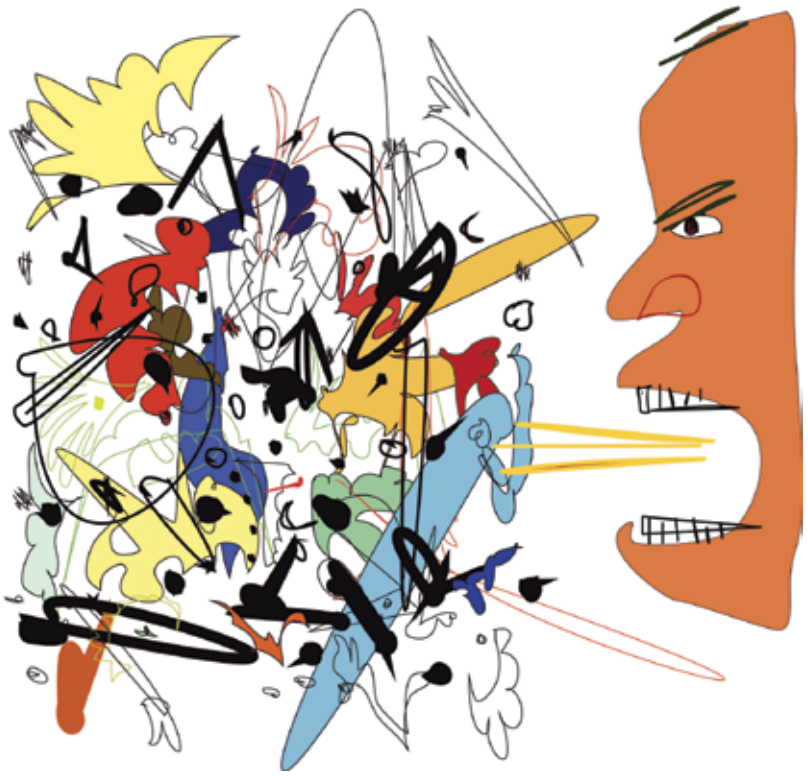
The 'whistleblower', a single member of staff, then submitted a grievance under the trust's 'dignity at work' policy – on almost identical grounds. After another lengthy investigation, all 14 points were again dismissed as being without foundation.

"The employer could and should have recognised that the whistleblowing complaint and the grievance were identical and that an independent investigation had already examined it in detail," says Smith. "We can see no negative consequences for this member of staff, who wasn't performing adequately and decided to get their retaliation in first.

"The end result is that the work of the unit has been severely disrupted for no good reason for nearly two years, and staff have been left feeling badly let down by their employer," he adds.

As well as supporting members by preparing evidence, attending hearings and representing them formally and informally, MiP presses employers to recognise that they have obligations towards people being investigated as well as those who make complaints.

"These MiP members were put under unnecessary stress and pressure, and our view is that their employer failed in the most basic duties of care towards them," says Smith. "If they had not been union members, they'd have been left isolated, unrepresented and vulnerable."



MICHAARCHER

"Jill said that without weekly contact and coaching from me, her mental health would have suffered," adds Pullar. "She also said that without my voice supporting her, the employer would have just blamed her and her career and reputation would have been negatively affected."

MiP is urging employers to tackle the scourge of vexatious complaints by rooting out shoddy HR practice and making the conduct of investigations more professional.

Valle says that many vexatious complaints arise after HR or senior management have failed to nip problems in the bud. "Sometimes the inability of managers or HR to identify areas of malcontent among staff and address the issues at the earliest opportunity gives rise to allegations that are unfounded," he explains. "This is not necessarily malicious, but can be the result of frustration and mistaken beliefs about the facts of the allegation."

He argues for more expert initial investigations that "should concentrate on the evidence available and advise the complainant of all the possible implications of pursuing an allegation for which there is little or no evidence". Shepherd agrees that employers need to assess the credibility of the evidence before suspending or moving accused managers. "They need to do an internal risk assessment and make clear to all individuals that, if the complaints are found to be vexatious, they could face disciplinary action."

