Issue 43
Autumn 2019

healthcare manager

Trauma at work: the shocking truth

SPECIAL REPORT:
We speak to MiP members who have contracted PTSD just trying to do their jobs as NHS managers. They got little or no support from their employers and most have lost their jobs. The bullying and harassment of hard-working managers is a blight on our NHS. Help us to stamp it out.

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inside

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Managers in Partnership

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

I've been writing about employment for more than 25 years and have interviewed hundreds of people about their experiences at work. Generally, our workplaces—in the NHS and elsewhere—are better than they used to be. We understand more about how working culture can affect people's mental health and performance. We know more about what stress does to us. And the sort of bullying and harassment that was commonplace a quarter of a century ago is no longer tolerated in many workplaces.

But as our special report on PTSD (*see page 15*) shows, we should have no illusions that toxic workplaces are a thing of the past. Bullying and harassment remain a particular problem in the NHS. We know it from the persistent findings of NHS staff surveys. We know it from our caseloads at MiP and UNISON. We know it from talking to our own colleagues and contacts.

I was genuinely shocked by the severity and longevity of the bullying we uncovered, and the seemingly uncontrollable effect it had on our members' mental health. But perhaps even more shocking was the total failure of their employers either to tackle the bullying, or to support our members through a mental illness caused by working for them.

I want to thank the three brave women who allowed us to publish accounts of their horrendous experiences, as well as other MiP members who helped with our research but couldn't speak out because of fear of losing their jobs, legal restrictions, or simply because their mental health is still too fragile. They deserve not only our thanks, but our full support as colleagues and trade unionists—and they will get it.

Craig Ryan, Editor

heads up

News you might have missed and what to look out for

Pay

Unions plan joint pay claim for 2021

NHS unions, including MiP, have agreed to work together on a joint pay claim for 2021, when the current three-year NHS pay deal for Agenda for Change staff expires.

Unions representing all staff except doctors—who are not covered by Agenda for Change—have held initial talks and are consulting with members on priorities for the 2021-22 pay round. The move follows the successful joint approach to negotiating the 2018 pay deal, which saw the first meaningful pay rises for many NHS staff in eight years as well as significant restructuring of the Agenda for Change pay system.

Helga Pile, UNISON's deputy head of health, said the unions would soon be engaging with members and activists on what should go into the new claim.

"This will involve asking for views on the impact of the current deals and members' priorities for the 2021 pay round," she explained. "It's also a chance to gauge how strongly members feel about pay issues relative to other workforce matters and any views on how pay settlements should be arrived at in future."

MiP chief executive Jon Restell said that, while most MiP members had welcomed the 2018 deal, there was some "unfinished business" for managers which the union hoped to address in new talks.

"MiP has some specific member concerns which we will want to address in the next pay round," he added. "High on the list will be avoiding any cap of the general award for staff on the higher pay bands: it was unfair and damaged morale."

An apology

In an article in the last issue ("Review disciplinary policies to protect staff, trusts told", *HCM42*) we mistakenly used the term "committed suicide" in connection with the death of nurse Amin Abdullah.

We're grateful to readers for pointing out that this phrase is outdated and offensive, and contributes to the stigmatisation of people with mental health conditions. We recognise that more sensitive phrases, such as "died by suicide", should be used. We apologise to Mr Abdullah's family, service users and all NHS staff working in mental health, and have taken steps to prevent such errors occuring in future.

Your new National Committee

Nominations for MiP's National Committee elections closed in early October, with all candidates elected unopposed. Four seats remain vacant and by-elections to fill these vacancies will be held in due course.

MiP NATIONAL COMMITTEE 2020-22

East Midlands: Anthony Nichols

East of England: Stuart Quinton

London: Sandie Belcher and Richard Carthew

North East: Clare Bannister

North West: David Cain

Scotland: two vacant seats

South Central: 1 vacant seat

South East Coast: Phil Kennedy

South West: Geoff Underwood

Wales: Helen Harris + 1 vacant seat

West Midlands: Yvonne Richards

Yorkshire and the Humber: Jeremy Baskett

Read more about your new National Committee members in the next issue of Healthcare Manager, or take the chance to meet them in person at the MiP Summit on 7 November (see page 24 for more details).

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leading**edge**

Jon Restell, chief executive, MiP

We live in a world where leadership and competent governance and management appear to have gone AWOL. I'm not going to waste time making the case for how politicians across the world have let us down. But most of us look at the populism and Bannonism that has captured so much public support—especially among the crucial middle—and despair.

Despair, not just at the crude uselessness of the populists, but also at the limp response to them. I meet more and more people who have become apathetic about leaders and the political process, and have started down the dangerous path of disengaging from the political space. I include myself among them. As I write this, I'm deciding whether to spend tomorrow night at a selection meeting for a parliamentary candidate for the constituency in which I've lived for 20 years. I'm not thrilled at the prospect, mainly because I'm not sure it matters.

Before you reach for the bottle—and I happily stopped doing that over a decade ago!—I should remind you that I'm a perennial optimist. And while I feel this unease—and, occasionally, dread—about the world in which we live, I also know that none of us are powerless to do something about it.

In health and social care, there is much that managers can do. Over the last three months, I've sat through some impressive debates about leadership in the NHS. Of course, we still sometimes seem to be going round in circles, and there's always the risk that energy can get dissipated or focussed simply on getting heads on spikes. But overall, I feel that there has been a breakthrough in thinking about workplace culture in the NHS, especially in respect of managers.

In health and social care, there is much that managers can do. Over the last three months, I've sat through some impressive debates about leadership in the NHS. Overall, I feel that there has been a breakthrough in thinking about workplace culture.

What's different this time is the huge cracks that have opened up in the corporate facade of the senior NHS. Chief executives and senior leaders are now openly questioning and debating the behaviour of regulators and other system managers. And those regulators and system managers are accepting that something needs to be done. This is, in my view, unprecedented, and those cracks have grown into a healthy, adult conversation between experienced leaders and public servants.

So the relationship between the national bodies and the provider organisations in England is now subject to a real conversation about standards of behaviour and support. The same conversation would be just as welcome—if not more so—in Scotland, Wales and Northern Ireland.

This important development should give more and more people in the NHS the opportunity, permission and confidence to change their own behaviour and challenge the behaviour of others. I'm increasingly using the term 'behaviour' to describe the issue and if I must use the term 'culture', I avoid preceding it with the word 'leadership'. Seriously, how would or should the leadership culture be different from the culture of everyone else?

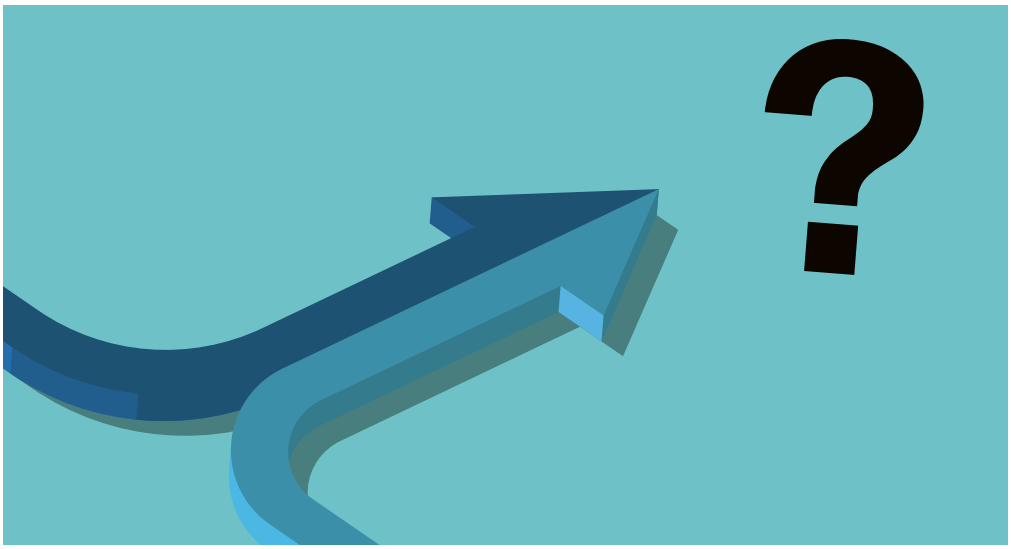
We can grasp this opportunity in so many ways, including through personal intervention. Here are three examples. I listened attentively at a meeting last week where the chair of a national body described how he intervened to challenge individual instances of behaviour that did not match the values of his organisation or the NHS as a system. On diversity and inclusion, men can be allies to women in the workplace—just see Samantha Allen's excellent guide to this on our website (bit.ly/mip-men-as-allies). And I recently shared a platform with an amazing London-based director of nursing whose great ward managers create environments around race where everyone feels valued, fairly managed and supported by the team. We're talking about how we can spread the practice.

I think MiP, its members, reps and staff can act powerfully as a professional community, amplifying the actions of individual managers and colleagues by creating awareness, hope and the kind of workplaces where challenge can be done safely.

Populism be damned: principled collective organisation and hard work still has the power to deliver for people and promote decent values. The action you take, the way you behave, and the strength you deploy—through your union and other organisations and networks—can still make a big difference, helping us to hold the line in a confused and worrying world, and to make things better wherever we can.

NHSE/I merger

Merger plans leave many members in the dark



MiP has criticised plans for the effective merger of NHS England and NHS Improvement, describing the employers' consultative document as "confusing, inadequate and, in some areas, riddled with errors".

In its response to the consultation on Phase 3 of the merger, which involves most Agenda for Change staff affected by the merger, the union said the proposed new structures were "not adequately designed" and many members were still in the dark about how the changes would affect them.

At two webinars held by MiP during August to support members affected by the merger, "100% of attendees reported that they did not feel that the consultation document was clear", the union said.

