issue 61 | autumn 2024

healthcare manager

"We haven't got a sustainable model for healthcare"

Royal Berkshire chief Steve McManus on the big challenges for NHS leaders of the future

The Transformers

How our managers are powering change in the NHS and delivering for patients and their communities

Uncivil society

Why NHS staff are facing more violence and abuse at work

Don't panic!

How to manage in a crisis and still come out on top

The union for senior health & care managers

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UNISON Living

healthcare manager

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Speaking to members recently for the MiP's Managing Our NHS campaign (*see page 17*), I was struck by how much today's managers talk about working with people outside the NHS. This is a real change. When I started working on *Healthcare Manager* 15 years ago, most managers were intensely focused on their own organisations or the inner workings of the NHS hierarchy.

It hasn't always acted like one, but the NHS is an integral part of our society in ways that go way beyond treating sickness. The NHS is also an educator, an employer, a builder, a protector, a weapon against poverty and a tool of economic development. To build a better society, we have to realise that health, economic prosperity, education and public safety are all linked. And those links run right through the NHS.

Whether it's working with Whitehall departments, local community groups and charities, local councils, schools, universities or businesses, the NHS is starting to recognise, not just its power and influence in local communities, but also that it doesn't have all the answers or hold all the levers.

This where NHS managers are on home turf. Our managers have worked in all areas of national life. They don't just know how the NHS system works, they know how other systems work too. Who's going to negotiate with the Treasury to fund a new dementia pathway? Who's going to reach out to local housing associations to help get impoverished tenants into good jobs? Who's going to work with the tech sector to get a secure platform for NHS data up and running? An NHS manager like you—that's who.

With its five 'national missions', the new Labour government says it wants to "break down silos" and get public services working in partnership with each other and the rest of society. Ministers need to realise that managers are the crucial component in the NHS workforce that can make that work. //

Craig Ryan, Editor
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headsup

analysis & opinion

features

regulars

healthcare manager

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headsup

News you may have missed and what to look out for

noticeboard

26-28 October 2024

UNISON Disabled Members Conference

The Brighton Centre

Details from: unison.org.uk/events/2024-ndmc/

30 October 2024

2024 Budget

Chancellor Rachel Reeves presents her first Budget, setting out tax and spending plans for 2024-25.

6 November 2024

Welsh NHS Confederation annual conference

Cardiff

Annual meet-up for health and care leaders in Wales. WelshConfed24 aims "to share learning and best practice, encourage innovation, and provide valuable networking opportunities."

nhsconfed.org/WelshConfed24

7 November 2024

Scotland's Health Awards

O2 Academy, Edinburgh

Annual awards ceremony for NHS staff and teams in Scotland, sponsored by the Scottish Government and *The Scotsman*.

nhsscotlandevents.com/event/scotland's-health-awards-2024

8-10 November 2024

UNISON LGBT+ Conference

Edinburgh International Conference Centre

unison.org.uk/events/2024-lgbt-plus-conference/

21 November 2024

HSJ Awards 2024

EVOLUTION London

Annual ceremony for the UK's most prestigious healthcare awards.

awards.hsj.co.uk/

MiP to launch BME Members Network

MiP is launching a BME Members Network this autumn. This will be MiP's first national network, and will be open to all Black and minority ethnic members throughout the UK.

Ahead of the network's launch, the union is carrying out a short survey for members, to gather views on the network's purpose, as well as suggestions for themes and speakers for the inaugural event.

To respond to the survey, or find out more about the BME Members Network, contact MiP's national organiser Katia Widlak: K.Widlak@miphealth.org.uk.

27 November 2024

NHS Confederation ICS Network Conference

155 Bishopsgate, London

Annual face-to-face conference for Integrated Care System leaders. This year its focus is on delivering the "four core purposes" of ICSs.

nhsconfed.org/events/ics-network-national-conference

3-4 December 2024

King's Fund: Listening to people and communities — the change we need

Online

Join this online meet-up to learn how healthcare leaders can "turn listening into action and enact meaningful change". Speakers, case studies and panel discussions.

kingsfund.org.uk/events/listening-people-communities

Got an event that MiP members should know about? Send details to the editor: c.ryan@miphealth.org.uk.

Politics

Streeting tells department and NHS England to work as "one team"

New health secretary Wes Streeting has told staff at the Department of Health and Social Care (DHSC) and NHS England to put aside long running tensions and work "as one team", according to accounts passed to the *Health Service Journal*.

During an unusual online meeting of staff from both organisations, held just days after Labour's election victory in July, Streeting was joined by NHS England chief executive Amanda Pritchard and DHSC permanent secretary Chris Wormald.

In comments shared with the *HSJ*, Streeting told staff: "We will only succeed in turning the NHS around by working as one team... That means I expect joint submissions from NHS England and the department, collaborative team working across both organisations, and again, where there are sometimes competing views and interests, I want that relayed to me, too."

Also at the meeting, Pritchard promised that NHS England would "work in lockstep" with Wormald and the department "to support the NHS and do what is necessary".

Grading

Healthcare assistants' dispute spreads as trusts refuse backpay

PD. AMEDZRO / ALAMY STOCK PHOTO

Several more NHS trusts were hit by strikes as a dispute over grading and backpay for healthcare support workers escalated this summer.

Hundreds of staff at Lewisham and Greenwich NHS trust in London staged a 48-hour walkout in early September, following strikes by healthcare assistants and other support staff at hospitals in Leicester, Northamptonshire, Ipswich and Colchester during July and August.

The dispute concerns staff employed on Agenda for Change Band 2 who regularly carry out clinical tasks such as taking blood, electrocardiogram tests and wound dressings, which are normally graded at Band 3. Some trusts involved have refused to consider regrading staff while others have refused backpay for the time they spent working above their grade.

In June, two trusts in North East—North Tees and Hartlepool and South Tees Hospitals—agreed to regrade 1,500 healthcare assistants and backdate pay increases for five years following a series of strikes by UNISON members. Some experienced staff could receive a pay uplift of nearly £2,000 and the bill for the settlement is expected to reach several million pounds.

Speaking after joining workers on the picket lines at Greenwich and Lewisham, UNISON general secretary Christina McAnea said: "These workers aren't asking for special treatment, just fairness. The trust has been underpaying support staff for years. They've been forced to carry out clinical tasks beyond their pay band, without fair compensation. Enough is enough."

UNISON leader Christina McAnea: "These workers aren't asking for special treatment, just fairness."