"It's time to put an end to the huge disruption caused by a tiny handful of underperforming or dysfunctional staff abusing entirely legitimate grievance and whistleblowing processes," adds Smith. "HR and executive teams should be far more cognisant of the huge cost to the taxpayer of these investigations and much more stringent about sanctioning those who are unfairly discrediting colleagues by gaming the system."■

Names of MiP members featured have been changed. If you are the target of a vexatious complaint, contact your MiP rep or national officer immediately.

Following the inconclusive general election result, MiP chief executive **Jon Restell** sets out MiP's challenges to the new government – however long it lasts.

A new deal from the new government

During the 2017 election campaign, MiP asked all parties to make four simple commitments to the NHS in England: to fund the NHS and social care properly, to switch resources to where they're most needed, to offer a new deal to the NHS workforce, and to support managers in the NHS. As we enter another period of political turbulence, we need your help to campaign on these priorities – they're too important to wait for the politicians to sort themselves out.

Proper funding for the NHS

It's hard to find anyone outside government circles who thinks the NHS has enough money to deliver what we expect from it. Even the government's Office for Budget Responsibility thinks we'll inevitably need to spend a bigger slice of GDP on healthcare – and has pencilled that into its long-term projections.

Of course, you know this already. MiP members work up close and personal with the effects of underfunding: longer waiting times, missed targets, a GP service in crisis, and social care and community health services under unsustainable pressure.

The Five Year Forward View (5YFV) says we should "take action on prevention, invest in new care models, sustain social care services, and over time see a bigger share of efficiency coming from wider system improvements".

> "The NHS spends just 2p in the pound on administration, compared to 5p for health services in Germany and 6p in France. Bureaucracy doesn't come much leaner and cheaper than this."

Managers know the reality is almost the exact opposite. Public health funding has been slashed, there's little or no money to invest in integration, and social care services are falling apart. What efficiencies there are come from staff cuts, freezing pay, and squeezing budgets and hospital tariffs.

Managers know that long-term social care is a ticking time-bomb under the whole system. This is so important that last year's MiP conference overwhelmingly supported any new money going into social care rather than the NHS itself.

But, as Theresa May's disastrous manifesto proposals showed, it's a political minefield. We believe the political parties must work together on a long-term plan for social care: if they don't like so-called "death taxes", let's discuss the alternatives, agree a way forward and take action before it's too late.

As well as this, we're calling on the new government to close the healthcare funding gap with comparable countries like France and Germany by raising spending from 9.8% to 11% of GDP. If they can afford it, so can we.

Switch resources

The 5YFV built on a powerful consensus among politicians, NHS staff and other experts that we need to switch resources and do things differently. But change is politically tough. People strongly support their local hospital and tend to oppose switching resources towards other services, especially ones that have yet to materialise.

This is why we need an open, transparent conversation with communities and healthcare professionals. It's wrong for the NHS and local councils to plan in private and then try to steamroller change through without taking local people with them. And we know that staff and local managers need to be meaningfully engaged – nothing will happen without them.

It's becoming clear that our fragmented and piecemeal approach to improving services isn't delivering the change we need. Social care is on its knees, spending on public health has been slashed, and mental health is still not getting the priority in local plans that was promised. And we lack a comprehensive workforce strategy to deliver the change we need.

We're calling on the new government to endorse "triple integration" of acute, community and social care services, and make sure local people have a meaningful say in the plans. We need to Involve staff, including local managers, more systematically and earlier in the process. And we need transformational funding to stabilise the system and run new services alongside old ones for a period of time.

A new deal for our workforce

The new government must stop hiding behind platitudes about the NHS workforce. Staff shortages are already a serious problem and the uncertainty hanging over colleagues from other EU countries simply makes them worse.

Pay isn't everything, but it's a big something. If you don't pay people properly for doing difficult jobs, sooner or later they will go off and do something else. When NHS employers, unions, the Institute for Fiscal Studies, Simon Stevens and virtually every independent healthcare expert thinks NHS staff need a pay rise, even the Treasury must see that the game is up.