Speaking after the union's webinars, MiP policy and communications officer Mercedes Broadbent said: "Members do not believe the proposed structures match the declared strategy of putting more resources near the frontline, and find it very difficult to understand how individual roles will be affected.

"Members feel that teams have been divided without clear justification, that large areas of work carried out by teams appear to not be accounted for, and that staff structures described by senior managers are not those reflected in the consultation document," she added.

The union reported "mass confusion" over job descriptions, with some members

Pensions Tax

Pensions tax fix must cover all staff, say unions

MiP and UNISON have criticised government proposals to introduce new pension flexibilities aimed at avoiding sky-high tax charges because the new provisions would be restricted to senior clinicians.

Under revised proposals published by the Department of Health and Social Care (DHSC) in September, high-earning doctors and nurses will be able to vary the proportion of their salary on which they make pension contributions in order to avoid unexpected tax bills—widely believed to be encouraging senior staff to reduce their working hours or retire early. But the scheme will not be available to other staff, such as non-clinical managers, who are also affected by the tax charges.

MiP chief executive Jon Restell said MiP was disappointed the revised proposals had not been extended to other senior staff: "We have challenged the DHSC to show evidence that taxes on pensions doesn't affect the recruitment and retention of managers, as it apparently does for doctors and nurses. Board vacancy rates are still very high and these recruitment problems are a major threat to patient care.

"Excluding senior managers, support staff and more junior clinicians is wrong, unfair and undermines the new positive focus on the whole workforce. MiP is involved in continuing discussions with the DHSC and we are pressing the government hard for an equality impact assessment of these proposals," he added.

saying they had had no access at all to job descriptions for posts they had been matched with, while other posts had "unhelpfully generic" job descriptions which made it impossible for members to tell whether the post was suitable for them.

MiP criticised the practice of advertising some posts externally while the consultation period was still going on. "While we understand that normal business must continue to some extent during a process such as this one, MiP members found this hurtful and insensitive," the union reported.

MiP has also raised strong concerns over the equality impact of the merger plans, which it believes may lead to disproportionate redundancies among senior black and minority ethnic staff and will affect more women than men in management jobs.

Broadbent said poor handling of the merger process had sapped staff morale and led some members to consider leaving the organisations altogether. "We have received reports from members that the consultation has had a serious impact on their mental health, that they believe it has led to an increase in bullying, and that significant numbers of staff are considering their future in their current role," she warned.

If you are worried about how the NHSE/I merger will affect your job, speak to your MiP rep or national officer as soon as possible. Visit miphealth.org.uk for the latest information on the NHSE/I merger and other reorganisations affecting MiP members.

Link members

Eight more members get link-ed up

Another eight colleagues have joined the growing ranks of MiP link members after completing two days of training in October. Chief executive Jon Restell (pictured above) was among the MiP staff who took part in the two-day course, which equips members with the skills they need to act as MiP's eyes and ears at local level and support and represent MiP members. Our new link members are: Oral Arrindell, Tarlochan Boparai, Hazel Taylor, Linda Kalinda, Yvonne Richards, Anne Brockman, Iain Mallett and Lysa Hasler.

To find out more about becoming an MiP link member, visit our website: bit.ly/mip-link-members.

Pensions

Government to compensate younger members for discriminatory pension reforms

The government has accepted that a court ruling that pension scheme reforms for judges and firefighters were age discriminatory will apply to other public sector pension schemes, including the NHS scheme.

In the 2018 'McCloud judgement', the courts ruled that transitional protection for some older members of the firefighters' and judges' pension schemes, offered when reforms were introduced in 2015, discriminated against younger staff. The government's attempt to overturn the decision was rejected by the Supreme Court in June.

The government has now accepted that the judgment will apply to all public sector pension schemes with similar protection arrangements. This includes the 2015 NHS scheme, which allowed members due to retire before October 2025 to retain some or all of their benefits under the previous pension scheme. The ruling that this amounted to age discrimination means younger members of the NHS scheme must be given some form of remedy for not being offered the same protection.

"What form this remedy will take in the NHS scheme, we still don't know," said MiP chief executive Jon Restell, who is a member of the NHS Pension Scheme advisory board. "MiP is working with the other NHS unions, employers and government departments to understand the implications of McCloud for the NHS scheme, and we will keep members closely informed."

Spending review

Training and social care budget left short by 'underwhelming' settlement

Chancellor Sajiv Javid announced increases of 3.4% for Health Education England and the NHS contribution to the Better Care Fund, with an extra £1bn for council-provided social care.

Government promises of extra cash for healthcare education, social care, NHS capital investment and public health programmes fall well short of what's needed, according to MiP and healthcare experts.

Chancellor Sajiv Javid announced new budgets in September for the four areas, which are not covered by the 2018 NHS funding settlement, as part of the government's one-year spending review. The government plans include increases of 3.4% for Health Education England and the NHS contribution to the Better Care fund, with an extra £1bn for council-provided social care.

In its evidence to the Commons Health and Social Care committee in August, MiP had warned that underfunding across these four areas represented 'an emergency situation' which was already having a significant impact on patient care.

MiP chief executive Jon Restell said: "This was an underwhelming announcement to say the least. Most of our members say they have been hit by cuts to education budgets and they are almost unaninmous in saying the funding shortfall in social care funding is damaging NHS services. There's nothing in this settlement that will change that."

The announcement also disappointed most healthcare experts, with the Nuffield Trust warning the increases were only a third of what was needed.

"Today's spending round is sadly a missed opportunity to turn around years of cuts to the crucial budgets that support the NHS and the patients who depend on it," said Nuffield's chief economist John Applebly.

He warned that the £150m boost for Continual Professional Development programmes would not even restore budgets to what they were in 2013-14. "And the rest of the budget is hardly rising, leaving almost nothing to get the additional nursing students and GP trainees we urgently need," he added.

King's Fund director of policy Sally Warren said the settlement would do little to tackle the crisis in social care. "This is the bare minimum needed to patch up services for another year and will not be enough to improve services for the people, families and carers who are being let down by the current system," she warned.

At the end of September, the government unveiled a £2.7bn boost to NHS capital investment, as part of a plan to rebuild six dilapidated hospital sites by 2025, including Whipps Cross in east London and Leeds General Infirmary.

BELINDA LAWLEY

"This is the bare minimum needed to patch up services for another year and will not be enough to improve services for people, their families and carers."—King's Fund director of policy, Sally Warren.

The announcement, by prime minister Boris Johnson in his speech to the Conservative Party conference, was given a cautious welcome by NHS Providers chief executive Chris Hopson, who pointed out that the NHS "has been starved of capital since 2010" and has a £6bn maintenance backlog.

"It's not just these six hospitals who have crumbling, outdated infrastructure—community and mental health trusts, ambulance services and other hospitals across the country have equally pressing needs," he said.

Read more about MiP's evidence on NHS funding to the Commons health and social care committee on page 22.

Bullying

NHS unions and employers call for culture of 'civility and respect' at work

MILADA VIGEROVA ON UNSPLASH

NHS staff still suffer high rates of bullying, harassment and abuse and "there is no room for complacency", according to a new report published by the Social Partnership Forum (SPF).

The SPF, the national negotiating forum for NHS employers and trade unions, launched a collective call to action in 2017, with the aim of clamping down on bullying and creating positive workplace cultures in the NHS. The report, *Creating a culture of civility, compassion and respect in the NHS*, reviews progress after the first two years and sets priorities for year three of the programme.

"Our review shows the great work going on across the service to tackle bullying, with NHS organisations the length and breadth of England implementing a wide range of initiatives in partnership with their staff. These cover: values, leadership development, partnership working, collecting intelligence, raising awareness and sharing best practice", it says.

But the report admits that recent NHS Staff Surveys show "continuing high rates of bullying across the NHS with considerable variation affecting different types of trust and staff groups, a trend that has persisted over many years".

The priorities identified for 2020-21 include:

- Investigating how the SPF can reduce sexual harassment in the NHS
- Promoting action to tackle high rates of bullying against LGBT, BME and disabled staff
- Support regional and local initiatives to reduce violence against NHS staff
- Encourage NHS organisations to make better use of their NHS Staff Survey data to identify problems and take action to tackle unacceptable behaviour
- Work with the National Guardian's Office and the Care Quality Commission to develop a co-ordinated approach to improving workplace culture in the NHS

MiP chief executive Jon Restell, who co-chairs the SPF Workforce Issues Group, which is leading the anti-bullying programme, said managers—particularly line managers—had a crucial role in promoting a culture of civility in the workplace.

"Workplace culture is strongly influenced by how managers behave and their commitment to supporting the wellbeing of staff", he said. "Managers act as role models for employees who then reflect their behaviour and values."

He added: "Employers and unions are determined to tackle this problem, and we have strong political support from ministers. As MiP's report on workplace PTSD shows, bullying can cause serious mental illness and ruin people's lives. That's not acceptable anywhere, and especially not in the NHS."

"Employers and unions are determined to tackle this problem, and we have strong political support from ministers. Bullying can cause serious mental illness and ruin people's lives. That's not acceptable anywhere, and especially not in the NHS."

Read our special report on bullying and workplace PTSD on page 15. The SPF report *Creating a culture of civility, compassion and respect in the NHS* is available online at: bit.ly/spf-bullying-2019.

Comment

The battle for maternity rights is far from over

Following the rise in pregnancy discrimination in recent years, managers in the NHS have a vital role to play in supporting pregnant women and new mothers, says **Kate Moran**.

There has been a dramatic increase in the level of pregnancy discrimination in recent years. Research by the Equality and Human Rights Commission (EHRC) in 2015 showed that 54,000 women lose their jobs each year due to pregnancy discrimination, and 77% of pregnant women and new mothers experience negative treatment at work.