MARK THOMAS / ALAMY STOCK PHOTO

MiP Reps' Day: 28-29 November

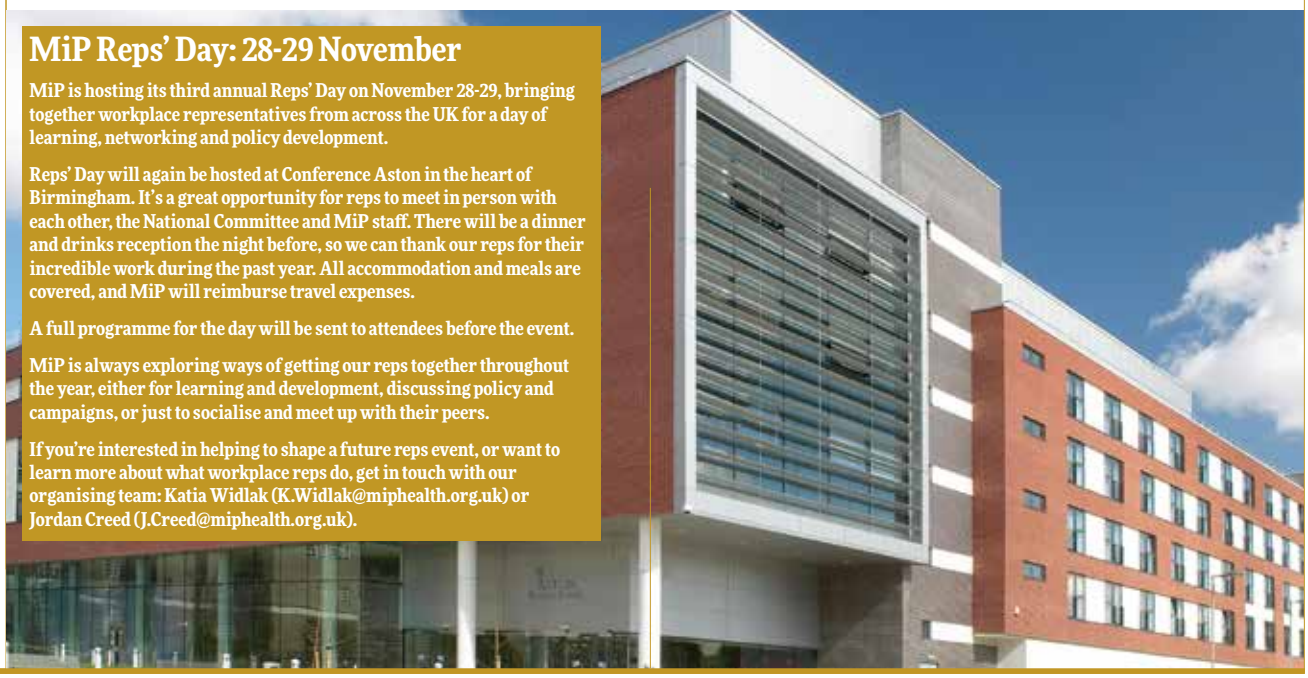
MiP is hosting its third annual Reps' Day on November 28-29, bringing together workplace representatives from across the UK for a day of learning, networking and policy development.

Reps' Day will again be hosted at Conference Aston in the heart of Birmingham. It's a great opportunity for reps to meet in person with each other, the National Committee and MiP staff. There will be a dinner and drinks reception the night before, so we can thank our reps for their incredible work during the past year. All accommodation and meals are covered, and MiP will reimburse travel expenses.

A full programme for the day will be sent to attendees before the event.

MiP is always exploring ways of getting our reps together throughout the year, either for learning and development, discussing policy and campaigns, or just to socialise and meet up with their peers.

If you're interested in helping to shape a future reps event, or want to learn more about what workplace reps do, get in touch with our organising team: Katia Widlak (K.Widlak@miphealth.org.uk) or Jordan Creed (J.Creed@miphealth.org.uk).



Agenda for Change

5.5% rise marks "noticeable shift" on pay

STEFAN ROUSSEAU / ALAMY STOCK PHOTO

NHS staff on Agenda for Change contracts are set to receive a 5.5% pay rise after Chancellor Rachel Reeves accepted the recommendations of the NHS Pay Review Body (PRB), following months of delays. MiP welcomed the above-inflation award—which has been endorsed by members—as "a notable shift" and a "good starting point" for future negotiations.

The rise will be backdated to April 2024 and is expected in pay packets in October. Unsocial hours payments and the thresholds for Higher Cost Area Supplements will also be increased by 5.5%. Pension contribution tiers have already been uplifted by 6.7%, meaning staff should not be pushed into a higher contribution tier once the award is paid.

Commenting on the award, MiP chief executive Jon Restell said: "The NHS needs to be able to recruit and retain the workforce required if it's to bring down waiting lists and improve patient care. Fair pay is an integral part of ensuring the NHS remains an attractive place to work.

"Although this year's award does not make up for the many years of below-inflation awards, it marks a notable shift and forms a good starting point for future awards," he added.

In her Commons statement at the end of July, Reeves said the Department for Health and Social Care will be expected to fund a third of the award out of existing budgets, with the remaining cash coming from the Treasury. The government will also consider options for opening the public sector pay process earlier in future years, the Chancellor said.

In an online consultation, MiP and UNISON members voted in favour of accepting the award and focusing efforts on the 2025 pay round.

"It took too long to get here, with staff waiting six months from when they were due the award to it being paid," said Restell. "We still support reforming the pay process to ensure future pay delays are kept to a minimum."

He added: "There's still work to be done on pay progression, the pay setting process and the shorter working week, all of which MiP and UNISON will continue to campaign for as we look ahead to the 2025 pay round."

Although the PRB's report covers Wales and Northern Ireland as well as England, at the time of writing, only the UK Government had formally accepted the recommendations. The Welsh and Northern Irish governments are expected to accept the 5.5% award, and MiP will update members in those nations once the governments have responded.

The PRB's remit does not cover Scotland, where the Scottish Government negotiates directly with staff and unions on NHS pay. An offer in line with the PRB's recommendation of 5.5% has been made and MiP and UNISON are consulting members in Scotland. At the time of writing, that consultation was still open.

Bands 8 & 9

Faster pay progression for managers in bid to tackle promotion blockages

Many MiP members are set to benefit from faster pay progression after the government accepted a review body recommendation to introduce an 'intermediate pay point' for Bands 8A and above. Staff will move to the new pay point after two years' service, bringing Bands 8 and 9 into line with most other Agenda of Change pay bands.

MiP chief executive Jon Restell said the union "has long been warning governments of the specific recruitment and retention challenges for Bands 8A and above and welcome action taken to begin addressing it".

He added: "While we don't think the additional pay points will resolve these challenges on their own, it's a good start. There are still too few incentives for staff to seek promotion, especially from Band 7 to 8A, due to the modest increase in salary and loss of overtime and unsocial hours payments."

The new pay point is effective from April 2024, meaning staff who reach two years' service on or after that date will have their pay increases backdated. Payments are expected to be made with November salaries, subject to testing, NHS Employers has said.

The NHS Staff Council ratified the decision in August and the NHS Terms and Conditions Handbook has been updated to reflect the new pay points. While the NHS Pay Review Body (PRB) covers staff in Wales and Northern Ireland, the new pay points will only apply to staff in England for now. Both devolved administrations are expected to accept the recommendations, but neither had responded formally at the time of writing.

The UK government also accepted a review body recommendation to begin talks on addressing wider structural issues within the Agenda for Change framework, such as the compression on pay bands resulting from variations in pay awards over the years. This work will be carried out through a funded mandate to the NHS Staff Council, working with the Welsh Government and Northern Ireland Executive.