Many staff already face unacceptable workloads. A quarter experience bullying and harassment, and many more feel pushed around by endless changes about which they're never consulted. Staff are still highly engaged, but we're stretching them to the limit.

As unions, it's our job to demand higher pay and better working conditions for NHS staff. But this matters to everyone in this country: the NHS is a people business, and quality of care depends on the skills, performance and engagement of all staff.

We know there's a direct link between bullying and poor care. We know people work better when they have secure, high-quality jobs, and when they're involved in decisions that affect them. We know we need flexible employment packages and proper investment in training and skills. We know mistakes are expensive, that we still spend more than £3bn on agency staff, and that the NHS is losing key professional skills – as the recent WannaCry cyber attack brutally demonstrated.

The last government had no plan for any of this. The NHS workforce needs a new deal from the new government. That must include a realistic pay policy to end poverty pay and ensure pay at all levels keeps pace with the rest of the economy. We need a comprehensive workforce strategy, meaningful action to tackle bullying and harassment, and a permanent right to remain for all EU staff working in the NHS.

STURTI

Supporting NHS managers

Managing in the NHS and social care has never been more demanding than it is now. We're trying to integrate two complex, fast-developing systems, both under enormous pressure, with dwindling resources and flaky political support.

The new government needs to stop pitting "frontline" doctors and nurses against "back office" management and support staff. Skilled managers matter, just as skilled porters, cleaners, administrators and accountants matter. They're all integral to the system and they're just as committed to the NHS as doctors and nurses.

Good planning is vital. Good relationships are vital. We need top-notch information and financial management, and state-of-the-art communications. The superb response of the NHS to the devastating terrorist attack in Manchester was the result of skilled and dedicated clinicians and managers working together across the city's eight trusts.

Does anyone really think our doctors and nurses need *less* support than now? According to the OECD, the NHS spends just 2p in the pound on administration, compared to 5p for health services in Germany and 6p in France. Bureaucracy doesn't come much leaner and cheaper than this.

The new government needs to take NHS management seriously. When we plan new services, cut jobs or merge back office functions, let's actually assess the impact on patient care. Let's invest in management skills at all levels. And, as health minister Philip Dunne said, let's "reset the rhetoric around NHS managers". Cheap, baseless attacks on NHS managers just drive people away and undermine those who remain – pushing us back to outdated and, sometimes daft, ways of running the NHS.

We're not asking for kid gloves or special treatment. We're just asking for NHS managers to be treated as the dedicated public servants they are. In all other walks of life, we value skilled professionals and good managers who get things done. Our NHS, its staff and the public we care for deserve nothing less. ■

Have your say: Are these the right campaigning priorities for MiP? Can you help by telling us your personal stories about what's happening on the ground? Get in touch with Dylan Underhill on mip@connectpa.co.uk.

legal**eye**

Rakesh Patel gives some pointers on how managers in the NHS should handle race discrimination complaints from staff.

While we hope it never occurs, some MiP members will have to investigate allegations of race discrimination or sit on grievance panels adjudicating on race discrimination complaints. Unfortunately, complaints like these do happen and it is important that managers are aware of how they should deal with it, the protocols to follow and the pitfalls to look out for.

Under the Equality Act 2010, 'protected characteristics', such as race, are protected from direct and indirect discrimination, harassment and victimisation. This means that employees cannot be discriminated against because of their race in the workplace – whether in recruitment or promotion, during training, or in dismissal and redundancy processes. Members should also be aware that the law does not only apply to 'employees' as narrowly defined. Interns, apprentices and self-employed contractors are also covered.

Public sector bodies, including the NHS, are under a duty to consider equality when making all decisions on service delivery and employment. This means that public bodies must give due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act
- advance equality of opportunity between people from different groups
- foster good relations between people from different groups

If an employee makes a claim of race discrimination, it is vital that the complaint is dealt with seriously and promptly. Many employees may 'suffer in silence' for a period of time if they feel they have been discriminated against, so it is important that, when and if they do come forward, there is no hesitation in investigating the issue. Once a complaint has been made, it is important to be receptive to the employee and make a note of every piece of information given. This can give you a clear picture of the issue in hand and makes it easier to pass on the information to the relevant managers.