Maternity Action is the UK's leading charity committed to ending inequality and improving the health and wellbeing of pregnant women, their partners and young children. Every day our expert advisers are contacted by women experiencing unfair and often illegal treatment from their employer, just because they are pregnant or returning from maternity leave. This can include, for example, refusing to address health and safety risks to the mother and baby, rejecting requests for flexible working for the flimsiest of reasons, or targeting women for redundancy, often on the basis of a spurious re-organisation.

Many women are afraid to challenge poor practices by employers. Some fear losing their job, while others in precarious employment, such as those on zero-hour contracts, fear they will see a sudden reduction in the shifts they are offered, which they can ill afford to risk.

The EHRC report showed that rates of pregnancy discrimination had increased since its previous report, published in 2005. Yet despite the clear evidence of growing discrimination by employers, the government has taken barely any action. Its response following the recent consultation on extending redundancy protection for pregnant women and new mums is a prime example of this. There were some small steps forward in terms of extending the period of pregnancy protection—but even this took more than two years to come about.

The government's proposals for protecting pregnant women from redundancy still do not address the real problem: women need the right from their first day of employment to be protected against redundancy from the start of their pregnancy until six months after their return to work. Maternity Action's view is that only in limited circumstances, such as when a business has closed or when there is genuinely no suitable alternative employment, should redundancy be an option.

There are many other steps that the Government must take to improve protection and ensure that employers are effectively deterred from behaving in discriminatory ways in the first place. Bad employers know that the chances of negative consequences are low. The costs to women of pursuing a case are high and there is no guarantee of success even if the evidence of discrimination seems clear cut. The stress of taking legal action at a time when they are often already exhausted by their pregnancy or taking care of a new baby is a major deterrent for many women. Even when they are successful, and their employer is instructed to pay compensation, many women never receive the money they are owed.

Many women are afraid to challenge poor practices by employers. Some fear losing their job, while others in precarious employment, such as zero-hour contracts, fear they will see a sudden reduction in the shifts they are offered.

Other changes that would make a real difference include:

- Better safeguards from redundancy discrimination—including protection for workers on zero hours and other precarious, insecure contracts—that enable women to be protected from the start of their pregnancy until six months after their return.
- A comprehensive review of health

and safety law and guidance by the Health and Safety Executive in order to tackle the failure of many employers to address workplace risks to pregnant women. The 2015 EHRC report found that half of all mothers either did not have a discussion about risks or did not have all the identified risks resolved. One in 25 women left their job because their workplace was unsafe. The European Court of Justice has ruled that women are entitled to a specific risk assessment that looks at their individual job and any health conditions. Employers must offer suitable alternative work or suspend a women on full pay if her job cannot be made safe.

- Women returning from maternity leave while still breastfeeding should also be entitled to a full risk assessment and need stronger rights to paid breastfeeding breaks and facilities for expressing and storing milk.
- Legislating to require employers to report retention rates for pregnant workers—one year after their return to work—as an extension of the existing gender pay gap reporting regime. This would be an effective way to check how many women are leaving soon after returning from maternity leave—including those leaving with a non-disclosure agreement—and provides an opportunity for employers to find out what more they could do to retain these valuable staff.
- Increases in Statutory Maternity Pay (SMP) and Maternity Allowance—their value has fallen in recent years to around just 50% of the national living wage. Women on precarious contracts often find that their earnings in the vital calculation weeks fall short, resulting in either not qualifying for payments or receiving less than they expected. It is not unknown for employers to reduce the shifts on offer just to avoid paying maternity pay, despite the fact that statutory payments can be reclaimed from the government.
- A review of the links between benefits and maternity payments. For women claiming Universal Credit, Maternity Allowance is treated as unearned income and deducted pound for pound from the claimant's award—while those on SMP only lose 63% because SMP is counted as earnings.
- Extending the time period during which women can make a tribunal claim for pregnancy or maternity discrimination. The level of awards against employers also needs to be increased, so they represent real compensation for the trauma, stress and loss of earnings women have experienced.

CASSIDY ROWELL ON UNSPLASH

Treating women with dignity and respect, over and above the often-inadequate statutory requirements, is likely to result in a workforce that is more committed to your organisation and service. As an MiP member, there are many things you can do to support women who are pregnant, on maternity leave or returning to work:

- Make sure a risk assessment is carried out as soon as you know a woman is pregnant—and again on her return to work. Work with her and your local union rep to draw up a list of risks and how they will be tackled.
- Make sure pregnant women or new mothers are not seen or portrayed as a burden to the organisation or colleagues. The EHRC report revealed that one in five mothers had experienced harassment or negative comments relating to pregnancy or flexible working from their employer and/or colleagues.
- One in nine mothers surveyed in the EHRC report had a negative experience related to flexible working—many had requests refused, often giving them no choice but to leave their job. Having a full discussion about flexible working requests, and involving local trade union reps, can usually result in a suitable arrangement that works for all sides. Piloting arrangements that genuinely may be more difficult to implement can help resolve any issues that arise. A positive approach to flexible working helps to reduce recruitment and induction costs and to develop a happier, committed workforce able to balance their caring needs with the job. ■

Kate Moran is senior policy officer at Maternity Action. For more information on Maternity Action's work and how to get involved visit: www.maternityaction.org.uk.

All too often people strategies in the NHS are handed down by employers, with staff, unions and patients only consulted after the fact. But Hillingdon Hospital took a refreshingly different approach. **Mercedes Broadbent** looks at what they came up with.

Better together

Hillingdon Hospitals NHS Foundation Trust is one of the first NHS organisations in England to jointly develop its people strategy with patients, staff and trade unions. The trust used conversations with clinical and non-clinical staff, the board and governors, patients and the unions to develop a plan that aims to reduce staff vacancy, turnover and sickness rates; boost staff health and wellbeing; and deliver equality for black and ethnic minority staff.

The project recently won the partnership working prize at the Healthcare People Management Association awards, which is sponsored by NHS employers and trade unions through the National Social Partnership Forum. The judges said the project showed "a combination of positive mindsets, effective working relationships and full-scale staff engagement", as management and unions worked together to tackle a range of workforce issues.

Hillingdon identified five streams of work that the people strategy needed to address:

- To attract and recruit for our values
- To educate, train and develop
- To build a productive, high performing workforce
- To transform the workforce model
- To nurture our people

The trust worked with staff and patients to develop a value system, know as 'CARES", which aims to create a culture where all staff feel valued, engaged and confident in raising concerns.

The trust worked with staff and patients to develop a value system, know as 'CARES", which aims to create a culture where all staff feel valued, engaged and confident in raising concerns.

The CARES system involves:

1. Communication: recognising the importance of listening and communicating in practice
2. Attitude: striving to understand others' needs; responding with care, compassion and professionalism
3. Responsibility: taking responsibility for consistently delivering excellence and being open in all that we do
4. Equity: recognising that people are different and valuing everyone equally
5. Safety: viewing patient, staff and visitor safety as a priority

The partners worked together to develop and embed a strong, unique employer brand which prioritises staff engagement, and is reflected across a range of media including social media. The brand will be continually refreshed in line with feedback and results achieved.

The project involves implementing values-based recruitment, based on a framework developed with managers. All managers will eventually be trained in values-based recruitment and this approach will be embedded in all stages of the recruitment process—with a specific drive to increase diversity at all levels.

The plan also incorporates delivering targeted and streamlined recruitment in order to reduce hiring times, and new initiatives to improve recruitment to the staff bank. In the future, divisional recruitment action plans will be put in place with bespoke interventions, and there will be organisation-wide initiatives and campaigns to recruit in the UK and abroad, and also to maximise student recruitment.

Hillingdon's measures to improve the learning and development experience for their staff will begin with a Learning Management System (LMS) to support e-learning and on-boarding, with one-to-one development meetings becoming the norm for all staff. Over time, this will eventually lead to career maps being developed for all staff groups.

The organisation will develop apprenticeship programmes from entry level to higher degrees. This means embedding clinical and non-clinical apprenticeship training into all hospital services, identifying gaps in apprenticeship standards and developing trailblazers. Eventually Hillingdon aims to become a government-approved apprenticeship training provider and Apprenticeship Levy funds will be fully utilised.

One of the most significant parts of the plan is the establishment of the Hillingdon Clinical School over the next one to two years. The trust is already in talks with higher education institutions

AIMS OF HILLINGDON'S PEOPLE STRATEGY

Reduce the overall staff vacancy rate to 8%

Reduce the annual staff turnover rate to 13%

Increase the trust's staff health and wellbeing scores in the NHS National Staff Survey by five percentage points

100% utilisation of Apprenticeship Levy funds

Delivery equity for black and ethnic minority staff

Some of the teams which have recently won Hillingdon's CARES monthly award.

about establishing a clinical school and deciding upon viable CPD modules and appropriate pathways to benefit the organisation and its future service provision. Once a location has been secured, staff recruited and marketing is in place, the clinical school will deliver a variety of courses, including a BSc Nursing via apprenticeship.

The trust is also focusing on leadership and management development, and is developing an improved leadership framework, a targeted talent management programme and improved succession planning for key posts.

Hillingdon is working to ensure best managerial practice by instituting a Leadership for All accountability and responsibility action plan. This aims to equip managers to deal with all but the most complex employee relations cases. There will also be new management controls to reduce agency expenditure, including a 'no purchase order, no pay' system, and a review of the trust's performance management framework.

Effective rostering and other e-solutions will be ensured by using rostering embedded across all clinical areas, and putting in place a suite of interactive reporting tools for managers to manipulate workforce information. E-job planning and e-HR tools will also be rolled out, to maximise use of the direct engagement model.