"MiP will continue to represent our members interests when this piece of work gets underway," Restell said. "Managers make a vital contribution to the NHS and they will be needed more than ever as the government attempts to drive up productivity and bring down waiting lists."

He added: "While there is still a long way to go, we hope that the government's recognition of specific challenges for managers reflects a change in attitude from its predecessors, and that they will value the contributions that managers make to the NHS, its patients and its staff."

VSMs/ESMs

Union welcomes above-inflation rise for board level managers

MiP has welcomed a 5% pay rise for board level NHS managers in England after the UK government accepted the latest recommendations from the Senior Salaries Review Body (SSRB).

The award applies to very senior managers (VSMs) working for trusts and ICBs and executive senior managers (ESMs) working for NHS England and other arm's length bodies. Pay rises will be backdated to April 2024 once implemented.

The SSRB, which also covers pay for senior civil servants and military top brass, urged the government to tackle delays in approving pay cases for the most senior NHS managers by introducing a "four-week turnaround" once a pay case has been submitted. The government said it was "still considering its approach to the recommendation" and "cannot confirm acceptance at this time".

Commenting on the 5% award, MiP chief executive Jon Restell said: "MiP submitted evidence to the SSRB arguing that a fair pay award is vital to ensure senior managers are motivated to stay in the NHS, so we welcome the above-inflation award.

"We encourage the devolved governments to follow suit to ensure the NHS in all parts of the UK can recruit and retain the experience and skills this extremely important group of staff provides," he added.

He encouraged board level members to get involved with preparing MiP's review body evidence for the 2025 pay round. "The strength of MiP's evidence to the SSRB lies directly with our members who contributed to it," he said.

Want to add your voice to MiP's evidence for next year's review body? Email MiP's communications and policy officer Rhys McKenzie: r.mckenzie@miphealth.org.uk

New health ministers: experienced hands & new faces

Healthcare Manager's quick guide to the new team at the Department of Health and Social Care. Reporting by Craig Ryan.

Wes Streeting
Health & social care secretary

MATT CROSSICK / ALAMY STOCK PHOTO

As secretary of state, Streeting has overall responsibility for health and care policy and the NHS in England, and as shadow health secretary since 2021, he should know his brief. He fought off a strong challenge from a pro-Gaza candidate at the 2024 general election, holding his Ilford North seat by just 500 votes. He has been the MP for the East London constituency since 2015.

Streeting, 41, was born to two teenage parents and raised in a council flat in Stepney. "This wasn't a nice place to live. I spend most of my childhood thinking I wanted escape," he said when he returned to the estate last year. He studied history at Selwyn College, Cambridge, where the came out as gay during his second year. "I spent many years choosing not to be gay. It was oppressive; it was like a straitjacket," he told the *Financial Times*.

President of the National Union of Students from 2008 to 2010, Streeting worked briefly for LGBT+ charity Stonewall and consultancy firm PriceWaterhouseCoopers before becoming a full-time politician as a Redbridge councillor and deputy leader of the Labour group.

Streeting has been criticised by some campaign groups and Labour left-wingers for his outspoken support for using private health providers to help clear the NHS backlog. He has branded critics as "middle-class lefties" who put ideological purity ahead of patient care, and has insisted that NHS would be privatised "over my dead body".

Streeting had one of his kidneys removed as part of successful treatment for cancer in 2021. He has admitted to taking a sometimes cavalier approach to his own health, telling the *Guardian* last year that he enjoyed "going out with friends and getting absolutely plastered". He added: "That's terrible messaging for the shadow health secretary, but I am a binge drinker."

Karin Smyth
Health minister

STEFAN ROUSSEAU / ALAMY STOCK PHOTO

Karin Smyth, 60, a former NHS manager and MiP member, has a wide-ranging role including emergency and elective care, workforce, finance, technology, estates and medicines. Labour MP for Bristol South since 2015, she had a similar remit in opposition before the election.

Born in London to working-class Irish immigrant parents, Smyth (pronounced 'Smith') studied at Bath and East Anglia Universities and worked in commissioning, primary care, planning and purchasing. In a 2022 interview in *Healthcare Manager*, she explained she was motivated to join the NHS because "it largely served the middle classes and wasn't doing anything about health inequalities."

It was trying implement the botched Lansley reforms of 2012-13 as a manager for a GP consortium that drew her into full-time politics, Smyth said. "I decided they needed more people in parliament who knew about the health service, so I was going to go and do it," she said.

As an opposition MP, she criticised NHS trusts for setting up wholly-owned private companies to take advantage of tax loopholes and spoke in support of assisted dying, chairing the all-party group for choice at the end of life. In 2017, a man was jailed for 14 weeks for threatening to kill Smyth during that year's election campaign. In her victim statement to the court, Smyth said she felt "sad" for the defendant and "worried" for her staff.

Stephen Kinnock
Care minister

Stephen Kinnock's role covers adult social care, NHS primary care, service integration, dementia care and community services. As these are all devolved policy areas, the MP for Aberafan Maestag is in the unusual position of taking ministerial decisions which don't affect his Welsh constituency.

The son of former Labour leader and EU commissioner Neil Kinnock and the late Labour MEP Glenys Kinnock, he is married to Helle Thorning-Schmidt, a former prime minister of Denmark. Kinnock studied modern languages at Cambridge University and speaks five languages fluently.

Kinnock's impressive CV includes spells working for the European Parliament, the British Council and the World Economic Forum, in Belgium, Russia, Switzerland and Sierra Leone. In opposition, he served as shadow immigration and defence minister, but had little to do with health or care policy.

Since taking office, Kinnock has described NHS dental services as "broken" and warned the UK is "in the midst of a mental health crisis". In his first Commons statement, he announced the scrapping of a planned increase in funding for social care training due to "overall fiscal pressures"—a decision that was criticised as "desperately short-sighted" by the Nuffield Trust.

VICTORIA JONES / ALAMY STOCK PHOTO

Andrew Gywnne
Public health & prevention

Andrew Gwynne was appointed as parliamentary under-secretary—the first rung on the ministerial ladder—with responsibility for public health, prevention, international healthcare and the management of long-term conditions. He held a similar brief on Labour's front bench before the election. An MP since 2005, he now represents the new constituency of Gorton and Denton in Greater Manchester.

Gwynne, 50, is the son of the late Sky Sports football and darts commentator John Gwynne. He grew up in Tameside and studied politics and history at Salford University. At age of 21, he became England's youngest councillor when he was elected to Tameside borough council.

Gwynne served in Jeremy Corbyn's shadow cabinet as shadow local government secretary, and achieved a brief moment of fame during the 2017 election campaign when he called Boris Johnson "a pillock" in a debate over Brexit. Gwynne has spoken publicly about his own health problems, including his struggles with depression and long Covid.

IMAGEPLOTTER / ALAMY STOCK PHOTO

Baroness Merron
Women's health, mental health & patient safety

Gillian Merron, also a parliamentary under-secretary, takes charge of women's health, including maternity services, mental health services, patient safety and experience, healthcare research and life sciences. She also speaks for the government on health and care in the House of Lords.