You should seeking advice from HR professionals in your organisation at an early stage. They should have the expertise on how to deal with the complaint and what to do next. It is important there is no delay in progressing a complaint as inaction can lead to further problems and could exacerbate the situation. It should be reported to the most senior level of management possible.

Managers should always keep records of the procedures followed in dealing with the complaint and how quickly it has been progressed. If an employee feels their grievance has not been handled fairly, these records could be an important piece of evidence in the event of an employment tribunal.

While it can be hard for an employee to prove that they have been discriminated against because of their race, a complaint which is not dealt with correctly may affect relations between the employee and their employer and could influence the tribunal proceedings and the final decision.

Managers should be aware of the damage a finding of discrimination can do to individuals and organisations. If a complaint is upheld in an employment tribunal and an individual is found to have been discriminatory, this will have a direct effect on the reputation of both the individual and the organisation involved. There is also no legal limit on the compensation that can be awarded in discrimination cases.

Litigation can be extremely costly, time consuming and stressful for all concerned. Therefore where possible, employers may wish to consider mediation to resolve matters. Obviously, this will only be fruitful if the employee is open to it. When effective, mediation can result in a mutually agreed outcome that provides the employee with the assurances and resolution they are seeking. However, if a successful mediation cannot be achieved, senior management will advise on the next stage of the process and the employee should be informed in writing.

In summary, all claims of race discrimination should be dealt with promptly and professionally, and by following your organisation's approved processes. Only by following the correct procedures can the best outcome be reached. ▪

Rakesh Patel is head of employment rights strategy 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.

Making the most of Agenda for Change

In today's NHS, you need to reward people as fairly as possible if you're going to recruit, retain and motivate staff. **Sara Gorton**, UNISON's deputy head of health, gives her top tips on applying the Agenda for Change agreement in ways that help rather than hinder relationships in your teams.

1. BE OPEN AND WORK COLLECTIVELY

Use the flexibilities within Agenda for Change (AfC) to fit the needs of your service. AfC can be an enabler of change, not a barrier to it. Approach your union reps with an issue, and collectively explore how you can achieve the change you want in a way that is consistent with the agreement. Try offering up the problem to staff and their reps rather than assuming your way of solving it is the only option.

2. BUT AVOID THE PITFALLS

A lot of time and effort is wasted through misapplication of the AfC agreement. No matter how good your intentions, trying to make changes to how or where your staff do their jobs will usually result in bumping up against one aspect of the agreement or another. That can cause real difficulty if it comes up at a late stage, or even ends up in a legal wrangle. It's nearly always avoidable if you...

3. ...KNOW YOUR ONIONS AND USE YOUR ANORAKS!

Trade union reps are often experts on AfC, with incredible eyes for detail. Don't be afraid to use their expertise, particularly with things like job evaluation; they'll be happy to help. If you get stuck on an interpretation, you can refer points of disagreement to your Joint Negotiating Consultative Committee and via them to the NHS Staff Council – it's what it's there for.

4. DON'T GET CYNICAL

Your staff know you're under pressure to deliver more – better, faster, and cheaper. They will see through attempts to manipulate the system. Make sure you risk-assess any changes for their impact on discretionary effort (see below) and tread particularly carefully with shift or rota changes.

5. CHECK THE RULES ON RE-PROFILING

If you're changing the skill mix in a team, follow the guidance in Annex 24 (formerly Annex X) of the AfC agreement. It's there to help protect against perceptions of 'down-banding' and help you assess the impact of changing some roles on the rest of a team.

6. RECOGNISE DISCRETIONARY EFFORT

If you manage diverse teams of staff, you might not be aware just how much work they do for free. Assess the 'goodwill quotient' in your units – it's only by understanding this that you'll be able to control the risks of change.