Hillingdon is also working on shared workforce solutions across the local Sustainability and Transformation Partnership (STP) footprint, including new models for temporary staffing and recruitment, and collaborative work to reduce agency rates and increase bank usage. A Capability and Capacity review has been undertaken, with the aim of eventually creating a fully integrated workforce and performance management system across the STP.

The trust is working to better understand changes in workforce supply and analyse its current and future needs. To do this, the trust will ensure that it understands future supply levels by working with higher education institutions, and by identifying gaps in the workforce. Future models will be defined with routine processes for reviewing the skill mix and analysing vacant posts. In the longer term, the trust will make plans for supporting prospective workers with social housing.

Hillingdon says securing equity for everyone is an essential part of its plan. 'EDI (Equality, Diversity and Inclusion) interventions' will be made standard in recruitment processes, and plans are being developed to tackle the gender pay gap at the trust. The trust is setting up a development centre for BAME staff and a BAME network. Finally, a new action plan to meet the Workforce Disability Equality Standard (WEDS) is being developed.

The trust is developing new ways to recognise, reward and listen to their staff, including a trust-wide 'Listening into Action'/ Improvement approach, with tailored actions to improve staff retention, informed by 'pulse' surveys, and action plans to tackle issues raised by the NHS Staff Survey being put in place on a rolling basis. Hillingdon will also implement new reward and recognition schemes to complement existing schemes, particularly focusing on external awards over the next five years ▪

Scotland's ambitious plans for partnerships across health, social care and other public services will be music to many managers' ears. But the hard work is just beginning, as Scotland's NHS chief Malcolm Wright explains to **Matt Ross**.

Hand in glove

One of the trickiest challenges in management is getting people to work together effectively across professional, organisational and hierarchical boundaries. And that makes Malcolm Wright's job one of the toughest healthcare leadership roles in the UK.

As the Scottish Government's director-general for health and social care, and chief executive of NHS Scotland, Wright handles the full range of policy, organisational and service delivery issues—unlike in England, where these briefs are split between the departmental permanent secretary and the head of NHS England. And Wright's priorities have been defined by Scotland's energetic promotion of cross-cutting agendas, including the government's flagship integration of health and social care; closer collaboration between primary and secondary providers; better partnership working between managers and clinicians; stronger relationships between senior leaders and unions; and, at local level, the involvement of health and care providers in community-led planning forums.

At least, he reflects, he's not trying to do all this in England, where trusts' governance and business models set them up to compete rather than co-operate. "Having worked at an [English] NHS trust and seen the unintended consequences of competition, I would wholeheartedly advocate a collaborative model rather than a competitive model," he says. South of the border, he believes, we've seen a "fragmentation of systems and services". But "at its heart, healthcare is a team game. Our clinicians are trained to work in teams of professionals. If you split them up across organisational boundaries and get them to compete with one another, I don't think you get the best outcomes for patients."

"Having worked at an [English] NHS trust and seen the unintended consequences of competition, I would wholeheartedly advocate a collaborative model rather than a competitive one."

Scotland's health system has long been more cohesive than England's: primary and secondary care are managed together by regional health boards, with specialised services provided by a handful of national bodies. But the government's agenda means reaching across a new set of boundaries to integrate care with local authorities, other providers and local communities. Wright brings long experience of NHS management: he's been a chief executive for 25 years, running hospitals, trusts and boards. And his broad remit, he says, provides "an opportunity to work really closely with ministers, other directors-general, board chief executives and local authorities. Collaboration across government needs that policy sign-up, and this is a unique role with the potential to make things work even better."

They will certainly need to work even better: Scotland has an ageing population with rising rates of multiple morbidity, plus patches of severe deprivation and many isolated, rural communities. Financial and staffing resources are always thin and, Wright notes, "there's a number of things that are potentially going to happen—not least Brexit and [its impact on] the availability of staff from the European Union, whom we hugely value—which will make things more challenging". Caught between rising demand and tight budgets, the Scottish Government has embraced integration as its way out of the trap—shifting resources towards community-based and preventive care, in a bid to relieve pressure on acute and emergency services.

Above all, this means bringing together health and social care. Since 2016 social, primary and community healthcare, along with unscheduled adult hospital services, have been overseen at the local authority level by 32 new 'integration authorities' (IAs). Some of these also cover social work, children's services and all acute hospital provision. Success, says Wright,

will depend on "the relationships we have: how the chief officers of integration joint boards work with their counterparts in the health board and local authority, how we work with the third sector, and how health services and local authorities are working together. When those relationships are right… we can get some remarkable results."

Inevitably, getting those relationships right has not been straightforward. Last autumn, a report by Audit Scotland found weaknesses in strategic planning and collaborative leadership, highlighting "disagreement over governance arrangements" and noting that "all partners need to be signed up to, and engaged with, the reforms."

Equally inevitably, these tensions are highest when the conversation turns to who's paying for what. "Financial planning is not integrated, long-term or focused on providing the best outcomes," said Audit Scotland, adding that financial pressures "make it difficult for IAs to achieve meaningful change". Last year, the IAs were asked to find £215m in savings.

The government is addressing Audit Scotland's concerns, Wright says, through a national review of integration carried out in February. He acknowledges the need to ease financial wrangling at the IA level, noting that health and care cabinet secretary Jeane Freeman and Stuart Currie, the local authorities' health and care lead, now oversee a national body looking "at very practical things, like making sure that integration authorities have a transparent reserves policy; that the money is there on the table; that all three partners know how it's being spent; and that where the integration authority runs into any financial difficulty, the partners come together to work on those things.

"There's a spectrum of some areas doing really well and some that are struggling a bit," he adds. "But we've got the structures in place, and I see significant signs of progress." He cites the 'hospital at home' schemes in Lanarkshire and Aberdeenshire, and the Scottish Ambulance Service's work to divert patients from A&E: "There are lots of examples where this stuff is happening today; our ambition is to see that develop across Scotland."

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But IAs are just one item on Scotland's multi-faceted integration agenda. Local authorities and health services are also involved in 'community planning partnerships' (CPPs), which Wright says are built around "a principle of place: how you work in a particular community to bring together statutory services and third sector organisations", building service delivery models that respond to the needs of individual communities. "If we involve communities in the changes that affect them, we're more likely to get better, well-informed outcomes than if we impose a grand plan on people," he comments.

Here too, Audit Scotland has its doubts, explaining in a summer 2018 report that CPPs are struggling for attention in an "increasingly complex landscape of public service reform", and pointing to tensions between national targets and the goal of allowing communities to shape their own services. "Some short-term national performance targets are making it difficult to reform services to deliver more preventive service models," the report said.

On CPPs, Wright gives less ground—arguing that partnerships can meet their national targets even while building services around local needs. "The health service has got a set of indicators, and they're not necessarily at variance with what other partners need to do," he says. "It's not an either/or, it's a both/and."

Not every field of integration is as complex: primary and secondary care, for example, enjoy unified governance and budgetary structures. "We've got

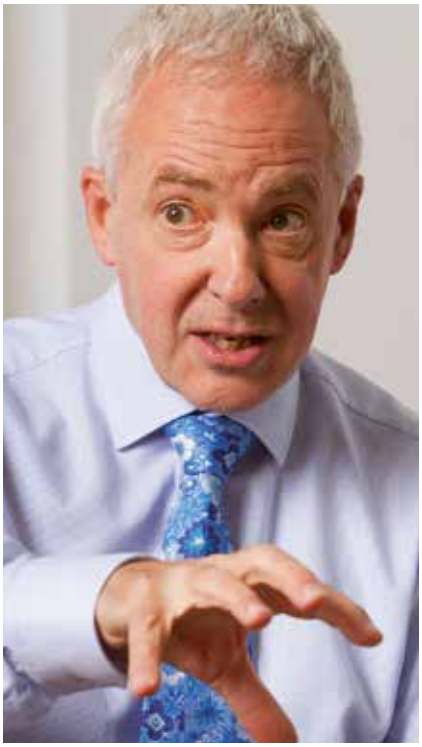
a number of good examples around the country where we're bringing GPs and secondary care clinicians together to design pathways of care that work across the piece," he says.

Even in relatively straightforward environments, though, managing integration demands a specific set of skills. Wright draws a "distinction between organisational leaders and system leaders," noting that health board chief executives must—for example—"be able to run that health board—to get the governance, the management systems, the culture and leadership in place—but they've also got important roles to play with their local authority chief executives, third sector partners, and the police and fire and ambulance and all the rest. So these are very complex roles.

"What we value in our leaders now is people who'll lead collaboratively across the system," he adds, signalling a shift away from "the kind of competitive organisational behaviours that we maybe saw previously". Supporting this change, the government's dedicated professional development scheme, 'Project Lift', aims to shape the next generation of leaders and managers, equipping them "not just to run their own bits of the organisation, but as system leaders with a much broader view of what public service in Scotland looks like".

Health and care managers must also focus on developing and strengthening their relationships with staff, Wright says. "I know from personal experience of working with the staff side that when you get into really hard, difficult positions, working with your trade union colleagues is really, really important," he argues. "If you involve staff in decisions that affect them, you'll get much better outcomes than if you try to impose things top-down."

Another key goal for managers, he adds, is to ensure staff "relate to each other with dignity and respect." Following the publication of John Sturrock's report into the culture of bullying at NHS Highland in May, he says, the government will appoint a national, independent whistleblowing champion and each NHS board will designate a non-executive director to take specific responsibility for whistleblowing. Here—for once—Scotland appears to have learned from the English system, where in 2016 Henrietta Hughes was appointed as the NHS National Guardian.



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"I very much support the development of professional management that can sit alongside clinical leads, and the notion of clinically-led, managerially-enabled services."