Merron, 65, was public health minister during the last year of Gordon Brown's government, having previously served as a junior minister at the Cabinet Office, Foreign Office and Transport. She grew up in Lincoln and was Labour MP for the city from 1997 until her defeat at the 2010 election. She was chief executive of the Board of Deputies of British Jews from 2014 to 2021, when she was made a working Labour peer.

During her previous spell at the department, Merron was an enthusiastic promoter of healthy activities like walking, cycling and dancing, and was dubbed 'the hip-hop tsar' by the *Health Service Journal*, which devoted a occasional column, 'Merron Watch', to her activities.

DAVID FOWLER / ALAMY STOCK PHOTO

The long and the short of it

The new government has an ambitious ten-year plan to transform the NHS by shifting care closer to home and tackling the UK's poor record on public health and prevention. But with multiple short-term challenges and little money to spend, ministers will need more than goodwill and good intentions if they're to turn those ambitions into reality.

The government believes the NHS is "broken" and wants to show how it will go about "fixing" it quickly. To that end, I'm pleased to see a welcome urgency about the ministerial team's early weeks in office.

We've seen immediate steps taken to attempt to bring the junior doctors' industrial action to an end and acceptance of the pay review body's recommendations for some other healthcare professionals. An audit of the NHS has been launched, led by Lord Darzi. More broadly, work has begun to develop a ten-year plan for the NHS and a cross-government 'mission' is being formed to transform the nation's health. The new government's legislative agenda set out in the recent King's Speech includes commitments to introduce much-needed reforms to the Mental Health Act as well as a phased ban on the sale of tobacco products.

Less positively, the new government has indefinitely postponed the introduction of charging reforms for social care, which were developed by the previous Conservative government and due to come into effect next year. In truth, Labour always seemed lukewarm on the plan. The problem with dropping these reforms is that the new government is left with no plan for social care.

Labour did make manifesto commitments to establish a fair pay agreement for care workers and to create a National Care Service, but we are yet to see what these mean in practice. There have been rumblings about a Royal Commission to examine policy solutions in social care. We have been here before, with previous commissions taking time to come up with recommendations that were then not enacted, which is why some in the social care sector responded to the idea with dismay. Fundamentally, our social care system is not sustainable, with people's need for care outstripping the availability of state support. However ministers decide to approach it, the central challenge is boosting the availability of publicly funded social care and creating a fairer system.

So, what are the other key challenges, priorities, and opportunities facing the new government?

The first, and most visible, is patients struggling to access timely care when they need it. It's one of the major reasons we have historically low levels of public satisfaction with our health and care system. Many of the constitutional standards to ensure quick access to key services—A&E, ambulance and elective care—have not been met for years. The government has ambitiously promised to fix this within a five-year parliamentary term. Resolving the junior doctors' dispute should help deliver the 40,000 additional appointments per week Labour promised in their manifesto. There's a small amount of money for scanners and other kit too, recognising that we have relatively fewer scanners compared to some of our higher performing international neighbours.

Second, in opposition, Labour made positive noises about a greater emphasis on preventing illness. In government, they have taken some promising early steps. A bill banning the sale of tobacco and advertising of vapes to young people will be introduced into parliament shortly. Ministers have also announced plans to restrict the marketing of junk food and high caffeine drinks to children, both of which are relatively easy to do and don't directly cost taxpayers much to implement.

Beyond these early steps, a child health action plan, implementation of a more comprehensive anti-obesity blueprint, an alcohol harm reduction plan and bolder clean air laws would all be generally popular with the public and should begin to address our poor population health, particularly in more deprived communities. A quarter of 11-year-olds leave primary school obese; life expectancy has stalled—and, in some communities, declined—over the past decade.

Sarah Woolnough is chief executive of the King's Fund (kingsfund.org.uk)

Third, ministers will want to do more to support health and care staff. The health secretary has already made welcome statements about the need for honesty in conversations and action to improve a culture that too often doesn't encourage people to speak up.

There has been talk of plans for professional regulation of managers, but nothing was said about this in the King's Speech. Of course, many managers are already professionally regulated, regulation is relatively costly, and it would not be a panacea to tackle the poor behaviour we have seen in recent high-profile cases.

Managers are central to realising an efficient and productive health service, streamlining processes, and creating environments for clinicians to focus on delivering patient care. The new government can and should partner closely with NHS managers to work through these issues.

The fourth big opportunity for the government, and one of the most exciting aspects of their health agenda, is to move care closer to home. This requires a big shift. It means preventing more disease and re-wiring our health system to provide proactive care in the community when disease is detected, negating the need in many cases for people to be admitted to hospital.

It means different approaches to managing multi-morbidity, including using tech-enabled devices at home, and embracing community rehabilitation to get people the support they need to leave hospital with confidence more swiftly. Successive governments have promised to do this for at least 30 years. They've largely failed. It requires a wholesale shifting of the spotlight from acute hospitals to primary and community sectors. We need to value and measure community activity, increase the status of the workforce, and differentially increase investment out of hospitals in the years to come. Put bluntly, part of the answer to overcrowded hospitals is decent investment in primary and community health and care services.

What will it take to deliver this shift to a health and care system centred on care closer to home?

To stand a chance of success there needs to be a sustained commitment to bolstering primary and community services, which runs through not just the centre of government but out to every system across the country. Integrated Care Systems have clear remits to improve population health and embrace integrated healthcare that is more person and patient centred. The problem is many systems have been under so much pressure to deliver to shorter term, performance related targets, particularly at a time of continued financial constraint in health and care services, that they have not had the time or resource to work on the long-promised shift to more community-based care. Finding the space to deliver on shorter term performance metrics, while not forgetting the longer-term change, will be tough but a major achievement if delivered.

> // *Systems have been under so much pressure to deliver to shorter term, performance related targets that they have not had the time or resource to work on the long-promised shift to more community-based care.* //

This is a government keen to hit the ground running and to be seen hitting the ground running. They have made many short-term commitments, but also set out ambitious, longer term reform goals. The challenge is how that ambition and pace is affected by harsh financial reality, and the inevitable challenges that crop up along the way. The key opportunity for the incoming government is that all of us across the health and care landscape are also committed to making progress on these important areas and will work alongside them to do so.

Parliament returned at the beginning of September, the Budget is due on 30 October and demand for health and care services will soon start to rise as winter bites. It will be an important few months for health and care in this country. //

It's time to be big and bold about NHS managers—give them the chance to deliver the renewal we need

The problem with NHS management is that no-one wants to do anything about the problem with NHS management. In John Major's government in the 1990s, there was an ambitious Eurosceptic minister who refused to sign any direction that originated in Europe. Someone else had to do it. I wouldn't mind betting that similar instincts of political distaste and fear of association stir in the mind of the average health minister when faced with decisions about management. So they tend to drag their feet before taking short-term, bitty decisions, driven primarily by the optics, avoiding—perhaps even unaware of—the need for a bigger, bolder strategic approach.