7. ASSESS FOR ROLE CREEP

Many staff will have accrued additional responsibilities when teams and their priorities have changed. Opportunities to develop can keep colleagues enthusiastic about coming to work, but make sure job descriptions are an accurate reflection of what people actually do. Ultimately, proper job evaluation ensures staff are rewarded fairly and and protects employers against equal pay claims. You'll need robust internal processes and regular checks that job evaluation is consistent. Where someone has taken a real step up, you should probe for re-banding possibilities.

8. RESPOND TO THE HUMAN COST OF PAY RESTRAINT

NHS pay policy has meant a real-terms cut of around 12% since 2010. This will be a concern for most staff, but it may mean extreme hardship for some, with all the health and wellbeing issues that come with that. Understanding the impact of lost pay on your staff will help you give the right support and advice.

9. FIND OUT WHY PEOPLE ARE LEAVING

The most common reason for leaving recorded by the NHS is 'resignation - other'. Consider digging into this – you could ask a specific question in exit interviews (e.g. "were there any reasons associated with your pay, terms or conditions that were a factor in your decision to leave the team/organisation?") or follow up after people have left.

10. FINALLY – GET THE BASICS RIGHT

Yes it's basic stuff, but making sure staff are paid accurately can make a difference. For example, miscalculations with holiday pay are really common – and fixing them is a fairly easy way of demonstrating honesty and goodwill.

The up-to-date *Agenda for Change Terms and Conditions of Service Handbook* is always available from the Staff Council pages of the NHS Employers website, where you can also find information on job evaluation and other advice on how AfC works. Visit: bit.ly/nhs-staff-council

CSUs

A national voice for members in Commissioning Support Units

With mergers and the loss of some contracts to the private sector, members in CSUs need MiP's support more than ever. National officer **Jane Carter** explains how the union makes sure their voice is heard at national level.

The CSU partnership forum sub-group was set up to enable detailed discussion between unions, employers and NHS England on organisational change affecting Commissioning Support Units, as well as national issues which arise from time to time, such as funding, STPs and workforce policies.

The group is part of NHS England's industrial relations framework and is therefore subject to the same terms of reference as other national partnership forums. CSU staff are employees of the Business Services Authority (BSA) – an arm's length body of NHS England – and CSU staff are hosted by the BSA under a memorandum of understanding.

MiP have two representatives on the group, myself and Phil Kennedy from NEL CSU, which supports Clinical Commissioning Groups (CCGs), mainly in London and the home counties. We are there to gather information and take part in consultations and negotiations with CSU managers on matters relating to employment and the implications of planned organisation change. We stand up for managers and make their voices heard.

On our radar

Key issues for the CSU partnership group at the moment

Governance reviews

This work includes an audit by Deloitte with an in-depth follow-up by the CSU Transition Team at NHS England. Workforce is one of four areas under review – with discussions particularly focusing on equality issues. Other areas include finances and how CSUs can work more closely with STPs, accountable care organisations and vanguards.

Mergers

The recent merger between NEL CSU and South East CSU, for example, raised many concerns among both staff and client CCGs.

Transfers of staff

Discussions on the terms under which staff may transfer to other employers – particularly local councils – are continuing, with particular concerns over equal pay and pension rights.

Cost cutting

All CSUs are under pressure to cut costs, especially property costs for CSUs based in London and south-east England. Some CSUs are looking at flexible and remote working solutions.

Competitive tendering

CSUs must compete for services via the Lead Provider Network. Although CSUs have demonstrated they can compete successfully against the private sector, the procurement process is resource intensive and hard work for CSU staff.

This work is important because there is no other forum where NHS England can inform and negotiate with trade unions at a national level on matters affecting CSUs. Working with NHS England, we try to emulate and enhance the good partnership relationships that already exist in many local CSUs.

At our meetings, the group receives and ratifies CSU policies which have passed through the policy sub-group of the National Partnership Forum, and we receive reports from every CSU. The CSUs group has successfully challenged local processes for redundancies and TUPE transfers from one CSU to another, as well as the process under which CSUs became autonomous in 2016. We were also engaged locally in the winding up of the Yorkshire and Humber CSU, including the transfer of staff to the eMBED consortium, which wone the contract to provide services to the region's CCGs.