Finally, says Wright, managers must work closely with their clinician colleagues. "I very much support the development of professional management that can sit alongside clinical leads, and the notion of clinically-led, managerially-enabled services," he says. Managers' understanding of system leadership must be aligned with clinicians' expertise in providing care, he argues, with both sides collaborating "in a climate of mutual trust, respect and accountability."

After all, he adds, "we're only going to get the outcomes we need if managers and clinicians stand side-by-side to address the challenges." And this, too, depends on strong leadership from the top, requiring senior managers who "value clinical leadership, and proactively encourage managers and clinicians to work together."

Asked about the way health managers are viewed in the public debate, Wright says he thinks "the narrative is better in Scotland" than in England—particularly around that intersection between managers and senior clinicians. "Actually, working relationships are pretty good on the whole, and I think there is a valuing in Scotland of system leadership," he says. "I think there's much more of a culture in Scotland where we need and value good management, just as we need and value good clinical leadership."

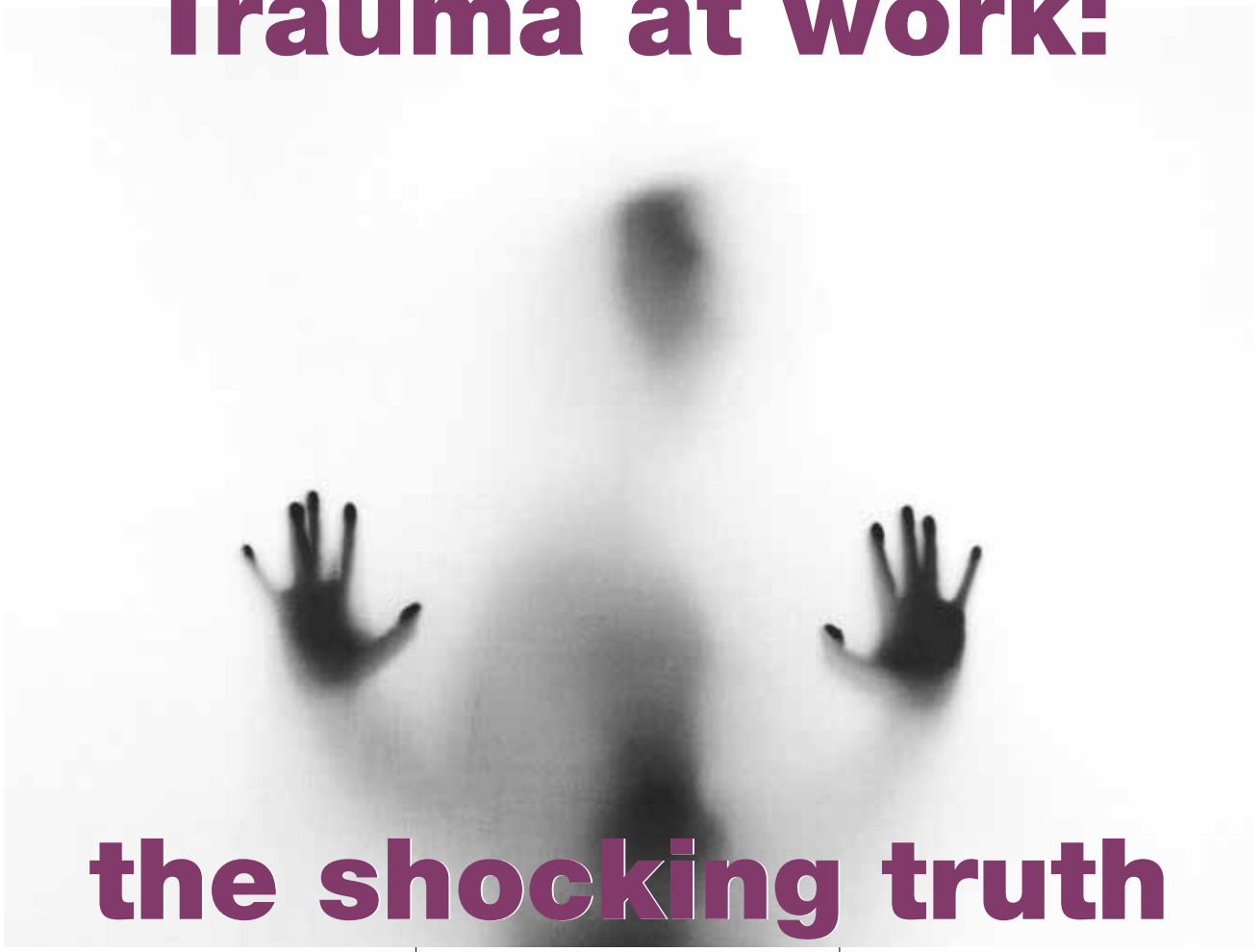
So Scotland's health and care managers face a testing period. Both IAs and CPPs require a fresh approach to joint working and service delivery. Reforms will demand strong partnerships with unions, plus good collaboration between managers and clinicians. Cultural issues are key to bearing down on bullying. And the challenges of tight finances and Brexit are unlikely to go away any time soon.

What advice can Wright offer on the skills and style managers will need to face those challenges? "My advice would be: don't neglect your personal professional development," he replies. "Make sure you're learning not only hard-edged professional skills, but also inter-relational skills; and that you can think system as well as organisation.

"The evidence suggests that we get better outcomes for patients on a collaborative model rather than a competitive one," he concludes. "I think this is a distinctive approach *vis-à-vis* the NHS in England, and I think it's one that produces a set of results that maybe we don't see in other parts of the UK. At every stage along the way, we're emphasising to all leaders of public services in Scotland that organisational leadership and system leadership go hand in hand." ■

SPECIAL REPORT: In a disturbing new trend, a small but growing number of NHS managers are being diagnosed with workplace PTSD. **Craig Ryan** spoke to three MiP members who have paid a high price for the NHS's failure to tackle toxic workplace bullying.

Trauma at work: the shocking truth



STEFANO-POLLIO-UNSPLASH.TIF

After months of bullying and extreme pressure at work, and following another traumatic meeting with her boss, Laurie, a senior manager with an NHS system body, broke down on her way home. "It was Christmas and I remember seeing the lights in the city centre," she recalls. "I was crying and crying on the train and I tried to read a book so people couldn't see how much I was crying. I don't remember walking home at all."

Laurie was soon suffering from suicidal thoughts and "horrible dreams" in which senior managers were trying to hang her. Her GP and a psychiatrist eventually diagnosed her with Post Traumatic Stress Disorder (PTSD), and she is now on a waiting list for therapy.

"Getting up for work would be almost impossible at the moment, so it's really limited my life," she explains. "I take anti-anxiety medication and anti-depressants, and I'm under a psychiatrist as well. The anti-anxiety tablets have calmed me down an awful lot, otherwise I wouldn't even be able to have this conversation."

Laurie believes her condition may be related to an extremely traumatic experience during her teenage years, which she disclosed to her occupational health department. Although they agreed with her PTSD diagnosis, Laurie's employer provided no support and did nothing to tackle the bullying that brought it on.

"Almost anything stresses me now. I clam up and freeze very easily," she explains. "PTSD strips away trust and it becomes scary—I mean, imagine not being able to trust your own family. And dealing with a lack of trust is emotionally, and therefore physically, very tiring."

Many readers will be horrified—even incredulous—that PTSD, a condition

associated with military veterans, victims of natural disasters and witnesses to horrific events, has become an occupational hazard in the NHS. Can you really get shell shock, as PTSD used to be known, just by doing your job as a healthcare manager?

Sadly, yes. Although PTSD is traditionally defined as originating in a single traumatic event, mental health practitioners in Europe and America now recognise that the same symptoms can result from continuous exposure to very stressful situations, such as serious bullying and verbal, emotional or sexual abuse. The term 'Complex PTSD' (cPTSD) is increasingly used to describe this condition, and is recognised as a variant of PTSD by the support charity PTSD UK.

The symptoms of cPTSD and conventional PTSD are identical: flashbacks, nightmares, panic attacks, high anxiety, severe depression and suicidal thoughts—often accompanied by alcoholism or drug abuse. Both are psychiatric injuries which can be treated and are not related to personality disorders.

MiP is aware of about a dozen members who have been diagnosed with workplace-induced PTSD. Most of them are women, reflecting the well-established finding that PTSD is more likely to affect women than men. Laurie is one of three women who agreed to share their experiences with Healthcare Manager on condition of strict anonymity. They have all been fully supported by MiP but, to protect their identities, we cannot reveal details of the support they received.

Like many PTSD sufferers, senior nurse manager Giselle began to drink more heavily to numb her symptoms as they developed. Her doctors believe she contracted PTSD as a result of her employer failing to deal with the psychological impact of a serious patient safety incident many years earlier, and subsequent blatant bullying from a series of managers. Giselle's condition became so severe, she was only stopped from taking her own life by police intervention.

"The PTSD diagnosis was suggested by the [cognitive behavioural] therapist and my GP, and a psychologist confirmed it," Giselle explains. "Three times I've had trauma at work and then I go into this cycle of mental health deterioration… and then in the end it becomes a disaster, and I reach a crisis point."

Workplace PTSD (or cPTSD) is caused by prolonged exposure to extremely stressful situations such as bullying, abuse or harassment. Common factors in the cases known to MiP include:

- Serious bullying by a manager or series of managers, extending over months or years, and often including gaslighting or mobbing
- Inexplicable and sometimes bizarre behaviour by managers, which is tolerated or even encouraged within the organisation
- Employers ignoring occupational health reports and independent medical diagnoses
- Individuals being kept in the dark about allegations against them
- Lack of support following previous traumatic experiences at work
- Victimisation and blaming managers for issues outside their control
- Treating mental illness as a performance management issue or character flaw
- HR and senior management backing the bully rather than the victim

Rather than accept responsibility, Giselle's employer used her symptoms against her and ignored advice from occupational health. "The trust completely said this was about my behaviour; that it's not about mental health, it's a character flaw," she says.