This wouldn't matter much if NHS management played only a bit part in successfully delivering one of the public services most dear to the hearts of this country's citizens. But the cosy myths on which policymakers fall back on to justify inaction—that NHS management is overpaid, overbearing and overpopulated, and that it doesn't matter much—are the polar opposite of the truth. A more accurate description would be overstretched, over-regulated and overlooked.

We've failed too often to take the big view of NHS management, and now we see the consequences. As the challenges facing the NHS—waiting lists, ailing productivity and the staffing crisis—become unprecedented in size, experts across the spectrum are clamouring for the effective management function that we have been negligently undermining for decades.

Can this change? Yes, but we're at crunch time. Lord Darzi has been lifting the floorboards on NHS performance. He is likely to say that many of our challenges are management ones and to recommend building management capacity. The Ten Year Plan expected in spring 2025 is a time-limited opportunity to respond to these findings by a big beast, and for the health secretary to be big and bold about NHS managers.

Can Wes Streeting swim against the tide of past political instinct and decisions? Here are three reasons why he should.

First, the recent slew of studies into the under-management of the NHS may not have reversed the tide, but they have made the debate non-tidal. During the general election campaign, for example, Streeting himself refused to match management cuts proposed by the outgoing government, and the Tories were at pains to value the role of operational managers—both firsts.

> *// There's an understanding that public service is a valuable vocation that should attract the best graduates, apprentices and managers. It should be a matter of pride to be an NHS manager, not a source of embarrassment. //*

Secondly, the new government wants a renaissance in public service. From the prime minister (a former director of public prosecutions) to the minister for the NHS (a former NHS manager), there's an understanding that public service is a valuable vocation that should attract the best graduates, the best apprentices, the best of our other staff and the best managers from other parts of the economy. It should be a matter of pride to be an NHS manager, not a source of embarrassment.

Thirdly, and most importantly, the government wants to rebuild the NHS in two terms. They will need managers to do it, as the last Labour government did, when it took the NHS to new heights of public satisfaction and achievement. Cheeky Simon Stevens liked to say that the Victorian public would have subscribed to statues for NHS managers. I don't think today's public will be much interested in memorialising NHS managers, but I do think that they will vote for anyone who sets managers to work restoring and rebuilding our NHS.

The Ten Year Plan is the place to lay lasting foundations for NHS management and turn our backs on the piecemeal, knee-jerk interventions of the past. With his eyes on the prize of a renewed NHS, Wes Streeting should demand from the plan an ambitious and achievable strategy for managers to deliver; the right management structures in the right places with the right number of managers; getting the right people and giving them decent talent and career development; system processes and technology that drive improvement and productivity; and incentives that change the culture and reward managers for doing the right thing. Managers won't get an easy ride—few want one—but the health secretary will finally have broken with the past and given managers a chance to show what they can deliver for him. //

We need to give managers reasons to join the profession — not risks to avoid

TIM KAVANAGH

Steve McManus's work developing the leaders and managers the NHS needs for the 21st century has caught the eye of national leaders. The Royal Berkshire trust chief executive talks to *Matt Ross* about transforming services, developing leaders and the right way to regulate the management profession.

"If we continue in this way, we haven't got a sustainable model of healthcare," says Steve McManus: we must stem the rise in medical need and cut the cost of providing care, or spending will soon exceed the country's ability to pay. So big changes are required in organisational structures and working practices—and managers must lead those reforms in an environment that's highly complex and under great pressure. "We're both system leaders and statutorily responsible for our own organisations," he comments. "We've got fiscal challenges; performance expectations for the NHS are rightly high; and a different disposition of health needs has emerged over the last five years."

McManus, the CEO of Royal Berkshire NHS Foundation Trust—one of the country's largest general hospital trusts—believes these challenges demand a new approach to leadership and management; and his work has caught the attention of national leaders, who've been thinking along similar lines.

Announcing a new, multi-disciplinary NHS Management and Leadership framework in June, NHS chief executive Amanda Pritchard said: "Bringing together expertise from inside and outside the NHS, learning from places like Royal Berkshire who already do this well, and working with the Chartered Management Institute and others, we'll create a new Code of Practice

"Regulation must create a really attractive, permissive environment for managers."

Royal Berkshire chief executive Steve McManus pictured in the trust's Wellbeing Centre. Opened during the pandemic to provide mental health and wellbeing support for staff, patients and visitors, the centre includes a community garden, a health and wellbeing space and a gym. The trust is now working on a cycle hub next door.

TIM KAVANAGH

for all managers and leaders."

Pritchard's agenda has now met that of the new Labour government. The party's manifesto pledged to "implement professional standards and regulate NHS managers, ensuring those who commit serious misconduct can never do so again". Health leaders are clearly facing a more universal and codified approach to performance management and standards of behaviour; this new framework, says McManus, must "create the professional conditions for us to operate in the way we need to, and to be valued in doing that."

The first task, then, is to understand how managers will need to operate in future. McManus began his career as a nurse in 1987, moving into management via roles in recruitment and specialist surgery—and aiding the late-'90s push to drive down waiting lists under the last Labour government. So he's seen the NHS pull itself out of a hole before; though with resources tighter this time, the way forward must lie through targeted capital investments and productivity improvements rather than big increases in resource budgets.

"We've got levels of inefficiency inherently locked into aspects of our service pathways," he comments: his trust still has "services running in a building opened in 1839; it's an amazing, iconic building, but not fit for 21st century care."

Improving the NHS's estate and its digital and data systems would enable staff to make much better use of their time, says McManus. The big savings, though, lie in wider change across the health and care system: this is "still segmented, based on the organisational silos of public health, local government and social care, primary care, community services, and then secondary and tertiary care," he comments. "And if you plot those as blocks with pound signs, the pound signs get bigger as you move from left to right."

So the task, he says, is to "move the point of delivery upstream, into a more preventative" approach. "How do we as leaders increasingly support the movement of our people—the expertise and capability within our service teams—so that in five years' time, more of their working week is spent providing advice, support, guidance, and direct clinical services into community and primary care locations?"

Integrated care systems (ICSs) will be key to these changes, says McManus, a former interim chief executive of Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board. To realise their full potential, however, ICSs will have to resolve four dilemmas.

The first is that of "scale versus subsidiarity": finding the right balance between centralising activities at the regional level, and providing services that are responsive and localised enough to meet the needs of individual neighbourhoods.

The second is how to push resources upstream without damaging secondary care providers. "There is, over time, a strategic commissioning element about the disposition and distribution of funding, that moves that resource but doesn't destabilise your acute organisations," he says, adding that this shift will "need provider support".

The third is the tension between "sovereignty versus solidarity": NHS organisational leaders are being asked to bend their operations around the wider system's needs, while being held to account narrowly against their own organisation's performance goals.

Fourth, ICSs themselves have been given conflicting objectives: their strategic goals involve long-term system change, he notes, but "over the last year or so, a significant proportion of their time and energy has been anchored into a small number of performance areas" such as waiting times and cancer standards.

The new Labour administration presents an opportunity to resolve these dilemmas, says McManus: there's a "better understanding from government about some of the drivers [of changing demand] over the last five years," and ministers are open about "the conditions we're working in at the moment, the resource challenges and constraints".