When they were set up as part of the Lansley reforms in 2013, there were 19 CSUs, but as a result of mergers and the functions of some being taken over by Kier Group and other private providers, only six remain. CSUs are no longer geographically defined, which means in some cases their customers are local or regional clinical commissioners, and in others they include CCGs in other parts of England. Some CSUs also provide

"This work is important because there is no other forum where NHS England can inform and negotiate with trade unions at a national level on matters affecting CSUs. Working with NHS England, we try to emulate and enhance the good partnership relationships that already exist in many local CSUs."

services to NHS England, local government and acute trusts. It also means CSUs are competitively positioned to work at scale across a wide geographical footprint.

The most successful CSUs will have the ability to be flexible in response to the changing NHS climate as well as being able to market themselves successfully to win contracts from trusts.

As a result, the future of CSUs depends on widening the scope of their work to offer support to the new regional collaborations being created by STPs. There is an important role for CSUs to playing in developing robust partnerships, developing new ways of working and identifying the key drivers of local health priorities – and how these can be addressed for each STP footprint. ■

If you want to know more about the work of the group, or about MiP's support for members working in CSUs, contact Jane at j.carter@miphealth.org.uk.

MIP REPS

Building our network of local support

MiP's first eight reps are already in action, following a successful pilot training course in May. The union's development programme for reps and link members will offer you a new level of workplace support.

MiP's first reps have taken up their roles following the successful pilot of our new training course in May. The course was attended by eight existing link members keen to develop their work representing and speaking up for MiP members in the workplace.

The reps training course follows on from the basic training course undertaken by link members and aims to equip reps with the skills and knowledge they need to do more advanced union work, such as negotiating with local employers, supporting members with problems at work and representing MiP in partnership forums. Members who have successfully completed the course become accredited MiP reps and work closely with the MiP national officer looking after their region.

The two day course introduces reps to the way the union works and covers a wide range of skills including negotiating, chairing meetings, employment rights and partnership working. Trainees examine a number of case studies, and discuss how they would handle situations arising in their own workplaces. They also consider how they can best use their existing skills in their union work.

The pilot course, which took place in London on 4-5 May, was facilitated by Unison education officer Jim Lewis, working with MiP national officers Corrado Valle and Claire Pullar, and MiP's office manager, Billy Turner, who runs the training programme.

Feedback from delegates was positive, and their comments will be used to refine and improve the course for the future. "The course met all the outcomes, provided excellent networking opportunities and good course materials," said Gail Bannister, a new rep from MiP's north-east region.

With trained reps already taking up their new roles and with more courses planned, Turner says the union is hoping to quickly expand its network of local support. "For example, we have two reps in Brighton and Sussex University Hospitals who are now accompanying members to 1-2-1 consultations. This provides a new level of support, as our national officers cannot normally attend such meetings with members," he explains.

The reps training programme comes at a crucial time for MiP, as the union seeks to expand the support it offers members in response to the widespread and complex changes expected to be unleashed by Sustainability and Transformation Plans (STPs).

MiP chief executive Jon Restell said: "Many employers are enthusiastic about the development of MiP reps because they can help support organisational change and encourage good teamworking in organisations under severe pressure. Our reps offer a powerful blend of management and trade union skills, and can help to tackle problems in the workplace and make sure staff are properly consulted and involved in system changes." ■

The next link members' training course takes place on 20-21 September in London. If you're interested in training to become an MiP link member or rep, please contact Billy Turner: b.turner@miphealth.org.uk

What our reps learn

The two-day MiP reps' course covers the basics of what you need to know to support and represent members locally, including:

- **The role of MiP reps**
- **Representing members**
- **Negotiating with employers**
- **Chairing meetings**
- **Working in partnership forums**
- **Employment rights**
- **Unfair dismissal**

One senior manager says the SNP government deserves credit for its realistic and supportive approach to reforming Scotland's NHS.

I'm no Scots Nat, but they know what they're doing on health

I'm a senior manager in NHS Scotland, managing a large budget and a substantial number of staff. We have the same challenges as our counterparts in England, but – though I'm not a nationalist – the Scottish National Party deserve an above-average score for their management of health and care. There is, however, one looming problem that could undermine their policies.