MiP national officer Ruth Smith, who has dealt with a number of workplace PTSD cases, says employers have been slow to recognise the condition and rarely offer the right support. "Even when they acknowledge that someone is suffering from a mental health condition, there's an expectation it will be a 'normal' condition like anxiety or depression," she explains. "The fact is that counselling and occupational health support just isn't enough to shift PTSD."

In rare cases where PTSD-specific therapies—such as eye-movement desensitising reprocessing (EMDR)—have been tried, they've met with "considerable success," she adds.

Ruth believes the PTSD cases known to MiP represent the thin end of the wedge. "What happened to many of these women—being bullied out of the job—is actually very common now, but we can't often report it because people just leave and sign non-disclosure agreements," she says. "These people have reacted psychologically very badly to something that is going on quite widely. Other people might suffer from stress and anxiety instead."

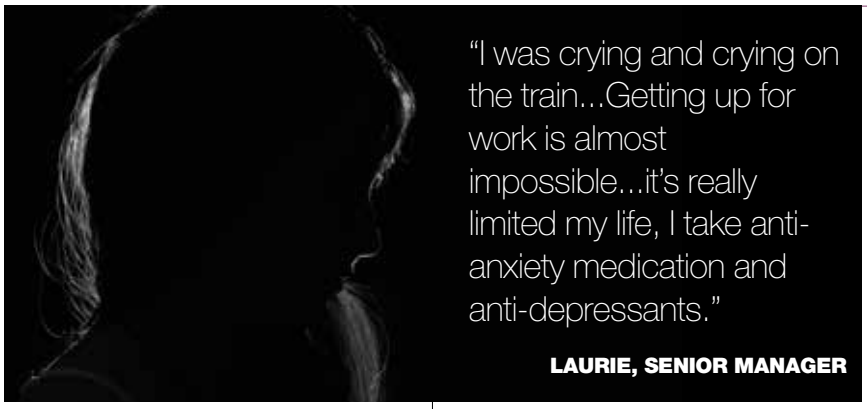
She stresses that employers have a responsibility to take action and cannot just expect people to cope. "Too often, employers are not willing to make the reasonable adjustments needed for people with serious psychiatric injuries to return to work," she warns. "That just puts pressure on people who are already vulnerable. Some of our members have suffered one breakdown after another because their employer has failed to take action despite knowing that they have a serious mental illness."

Clinical manager Steph has undergone bullying and gaslighting behaviour from a senior colleague for more than 12 years. This includes spreading and encouraging false rumours about her, deliberately exaggerating problems and even making a false and malicious complaint to Steph's professional regulator.

"She flatly just lies—that's her usual way of operating," says Steph. "But even when you know she's lying, it does make you doubt yourself… I did get my line manager and a board member involved, but nobody did anything about it—they were all just pussy-footing around her.

"She was furious that I'd been to [the board member] and she came over to the office and was screaming in my face," Steph adds. "I thought she was going to hit me."

Steph also experienced group bullying or 'mobbing' at the hands of other colleagues, many of whom seemed to have been intimidated by the same manager. "I ended up in a situation where this really close clique of people were judging my every word and move," she recalls. "It was like they were saying, 'you're nothing here, this is our world'. I heard them talking about other people in the same way. It was like a gang culture—an all for one and one for all kind of thing."



KEVIN-JESUS-HORACIO—UNSPLASH

"I was crying and crying on the train…Getting up for work is almost impossible…it's really limited my life, I take anti-anxiety medication and anti-depressants."

LAURIE, SENIOR MANAGER

Even after occupational health had accepted she was suffering from a mental health condition as a result of previous traumatic experiences at work, Giselle was repeatedly bullied by her then chief executive, and later by her line manager, a member of the trust board.

"I started to get micromanaged, I started to get bullied, I started to get humiliated," she recalls. Like Steph, she feels other colleagues were intimidated into joining in. "It was almost like classic childhood bullying. You're being bullied at school, so you become unpopular and everyone just migrates over there because it's safer. People were thinking, 'If it can happen to Giselle, it can happen to anyone'."

She found occupational health (OH) sympathetic but ultimately powerless. "The therapists they referred me to suggested PTSD, but the trust wouldn't engage," says Giselle. "We asked them why they didn't use the OH report but they just said, 'We didn't think it was relevant'. I mean, how could it not be relevant?… I was made to feel like I was lying, that I was making it up about having mental health issues to cover up my alcoholism."

No one involved with Giselle's investigation had any knowledge of mental health issues. "One HR manager admitted that he'd made up his own diagnosis about me, even though he wasn't qualified to make a diagnosis about anything," she recalls.

Laurie had a similar experience. "OH recognised my condition and recommended a stress risk assessment," she explains. "At a meeting, my manager actually had the report in his hand, but just ignored it and carried on… repeating all these allegations for which he had no evidence whatsoever."

As she describes it, Laurie's ordeal resembles a Kafkaesque nightmare, in which she was kept in the dark about allegations against her and left in state of confusion by her employer's increasingly bizarre behaviour.

"They kept sending me letters that conflicted with each other," she recalls. "One letter would conflict with the last letter, or the letter would conflict with itself, and still there was no information about what I'd done wrong, so I was utterly confused by it all.

"I thought at some point they were going to stop because it was just crazy, but it felt like they'd let it get so out of control they didn't have a way out of it themselves. I had a schedule of allegations which my MiP rep said didn't amount to anything—they either had no evidence or were really minor. One them was a complaint that I'd opened a window at a meeting!"

MiP's Ruth Smith says bizarre behaviour by employers is a common feature of the most serious bullying cases. She describes one case in which a member was inexplicably threatened with performance management measures shortly after returning from maternity leave.

"It was a high-performing service which fell apart when our member was away, because managers refused to backfill her post," Ruth explains. "They had nine months of disaster, but within a few weeks they were putting pressure on her, asking why the department hadn't come back into line.

"Managers suddenly started questioning whether she was too young to be in a senior post and making sexist comments about her appearance," Ruth continues. "Our member was never told what she'd done wrong, and just couldn't understand why this was happening to her. They were desperately trying to make out it was an issue with her performance, when there'd never been one previously."

These three cases fit a disturbing pattern MiP has observed in dozens of bullying cases across the NHS: evidence from the employee, their GP, therapists and even the organisation's own occupational health services is ignored, while unsubstantiated allegations, trivial complaints and even rumours are taken seriously and used as the basis for aggressive disciplinary or capability action.

"When someone has suffered a psychiatric injury at work, it's often a result of the way they've been treated by the management team," explains Ruth. "And then we get this defensiveness on the part of the organisation. They close ranks and go to great lengths to protect the bully. And we know that this person will do it again. It's about power. The bully is often someone who everyone is afraid to stand up against."

Employers often seem to get locked into a cycle of defending the indefensible for fear of incurring legal liabilities, she adds. "It becomes easier to just dismiss the person who's being bullied than to continue having them in the workplace. The amount of public money that goes on all the processes, disciplining people and fighting cases, is ridiculous."

The real tragedy is that the serious mental illness inflicted on these women—and the other members MiP has supported—were not just the result of the inevitable pressures of working for the NHS. They were caused by the failure of particular employers to tackle bullying at work, or to take seriously the mental health problems it can cause. For that to happen in the NHS—which more than any other employer ought to understand mental health—is a nothing short of a national disgrace. ■

The names of the MiP members participating in this story have been changed to protect their identity. To read their full stories and find out more about MiP's campaign against bullying in the NHS, visit the MiP website: bit.ly/mip-bullying.

Understanding the needs and attitudes of patient groups is vital to redesigning services, as Poole Hospital found out during its successful revamp of youth diabetes services. **Matt Limb** reports.

Listen up

Many young people with diabetes struggle to manage their condition and risk developing serious complications once they hit their mid-teens. "That's because up to the age of about 15 or 16, their parents look after it and manage it for them," explains Mike Masding, a diabetes consultant at Poole Hospital NHS Foundation Trust. From that point until they move onto adult diabetes services around their mid-20s, young patients can be especially vulnerable," he warns.

Big life challenges like exams, university, work and relationships can get in the way of clinic visits and sometimes push management of diabetes "off the rails", he says. "There's a lot of evidence in the literature to show that if young people with diabetes do badly at that time it can have a lot of consequences down the line, in terms of developing complications like foot, eye and kidney disease. Non-attendance at clinics leads to poorer diabetes control."

Masding leads Poole's Young People's Diabetes Service, which cares for around 100 patients aged between 15 and 23 with type 1 diabetes. The trust wanted to reduce high levels of non-attendance at clinics, cut diabetes-related admissions, and show improvements in the clinical control of diabetes.

Work to improve services began several years ago, using money from the Best Practice Tariff for paediatric diabetes, which allocated £2,000 to £3,500 per patient to organisations meeting a minimum standard of care for young people. A new multi-disciplinary team structure was introduced, with Masding as one of two consultant diabetologists working alongside a full-time diabetes transition nurse, a consultant paediatrician, a dietitian, a clinical psychologist and an information assistant.

> "We work holistically to really try to understand what a young person may be going through, how this may be impacting on their diabetes management and how we can best support them."

"Understanding the experience of young people has been core to the design of the service," says Sarah Cook, the team's diabetes clinical psychologist. "Many of our young people have had very difficult childhoods, adverse early years experiences and now struggle to look after themselves and their diabetes. Simply telling young people what to do, or threatening long-term complications, is rarely effective at maintaining engagement or creating change."