The young government should do

"three big things", he argues. First, adopt a long-term "approach to public sector capital within the NHS": that, he adds, means longer than a five-year parliamentary term. Second, ensure stability in political leadership and national policy: "The fact that the secretary of state has said that his expectation and desire is to be secretary of state for the whole life of this Parliament is really welcome." And third, reform primary care: McManus believes that the current system—under which GPs cluster together in small businesses, often taking personal financial risks and "fighting tooth and nail to get the best out of a contract"—puts them in a "wholly asymmetric relationship" with the much bigger community, mental health and acute trusts. It's difficult to push care provision upstream, he suggests, when that involves developing dozens of separate relationships with frontline providers of very different sizes, capabilities and attitudes.

All these reforms will demand expert management—and the system has lost a lot of skilled leaders since Covid-19: "People with experience have maybe made the choice to move on and move out," says McManus. Meanwhile, "because of the pandemic, there was a hiatus in terms of management and leadership development coordinated at the national level, so I think we've had several years where there's been a fallow period," he adds. "We've had a vacuum around that."

Now—as Amanda Pritchard has made clear—national leaders are focusing on the topic again. "Really positively, we're seeing a re-emphasis nationally on how we create that talent pipeline," says McManus, noting that NHS England has "used some of the work that we've done here in supporting the development of the relaunched Aspiring Chief Executive programme." McManus champions both this NHS Leadership Academy scheme—he joined its first cohort in 2016—and the leadership development work of regional teams, which allows "us at executive and senior leadership level to take a view on how we get talent into the NHS to deal with these complex challenges."

At the trust level, McManus has also caught NHS England's attention with Royal Berkshire's "multi-professional management leadership development programme"—which is funded by the apprenticeship levy, provided by Henley Business School and accredited by the Chartered Management Institute. The three-year scheme has been running for eight years, he explains, providing nearly 300 people with "the knowledge, the skills and the networks to build their career, with the aim of taking on increasingly complex management and leadership portfolios." Initially aimed at people from minority communities, the programme has since been expanded to pull staff from clinical and medical roles through into leadership jobs.

This has long been a focus for McManus. "When I arrived here in 2017, one of my key aims was to see our senior clinical body and our senior medical body re-engaged with the life of the organisation and our senior decision-making, through their taking formal roles in our management and leadership structure," he recalls. "We now have a really strong pipeline of colleagues in that space."

Asked about Labour's plans to regulate managers' professional standards, McManus points out that his trust operates a "leadership behaviours framework" that essentially operates as a code of practice. "People really engage with that, because it's seen as a positive aspect of how we professionalise leadership and management," he says, noting that regulation could help promote this professionalisation agenda. So he's a supporter: clinical staff already operate under statutory regulation, he adds, "and I think managers and leaders should have the same standards applied to them as other regulated professions".

Such regulation must, however, "create a really attractive, permissive environment" for managers—providing would-be NHS managers, chairs and non-executive directors with another reason to join the profession, rather than another risk to avoid. "Regulation can be seen as a way to support the drive for high-quality management and leadership, professionalising it," says McManus. But it could also be seen as yet another stick with which to beat NHS managers.

If regulation is developed and presented "with a view of, 'we're going to regulate out the bad apples; we're going to regulate out the incapable,' without balancing that with development and support, then that will create a hugely negative context and risks driving out talent," McManus argues. The danger here is that regulation could hit the recruitment of both managers—including from among the clinical workforce—and non-executive directors. "We are hugely reliant on our non-executives within statutory organisations, and they play a massively important role," he says. "There is a risk, if that balance isn't managed, that we don't have that pipeline of talent from outside the NHS coming in to support the work that we do."

Trust leaders have a crucial role to play in attracting high-potential people through into NHS management roles. "Nurturing that talent, creating the right set of cultural conditions within organisations: that's my responsibility as the chief exec," he says. "We should not be looking to government or NHS England nationally to help create the right cultural conditions in our organisations—that's our job. Clearly there are challenges in terms of resource and all the rest of it, but we hold that responsibility."

To create those positive, attractive environments, however, local managers need the support of national bodies—whose activities can either help that work or undermine it. "What government and NHS England—nationally and regionally—have a unique ability to do is to create language which is positive and supportive," McManus comments. "Language about 'too many managers' and 'poor management capability'—language which is about the stick of regulation, not the support of regulation—is a real risk in terms of not creating the right conditions.

"If we get that balance right, I think there's a real opportunity over the next five years or so to ensure that we've got the right management and leadership capabilities in the NHS," he concludes. "If we get it wrong, we may well find a challenge in terms of the pipeline of talent that we want to bring in." //

LAUREN SETCHELL

BARBARA McCREADY

STEVE RAVEN

Harmed & dangerous: how do we STOP violence against NHS staff?

More and more people in public-facing jobs are being confronted by violence and abuse at work, and the NHS is at the sharp end. Existing policies are failing—we need a more co-ordinated and energetic approach to tackle the root causes and protect the staff who care for others. Craig Ryan reports.

Barbara McCready, a specialist physiotherapist at the North Cumbria Integrated Care trust (NCIC), has experienced aggression and abuse from patients and relatives—often arising from long waiting times and "frustration and concern about the care of people's loved ones," she says. "I understand why emotions can be high in these circumstances but aggression or violence doesn't resolve things."

It's important to remain calm, McCready says, and to try to respond "with kindness and compassion" even when facing abuse. "When things go wrong or communication breaks down it feels very difficult for us too," she adds. "We're human, and we're in these roles as we're very passionate about caring for others and really do want to help."

McCready took part in the trust's 'HUMAN' campaign, which aims to reduce violence, threats and verbal aggression by trying to build a rapport with people who may be angry or worried. Instead of stern 'zero tolerance' messages and prosecution threats, the trust's posters feature striking, close-up photos of real staff members under the headline 'We Are All Human', supplemented with simple messages like 'I'm a Dad too' or 'I'm a carer too'.

"We wanted to make a calmer environment," explains Kath Hughes, NCIC's head of communications, who helps to run the campaign. "We knew zero tolerance messages weren't effective. They just add to a pressurised environment and people rebel against it. We thought seeing 'I'm a Mum too' might make some people—not all—think about how they respond to those who are trying to care for them."

It's hard to gauge the true extent of the problem, since the NHS stopped collecting national statistics on violence and abuse in England when NHS Protect was wound up in 2016. In the latest NHS Staff Survey, 26% of staff reported experiencing "harassment, bullying and abuse" from patients or the public, slightly down on previous years. Good news? Well, not really. The survey only measures the number of staff experiencing abuse, not the number of incidents or their severity. Figures published by individual trusts, often as part of their own anti-abuse campaigns, point firmly in the opposite direction.