My biggest challenge is balancing four competing demands: keeping within budget, treating people inside 12 weeks, maintaining service quality and ensuring patient safety. With demand for services, multiple morbidities and drug prices constantly rising, I can't achieve all four. So I have to make choices – and those are really lonely decisions.

It's like walking a tightrope, with crocodiles on one side and lions on the other, while being followed by someone with a knife. My response is always to focus on quality and safety: whilst I might lose my job for overspending, if something goes badly wrong on safety, I could be responsible for a patient being harmed or end up in court.

In Scotland, we have no purchaser-provider split or competition between health providers. Regional health boards run both primary and secondary care – it's a more collaborative model than England. That's particularly helpful at the moment, as in April 2016 we merged health and social care and created Integrated Joint Boards (IJBs) at the local authority level to manage combined budgets. This gives us a fighting chance of being able to build sensible plans for the next crucial steps.

The government's strategy is to move more money into the IJBs, which I support – but it means that acute budgets and services will take the pain. So we need to reduce demand for them by working jointly with our IJB partners to provide non-acute models of care – for example, by creating new care home places or elective care centres.

JOHN LEVERS

Quite bravely, the SNP also has a 'Realistic Medicine' agenda, which is about having an honest conversation with the public about over-medicalisation and trying to ensure that all treatments have real benefits for patients. That provides an opening into difficult conversations about our ability to meet competing expectations on waiting times, quality, safety and budgets.

So the SNP do recognise the huge pressures we're under, and the need to bring down demand for acute services. If the opposition brings up a patient's case in First Minister's Questions, the heat can turn up quite quickly and it all gets a bit political. But they do try to be supportive, particularly when the media try to whip up a (non) story.

Demand for health services is going to outstrip supply for a generation; unless there's significant tax changes, we'll always be climbing a very steep hill. On balance, I think the Scottish Government has the right policies to minimise the steepness of that hill.

It is a leap of faith, though. Will we be able to transform our services? Will the public accept that patients won't always get the treatment they feel they need? Will politicians be willing to stay the course? And there's another major obstacle: staffing.

There's just not enough medical and nursing professionals coming through the system. We try to plug the gaps with agency locums, but they're expensive; and it's even harder to recruit into services that are already reliant on temporary staff

The problem is partly rooted in our education system's failure to train enough healthcare professionals, and partly due to Brexit: our EU staff are really concerned about their futures here. This is a serious threat to our IJB plans, which rely on EU staffing in new health and social care facilities. I'm no fan of the SNP, but they've been really positive about protection for EU nationals. In the end, though, it all depends on the final settlement with the EU – and that's in the hands of the UK government.

So it looks like I'll be walking that tightrope for a long time yet. Right now, its far end is anchored to the SNP's health policies. But as I said, they're built on a leap of faith. And if they don't work out, then I won't be choosing between the lions, the crocs and the knifeman. I'll be facing them all at once. ■

The Sharp End is your chance to tell politicians and civil servants how their policies affect your work and your organisation. This story was published in the *Guardian*. If you'd like to work with a reporter on your own story, email us at thesharpend@healthcare-manager.co.uk. Anonymity is guaranteed.

Our pledge to you

THOMPSONS
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STANDING UP FOR YOU