Young people had often been "told off" for not managing their diabetes and faced pressure to "control things perfectly", Cook explains, and some sought to avoid anticipated criticism—by not attending appointments or 'forgetting' their diabetes meter, for example. Trying to form trusting and supportive relationships with young people has been part of the team's core philosophy, Cook says: "We work holistically to really try to understand what a young person may be going through, how this may be impacting on their diabetes management and how we can best support them."

An approach based on understanding, compassion and collaboration has helped young people to feel "more accepted", she adds, and avoided some of the pitfalls providers can fall into—such as not following up challenging patients or discharging those who don't engage. Young people who repeatedly failed to attend clinics were initially visited by the nurse specialist to find out the reasons why.

Patients' psychological wellbeing is monitored informally through all contacts and measured more formally using a set of screening tools to assess diabetes-related distress, symptoms of depression and anxiety, eating disorders or hypoglycaemia.

The results are reviewed by the team's clinical psychologist and inform future care plans with the young person. They also help to identify people at risk or those who need additional assessment or follow up.

Another key initiative was to improve accessibility, so that young people could fit clinic visits around work or classes. A monthly clinic was started at a local sixth form college where a significant number of patients were studying, and Poole

The team: Mike Masding, Antoinette McAulay, consultant paediatrician, Jo Dalton, diabetes specialist nurse, Sarah Cook, clinical psychologist, Jo Hanna, dietitian, Linda Burles, Transition Information Assistant, Adam Nicholls, consultant physician specialising in diabetes.

hospital introduced a weekly afternoon and a monthly evening clinic. A specific exercise-based clinic was also set up for the many young patients who are keen footballers, sailors and runners.

After careful consideration, the team opted to use Instagram—rather than Facebook or Twitter—to maintain contact with young patients and keep them well informed. The Instagram account is used to give guidance and tips on diabetes management, with focused advice around particular times of the year like Christmas. Texts and emails are also used to contact patients, instead of 'traditional' hospital generated letters.

As well being named Diabetes Team of the Year in the 2019 *British Medical Journal* awards, after five years the Poole team can point to significant results after five years, with tangible benefits for both patients and the trust. Rates of non-attendance at clinic appointments have fallen by a third from 19.8% in 2015-16 to 13.4% in 2018-19, while hospital admissions have dropped dramatically, from 35% in 2014-15 to just 8% in 2018-19.

"That's good for young patients as being admitted to hospital interferes with their school, college, work, family life and relationships," says Madding. "It's also good for the trust, not least from a financial point of view."

Patients' diabetes control has also improved. The HbA1c test measures a patient's average blood sugar levels for the last two or three months—the higher the score, the more likely patients are to develop complications. Among Poole's cohort of young patients, the average score has fallen from 80 to 73 mmol/mol since 2014.

While an ideal level is 50 to 60 mmol/mol, this is difficult to achieve in young people, explains Masding. "Any reduction is better for the patient. Across a population of 100 people we've achieved a pretty significant fall," he says. He also points to a marked reduction in admissions for diabetic ketoacidosis—a serious problem that can occur in people with diabetes if their body starts to run out of insulin.

Masding believes the way the team has worked together has been the key ingredient in its success. A "flat hierarchy" has allowed all team members to contribute ideas equally, he says, while the co-location of clinical and admin staff has overcome an obvious potential obstacle to better care.

Masding also notes the value of regular case discussions at multidisciplinary meetings, quarterly business meetings and lunchtime reviews, and the importance of gathering data and testing ideas out to see what works.

"There's a lot of national work about group session education for people with diabetes," Masding explains. "We talked to young people and found that it was very unpopular; they didn't want to be in groups. So we offer them a menu of different education options, including online education and one-to-ones. That seems to be very popular."

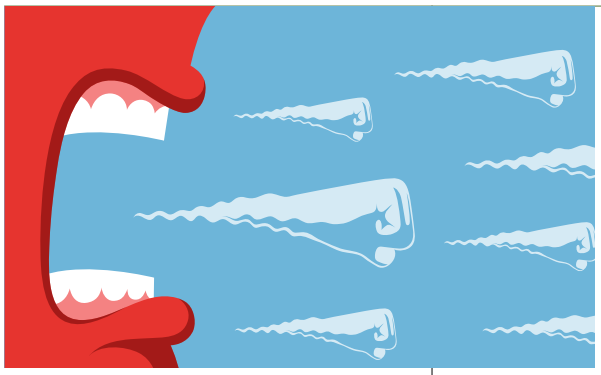
"We have embraced inclusion of young people in service design and regularly ask for patient feedback," adds clinical psychologist Sarah Cook.

The team now wants to increase its use of social media and introduce iPads into clinics so patients can give "real-time feedback" about the service. "There are new technologies coming out in diabetes—new ways of testing glucose, new ways of giving insulin through insulin pumps—and we'd like to increase our utilisation of that because, in the longer term, achieving that improves people's diabetes control and will save the health economy money in the future," Masding adds.

The team is now working with Dorset CCG and neighbouring trusts to spread good practice and apply the lessons from the project to other clinical settings. "We know the transition between paediatric and adult services in long-term conditions—not just diabetes—is a difficult time, when patients are particularly vulnerable and it's a bad thing if we're not able to follow up with them," says Masding. ■

legal**eye**

Phil Liptrot outlines the responsibilities of NHS employers and managers in protecting staff from violence at work.



No one should fear for their safety while doing their job. For many healthcare staff, however, facing assault and violence has become a grim reality of their job.

In 2018, the Royal College of Nursing estimated there are, on average, 312 assaults per NHS England trust each year. Just last year, a care worker and UNISON member from Herefordshire won his claim for compensation after a care home resident assaulted and injured him on a night shift.

The attack involved the care worker being thrown to the ground and briefly losing consciousness. The head injury he suffered in the assault left him with six months of frequent headaches, post-traumatic stress disorder and anxiety, and exacerbated his pre-existing depression.

At the time of the incident, there should have been another staff member sleeping on site, contactable by radio, but the rural location meant reception was poor and the UNISON member was unable to reach his colleague. After the assault, he had to walk to another building to find help.

Sadly, this case is typical of many we encounter at Thompsons Solicitors, and it highlights the importance of management thinking through scenarios to ensure they keep staff safe.

Keeping staff safe

Assaults at work are often preventable. Like other accidents at work, pre-emptive measures can help minimise risks. Circumstances where management can be held responsible for a workplace assault include:

- **Working alone or understaffed**
  Members of staff who are left to work alone or in a short-staffed environment can be particularly vulnerable to attacks or assaults. If a risk of violence has been identified beforehand, then sending staff to fulfil their duties alone opens up employers to a potential claim if the worst happens.

- **Ignoring previous violent behaviour**
  If a client or another member of staff has committed violent acts in the past but adequate preventative or safeguarding action has not been not taken, and that person then assaults a worker, their employer is liable. In the case highlighted above, staff had already complained to the care home's management that they felt unsafe—but no action was taken.

- **Lack of training or personal protective equipment**
  When working in a profession where someone is likely to encounter angry, violent or difficult clients, it is important that staff receive training on how to diffuse potentially dangerous situations. As a last resort, personal protective equipment (PPE), such as panic alarms, should be provided to try to prevent or limit the seriousness of injury. All safety equipment (like the radio in the claim above) should be in full working order.

New laws to deter violence

Last year, Labour MP Chris Bryant introduced a bill to substantially increase the maximum sentence given to those who assault emergency workers while they are on duty, including ambulance workers and NHS staff. The bill, which secured cross-party support, became law in October 2018.

The Assaults of Emergency Workers (Offences) Act has created a new offence of assault against an emergency worker, increasing the maximum prison sentence for assault against emergency service workers from six months to a year.

The new law is meant to deter violence in a bid to 'protect the protectors', but only time will tell if the tougher sentencing will work. The Act does not change the responsibility of managers to protect their staff.

Everyone working in healthcare—whether they work in A&E, a care home or on an ambulance—knows it can be a dangerous sector. Violence is not uncommon and some of it is unpredictable, but healthcare managers are expected to do everything in their power to identify day-to-day risks and ensure these are minimised wherever possible. ▪

Phil Liptrot is a lawyer with Thompsons Solicitors, specialising in workplace injury claims

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

Everyone hates doing appraisals, right? **Ian Reid** explains how keeping it simple and focusing on having an honest and open dialogue can banish cynicism and make appraisals something to look forward to.

How to make appraisals work for everyone

1. KEEP IT SIMPLE

Don't try to cover too many skills and competencies or set too many objectives. Keep the discussion structured by concentrating on the two or three main issues that you want to get across. If there are no performance concerns, look at the skills and attributes staff may need to develop in order to seek promotion.

2. STRIKE THE RIGHT TONE

Don't suddenly adopt a formal tone for the appraisal meeting. That just puts people on the defensive and is not conducive to the truthful and meaningful conversation you're looking for. Just stick to the same style of interaction you use in your day-to-day management. Think of the meeting as an opportunity for a constructive dialogue and to build a relationship with the people you manage.

3. FOCUS ON DEVELOPMENT

While there's always an element of performance management, appraisals should primarily be about finding a systematic way to developing people's skills and competencies. In Scotland, for example, we're moving towards a system that links appraisal to mandatory and statutory training. Use the appraisal process to check staff are up to date with the training required for their job and, if not, make a plan for completing it during the next year.

4. KEEP OBJECTIVES SIMPLE

It may not be necessary to set individual objectives for all staff; for many clinical staff, team-based objectives can work better. Keep people's objectives manageable by focusing on only the most important aspects of their or the department's work. Resolve disagreements over objectives by discussion, involving the 'grandparent' manager when necessary.

5. KEEP YOUR APPOINTMENT

One of the main reasons for staff cynicism about appraisals is that managers often seem too busy to give them their full attention. Appraisals don't need to be time-consuming if you keep it simple and focus on what really matters—it's more important to have a meaningful discussion on the day than spend a lot of time on paperwork in advance. Avoid cancelling appraisal meetings unless it's absolutely unavoidable.