A typical large trust now has over 1,000 incidents of violence and abuse a year. Figures compiled by ITN found over 41,000 physical assaults on NHS staff in 2023—a 21% increase since 2019. One trust, Nottingham University Hospitals, reported over 1,800 incidents of "aggression, violence and harassment" during 2022-23, and over 1,100 during the first six months of 2023-24—the

EBRAHIM BITA

Bita Ebrahim, a hygiene specialist at West Cumberland Hospital, was abused by a patient when he moved tables and chairs to clean the floor: "I had to request assistance from the ward staff to calm the patient down. As much as I understood the patient, I felt embarrassed."

Dr Olaniyi Kehinde, North Cumbria's clinical director of paediatrics, suffered aggression from the parents of a child he was treating: "It makes you realise not everyone is appreciative of what we do. I felt intimidated... they were not respectful in their behaviour towards me. In the middle of this is a child who I'm trying to care for. My thoughts are always what's best for that child."

OLANIYI KEHINDE

highest on record. All but one of the organisations I spoke to—including several who would only comment off the record—said the problem has got significantly worse since the pandemic.

When work can be scary

Ambulance staff have long borne the brunt of this. Adam Hopper, violence prevention and reduction lead for the Association of Ambulance Chief Executives (AACE) has collected statistics on violence and abuse against paramedics for the last eight years. He found a staggering 17,000 incidents reported in 2023-24, more than double the 2016 level. While some of this can be attributed to more frequent reporting, there's "a clear upward trend" since the pandemic, he says.

"Going to work, you can expect to get threatened and abused quite often, unfortunately," Hopper warns. Paramedics are taught to spot the warning signs: swearing, clenched fists, people standing in a certain way. "It can be scary," he says. "The hairs go up on the back of your arm, you get that feeling and start looking for your exits. You think, if this goes wrong, how do I get out?"

The AACE's Work Without Fear campaign has highlighted some of the shocking abuse paramedics face, and the "real, deeply personal impact it can have"—often leading to absences from work and sometimes to paramedics losing their careers, says Hopper.

Lauren Setchell, a South West Ambulance Service paramedic, was sexually assaulted by a patient she had gone to help. "Most people would be shocked to know that after the sexual assault, I had to clean the back of the ambulance where he'd urinated on it," she says. "It really hurt me. Any sense of safety I had disappeared." It was "a huge relief", she adds, when local police reversed their original decision not to proceed against the attacker and charged him with sexual assault.

Steve Raven was attacked by a drunk patient while on duty with the West Midlands Ambulance Service. "I thought I was going to die. He broke my jaw, caused facial nerve damage and affected me mentally as well," he recalls. "It's sad... I was there to help him, but he ended up putting me in hospital." He has mixed feelings about the two-year prison sentence handed to his attacker—"a young man has damaged his life, ruined his own prospects," he says—but the incident left him needing anxiety medication and regular counselling. "Every day, to go to work, is always a tough thing to do, but I still want to do my job," he says.

'More aggression out there'

The apparent trend towards more public violence isn't confined to the NHS. A recent survey by USDAW, the shop workers' union, found that assaults on retail staff doubled last year, with one in five reporting that they'd been physically assaulted by a customer. The Unite union recently reported a "tsunami of abuse" against Britain's bus drivers, with 82% reporting abuse and 79% saying the problem was getting worse. Job centre staff and railway workers have also reported sharp increases in abuse and violence in recent years.

"There's more aggression out there, we're becoming a less civil society," warns Alan Lofthouse, UNISON's deputy head of health, and this, combined with frustration about NHS services, creates a "perfect storm" where violence and abuse are more likely to happen.

"Staff are at breaking point over here, so they're less likely to see the signals of aggression as they escalate. Meanwhile, over there you've got angry relatives who are frustrated for their loved ones," he explains. Another factor is "patients in the wrong areas"—dementia patients on general wards, for example. "You need specialist training to deal with patients with specialised conditions. Without that, things can easily escalate," he says.

He's sceptical about the impact of security measures such as body cams and new laws mandating tougher sentences for people who assault emergency workers. "They were brought in as a deterrent, but violence has gone up since," he says. "Politicians say, 'We have a zero tolerance approach, a law to prosecute offenders, and a camera to capture the assault.' But what's being done to prevent the assault in the first place?"

Dr Rob Hendry, medical director of the Medical Protection Society (MPS), which now offers a telephone counselling service to doctors experiencing abuse at work, agrees that staff shortages and long waiting times are "key triggers" for abuse. They account for the vast majority of incidents reported in a recent MPS survey, he says, but "the constant flow of negative stories in the press about the NHS may also be fuelling the public's anxiety... and making people feel they have to fight for their relatives to get treatment."

Hendry believes that unless zero-tolerance policies are visible and "properly

enforced right across the NHS"—and taken seriously by the police—staff may be discouraged from reporting incidents. "There's a worrying notion that that violence and intimidation are now somehow part of the job, with some healthcare staff becoming desensitised to it," he warns.

Hard work

The Social Partnership Forum (SPF), the national negotiating body for NHS unions and employers, advocates a 'trauma-informed public health approach' to reducing violence and abuse against staff. Lofthouse, who chairs the SPF violence prevention and reduction group, explains: "That basically means understanding the causes and drivers of violence. And they are there. The guy with the tattoos who's violent in A&E—that might be traced back to an unloving childhood and a history of alcohol and drug dependency. We need to fix the issues in the NHS and broader society but, in the moment, we shouldn't accept that it's part of the job."

It also means investing time and money to make sure vulnerable staff are equipped to resolve conflicts and de-escalate tense situations. "If trusts invest, make roles clear, give staff a say, work with health and safety reps, this stuff starts to make a difference," says Lofthouse. "But that's the difficult to do, boring stuff. It's much more appealing to just slap cameras on people and throw them into dangerous situations."

The Violence Prevention and Reduction Standard (VPRS), agreed by NHS unions and employers in 2021, sets out what organisations should be doing tackle the problem, including training, monitoring, encouraging the reporting of incidents and consulting with unions on new measures and technology. Someone at board level should be accountable for meeting the standard, with commissioners expected to make twice-yearly compliance checks as part of contract reviews.

There's little sign that the VPRS has made much impact so far. Adam Hopper says the framework "relies on self-assessment with an emphasis on continuous improvement", and isn't as "rigorous" as the NHS Protect regime. It's also voluntary—employers are only expected to make "all reasonable efforts" to comply. A recent UNISON survey found only 19% were fully compliant, while 40% didn't even know about it. The union wants the VPRS to be mandatory and baked into contracts between commissioners and providers.

Hopper praises the "hard work" of the ambulance service in generating an "effective reporting culture". This isn't just for compiling statistics: perpetrators of abuse and are now flagged, so paramedics know in advance they may be dealing with a dangerous individual. "The last thing we want is somebody going into a situation completely unaware of how bad somebody can be. You need as much intelligence as possible," he explains.

Money has also been put into training, Hopper says, teaching paramedics about conflict resolution and de-escalation, and how to break away from an attacker, as well as dynamic risk assessment—"understanding what's going on around you", he explains. "If we were looking after ourselves as well as the patient, that first punch might not hit us. I think, generally, we don't understand how much we put ourselves at risk."

But training standards are inconsistent, he says, with some trusts offering no training and others leaving it to e-learning. And unlike the police, who do annual refresher courses, paramedics are offered them only every three years.