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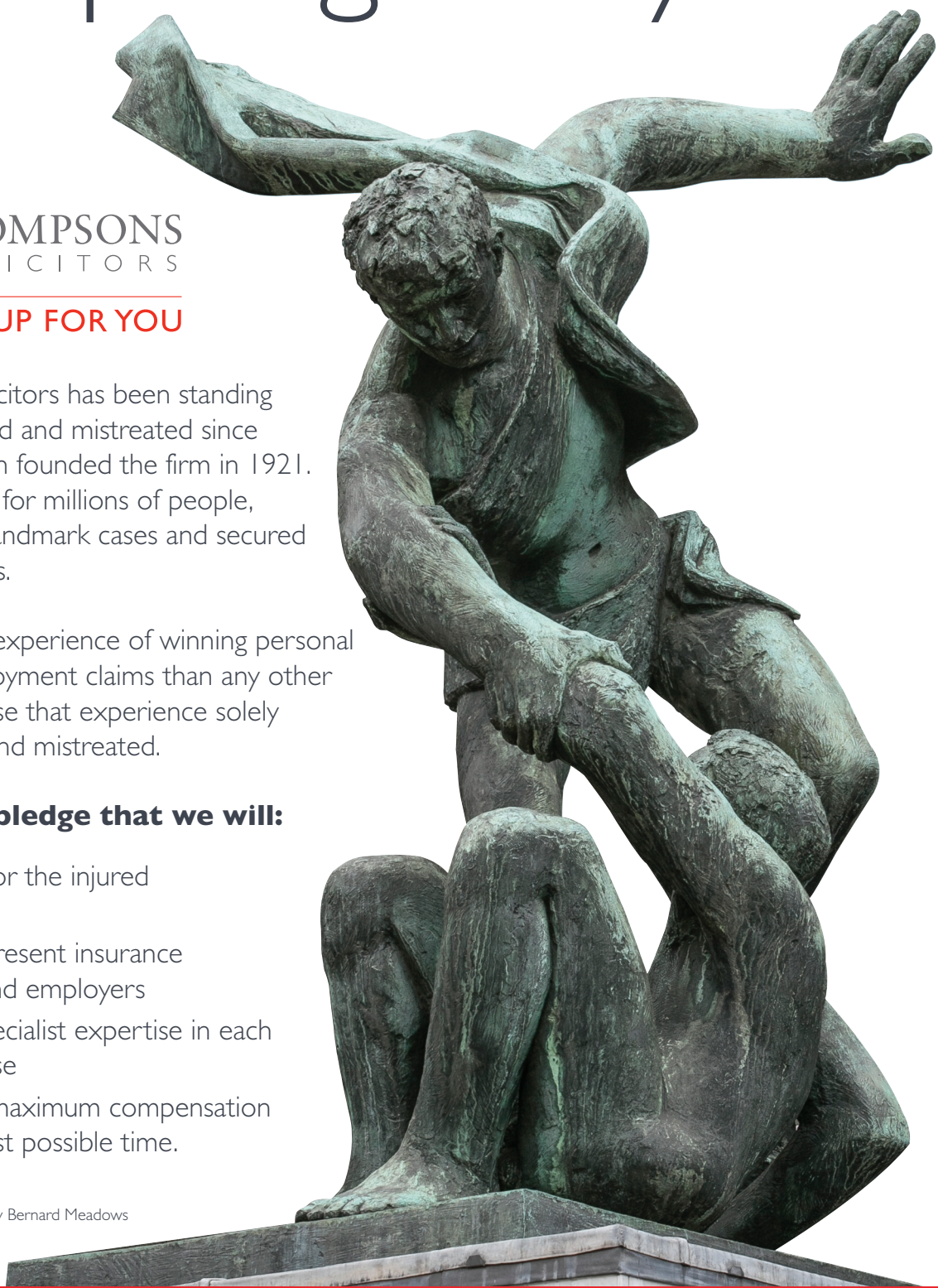

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Free to attend for MiP members

MiP Members' Summit 2017

ACTIVE MANAGERS, ACTIVE UNION

Tuesday 31 October 2017 ■ 9.30am-6.00pm
Westminster Central Hall ■ Storey's Gate, London SW1H 9NH

We are excited to announce 31 October 2017 as the date for the MiP Members' Summit 2017, our new look annual event for members from across the UK – a full day of interactive training and practical workshops, debate about our union priorities and networking with other members. The summit will give personal support and a voice to members as both employees and managers in health and care.

The day will include:

- 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
- Learning from positive experiences to take back to your workplace

After the summit, we will walk across Parliament Square to the House of Commons to host a parliamentary reception and lobby MPs on support for health and care managers.

mip
managers in partnership

More information will be available soon at www.mipsummit.co.uk