PAUL THOMAS

6. DEAL HONESTLY WITH POOR PERFORMANCE

When tackling poor performance, it's important not to let things drift. Don't wait until yearly or six-monthly appraisals to raise issues like poor behaviour, excessive absences or difficult relationships with colleagues. During appraisal meetings, concentrate on the positive things the individual can do to improve their performance or behaviour.

7. AVOID GOING FORMAL TOO SOON

Once you begin formal capability or disciplinary procedures, you're closing off the appraisal route—and the possibility of resolving things by discussion more generally—in favour of an adversarial approach. Except for the most serious issues, such as gross misconduct or fraud, always try to resolve issues with an informal discussion—involving the line manager and 'grandparent' manager, if necessary—before involving HR or starting formal procedures.

8. GET THE CULTURE RIGHT

The effectiveness of your appraisal system reflects the working culture of your department. We've all experienced the quite different atmosphere in wards and departments where there's a good manager who encourages open communication between staff. Appraisals will be much more effective in an environment where staff are fully engaged and can give and receive feedback all year round.

9. IT'S A TWO-WAY CONVERSATION

Encourage staff to give feedback on the way they are managed and your own performance as a manager. Ask what more support you can give, particularly if there are performance issues to resolve. Although not directly linked to appraisal, staff engagement initiatives—like the iMatter system in Scotland, which encourages staff to report on how they are being managed and whether they are being listened to—help to foster the open and honest dialogue which makes appraisals most effective. Although impractical for most staff in large organisations, peer review and 360° appraisals can be useful tools for improving management at very senior levels, or in small organisations.

10. NO SURPRISES

The single most important piece of advice I can offer is: never use an appraisal to raise significant problems with performance or behaviour out of the blue. Always discuss such issues at the time they arise. Springing surprises at the appraisal meeting will destroy trust and ensure the discussion goes pear-shaped from the start. ■

A former senior NHS manager, Ian Reid is secretary to the Scottish NHS Terms and Conditions Committee.

An emergency situation

A survey of MiP members revealed stark evidence of the continuing impact of underfunding on both health and care services in England.

Shortfalls in funding for capital investment, training, social care and public health are threatening to undermine implementation of the NHS long-term plan in England and "represent an emergency situation", MiP has told a committee of MPs.

As part of its evidence to an inquiry into funding by the Health and Social Care Committee (HSCC), MiP presented the results of a survey of members' views on the current state of funding in these four areas, which were not covered by the 2018 funding settlement.

"The results were very stark, and paint a picture of decay, crumbling services, and imminent collapse across many areas of the NHS," says MiP's report. The survey found that more than three-quarters of MiP members said their own area of work had already been affected by shortfalls in social care funding, while 69% said they had been hit by lack of funding for training and education. Only 2% said social care services were adequately funded in England.

The report added: "The responses were numerous and very clear regarding the impact of failing to fund these areas and the likely impact on the wider economy and other public services—positive if funded, severely negative if not. Many members expressed a similar view that all of these four areas represent an emergency situation that must be responded to swiftly and with a great deal of planning."

"This is a message which has been communicated to us from our membership, not only from this survey but also from our consistent engagement with our membership on these issues," said MiP's policy and communications officer Mercedes Broadbent, who wrote the union's evidence. "Our Members' Summit in 2018 was dominated by membership concerns about social care, and the impact that struggling service provision was having upon staff welfare, including the impact on bullying and harassment."

The strongest response from MiP members came on the impact of social care funding on the NHS and other public services: 98% said social care funding was inadequate, and 97% that this was having a negative impact on NHS services.

MiP highlighted a number of risks posed by the lack of capital investment in the NHS, of which the most urgent is the physical danger to both staff and patients from unsafe buildings and equipment. MiP members reported that many buildings are not fit for purpose, for a variety of reasons. Examples included 19th century buildings which have been difficult to update, building improvements that have been chronically underfunded, and problems with temperature control that not only affect staff and patients but also make the buildings more difficult to preserve and maintain. The language used by our members is very stark—buildings are "falling apart", "poorly maintained" and "make staff and patients sick".

MiP's report welcomed "notable progress" on improving education and training in recent years, particularly with the courses and training provided by the NHS Leadership Academy, but warned that significant gaps remain. "Such gaps include that clinical staff are viewed as being given priority over non-clinical staff, especially when it comes to organisation-funded training; that it is difficult for staff to be released to complete their training; and that many members were required to self-fund their training and education," said MiP's report.

The strongest response from MiP members came on the impact of social care funding on the NHS and other public services, with 98% saying social care funding was inadequate, and 97% that this was having a negative impact on NHS services. "This is a shockingly high figure, and the responses we received demonstrate that it is a direct response to the dire impact the lack of a proper social care funding model is having upon our members and upon the NHS," says the report.

"Most members reported that they were unable to provide beds and other services for incoming patients because patients who were well enough to be discharged could not be moved through the social care system," added Broadbent. "Our members described a system rife with suffering, and where vulnerable people often fall through the cracks. Too many patients cannot receive the care they require at home, where they could be treated with dignity and continue to live relatively independent lives."

MiP members identified multiple areas of population health which they expected to worsen if public health continues to be underfunded — especially around drug and alcohol addiction, which is significant as overdose deaths recently hit

IN YOUR OWN WORDS

Responses from MiP members show the stark reality of how under-investment is undermining NHS services

GILBERTO OLIMPIO ON UNSPLASH

Capital investment

"We have high levels of respiratory infections in our team which we think is due to a wall in our office which has water leaking down it on the inside most of the year and the wall has black mould on. The trust cannot prioritise fixing it because it is an office not a patient facing area."

"I have held roles where ceilings collapsed, thankfully between patients. But it resulted in unit closure for weeks disrupting treatment plans for patients."

"The NHS is close to collapsing as staff are working ever increasing hours due to lack of resources. There's only so much that can be cut before it becomes a safety issue not just for patients but staff, too."

Education & Training

"Staff cannot attend training due to staff shortages and lack of backfill. This is also true for mandatory training. Staff are also not in the classroom because they have to respond to bleeps, emails and phone calls during training."

I believe [underfunding] it is holding me back from progressing in my career. I have been offered study leave to attend NHS Academy courses, but no funding and told I will need to find thousands of my own pounds if I wish to do a qualification."

"As a non-clinical manager I have already been told by a director that… clinical staff were the priority for education. In general admin/non clinical managers receive very little investment. If a manager who was previously working in a clinical role was now working in a non-clinical management role, then the organisation would continue to invest in them."

Social Care

"Large numbers of older patients [are] ending up in hospital, and the complete collapse in funding for drug and alcohol support is leading to more crisis admissions for substance misuse and more homelessness."

"Ultimately I don't believe we can continue to think of services in the 'boxes' we have. lack of funding in social care or any element of NHS care will have an impact."

"The NHS is the go-to solution when people break down...social care cuts result in more ambulance/111 interventions just because the patient has nowhere else to turn."

Public health

"Very poor support and services offered for the national problem of massive amounts of alcohol and drug misuse."

"We need to address some serious societal issues about what the NHS is for... there are difficult questions which politicians avoid but without some serious decisions being made we are facing public health ruin or revolution."

"We are building up problems for the future, rather than putting plans in place to address and reduce the burden of disease. We are heading for disaster."

a record high in England. "Our members highlighted the important link between prevention and poverty—there is a moral aspect to not attempting to improve population health through public health initiatives, and not doing so will maintain and create cycles of poverty and ill health which could be avoided through adequate public health campaigns," said MiP's report.

Commenting on the findings, MiP chief executive Jon Restell said: "We will carry on supporting our members to improve and maintain their services by pushing for better education and training provision, acting as a voice for our members who have concerns about service provision, and amplifying the voices of those who have successfully transformed their services.

"We will also be contributing to the production of the NHS People Plan, which we hope will form a new compact with NHS leaders as they work to implement the Long Term Plan," he added. ▪

Read MiP's evidence and the full survey results on the MiP website: miphealth.org.uk.

MiP Members' Summit 2019

Managing Change Well

7/11/2019

Your Members Summit

7 November 2019, Austin Court, Birmingham B1 2NP

A few places are still available for MiP's Members Summit in Birmingham on 7 November. The Summit is our annual event for members—a full day of interactive training and practical workshops, debate about the union's work, and networking with other members from across the UK. The Summit gives you personal support and a voice, both as an employee and as a professional healthcare manager.

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

This year's speakers include:

- **Andrew Foster:** Former CEO of Wrightington, Wigan and Leigh NHS Foundation Trust & development lead for the NHS People Plan
- **Sam Allen:** Chief Executive, Sussex Partnership NHS Foundation Trust (invited)
- **Sara Gorton:** head of health, UNISON
- **Dale Walmsley:** Actuary, First Actuarial
- **Paul Jennings:** Chief Executive, Birmingham and Solihull CCG
- **Yvonne Richards:** programme lead, NHS England (invited)
- **Jon Restell:** Chief Executive, MiP

You can also take part in a range of discussion sessions led by MiP national committee members, staff and other experts in their fields, including:

- Managing change in the West Midlands
- Organisational; change in commissioning and regulatory bodies
- Future of the Agenda for Change pay system
- A just, inclusive and respectful culture
- When can I afford to retire?
- Women in leadership
- The NHS leadership compact and management regulation

To book your place, visit the Summit website:

connectpa.co.uk/events/mip-members-summit-2019

You can also read reports from last year's Summit on the MiP website:

miphealth.org.uk/home/our-services/members-summit.aspx

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The Spirit of Brotherhood by Bernard Meadows

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