Efforts to reduce violence and abuse have been hampered by a lack of co-ordination and policy direction for years. The NHS can't stop this on its own, but it can do much more to put its own house in order and work better with other parts of government to tackle the root causes. That requires political will and a sense of urgency from NHS leaders that seems to be missing. It may be significant that during the recent re-organisation of NHS England, the violence reduction team was cut from 12 posts to 2.5.

"There's some really good practice and innovation but it's largely driven by individuals, a few good trusts and one or two ICBs," Lofthouse concludes. "It's patchy at best. There's a lack of strategic direction from the government and NHS England." //

Understanding 'social' and 'anti-social' violence

"People who are very emotionally charged are not going to act calmly or rationally. It's often a good person having a bad day, but they have this need to vent which can escalate into physical violence," says Dene Josham (pictured left), former Royal Marine and celebrity bodyguard, and now lead instructor at Streetwise Defence. Josham and co-founder Julie Waite have worked with NHS trusts, universities, community groups and private businesses, training thousands of people in personal safety and violence prevention.

Streetwise do not teach punching, kicking or martial arts, but use the 'trauma-informed' approach to violence prevention now widely favoured in the NHS. "The aim is to understand the human psychology behind violence, the motivations, so people can take preventative measures," says Josham.

Identifying the type of violence can give you "a roadmap" for dealing with it, Waite explains. 'Social violence'—patients or relatives frustrated by treatment delays, for example—can usually be escalated (or de-escalated) "verbally by the steps you take", she says. "Interactions with staff can escalate up to a breaking point. But the actions staff members take can make a difference." 'Anti-social violence', by contrast, is usually motivated by criminality or hatred. "It can't be de-escalated and you need to move straight to getting support," she adds.

Streetwise recently worked with Stagecoach bus drivers and conductors facing abuse from passengers angry at rising fares and cuts to services. Rising public violence is a problem "across the board", warns Josham. "Everyone's under pressure and the systems aren't in place to deal with it. A lot of organisations don't appreciate the the damage violence can do—the trauma and the knock-on effect," he says. "They say we can't afford that. But we need to protect our people."

For more information, visit: streetwisedefence.com

Read more about this

Violence Prevention and Reduction Standard & guidance notes, NHS Social Partnership Forum (2020): mip.social/vprs

You Gov survey on violence against NHS staff: mip.social/yougov

Work Without Fear campaign, Association of Ambulance Chief Executives: mip.social/wwf

Trauma informed practice guide, Department of Health and Social Care: mip.social/TIP

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Reporting by Rhys McKenzie & Craig Ryan.

SHERIF AL-MARAYATI
PRACTICE MANAGER
ST JOHN'S WAY MEDICAL CENTRE, LONDON

"We had to make some drastic changes. We reduced the wait for GP appointments from six weeks to two."

By spring 2023, patients at St John's Way medical centre were waiting an average of six weeks for a GP appointment. "We had lots of angry patients and unhappy staff," recalls practice manager Sherif Al-Marayati. "The GP partners and I thought enough was enough. We had to make some drastic changes."

St John's Way is a large practice in Archway, north west London. "It's quite a deprived area, with a lot of council estates and patients with complex co-morbidities," explains Sherif. "But other local practices had reasonable wait times and we wanted to know what they were doing."

Over the next six months, Sherif led a radical revamp of the centre's operating model, introducing online bookings and a 'total triage' system—reducing the maximum wait for a GP appointment to just two weeks.

With total triage, patients supply details of their symptoms online or to a receptionist for review by a doctor before an appointment is made. "Not every patient needs to be seen by a GP, but the GP makes that decision," Sherif explains. This 'triaging GP' can direct patients to a pharmacy or a local clinic, or book a GP appointment within two weeks—or sooner if the case is urgent.

After three months talking to experts and visiting other practices, Sherif and the team settled on a triage model and a simple-to-use online platform. Receptionists were trained in 'care navigation', he explains, equipping them to record patient information clearly and accurately, and redirect the simplest cases. Thanks to a protocol written by Sherif and a GP partner, "the whole team knew what we were doing, and when we went live it felt quite comfortable," he says.

Sherif also secured ICB funding for the investment in overtime and locum fees needed to clear the appointment backlog before going live. "With total triage, you need to free up a doctor to work on triage for the whole day—nine to five. You can't do that if you've got dozens of patients to see," he explains. "Without that funding, we would have really struggled."

He admits the new system was "a bit of a culture shock" for some patients, who were reluctant to go online or speak to a receptionist. "We try to educate them that the culture of the practice has changed and, to give the best care, we need to triage them," he says. But overall, patient feedback has been "really good", he adds. "I've been proudly showing the graph to our commissioners, saying, 'Look how well we've done here.'"

With GPs identifying urgent cases in advance, the practice has also seen improvements in patient safety, and fewer complaints and 'no-show' appointments.

Sherif gives a lot of credit to support from other NHS organisations and networks like the Institute of General Practice Managers. "We didn't even know what total triage was. Thankfully, there were great people within our network to help," he says. "Now we're showing other GP practices how we run total triage. So we're passing that knowledge on." | CR

JAMES ZWIERS
DEPUTY DIRECTOR OF DATA PLATFORMS
NHS ENGLAND

"We've got to be courageous as managers—set some stretch targets and let staff go for them"

Effective clinical research demands high quality data. Data must be accurate, cover a wide enough range and most importantly, says James Zwiers, NHS England's deputy director of data platforms, it must be secure.

The National Secure Data Environment, developed by James's team, allows accredited researchers to safely access NHS data in a controlled environment that ensures strict patient confidentiality. Previously, researchers could only receive a small extract of data, which was "statistically manipulated" to protect confidentiality. This made it difficult to discover data patterns which could help unlock better treatments.

A secure data environment gives approved researchers access to data "that is still pseudonymised and non-identifiable," James explains, allowing them "to work with larger datasets that are more statistically correct and completely secure."

This results in more impactful research leading to more effective medical interventions. Using the platform's predecessor service, researchers identified new treatments during the pandemic which were used in hospitals to save lives. The new service is already being used to open new treatment options and evaluate existing ones. "If a treatment is only effective for 10% of patients, we can help target that option more and reduce waste in the NHS," James explains.

The cost of the secure data environment will be completely offset by money recovered from the research organisations using it—improving patient care at no additional cost to the taxpayer.

Developing the service at the tail end of the pandemic and during the merger of NHS Digital and NHS England was a challenge. Work is continuing on the platform—now in beta form—and James is keen to give his team credit for getting the service up and running so quickly. "We gave the substantive teams a target of nine months to have the core of the new platform built and into service," he says. "And they achieved that."

A motivated team is a productive one, he says, and while the NHS is perceived to be "slow and cumbersome to change", it doesn't have to be. "As managers, we've got to be courageous enough to set some stretch targets and let staff have free rein to actually go for them," he explains.

For James, the key to keeping the team motivated through the upheaval of reorganisation was maintaining as much stability as possible while embracing the positive aspects of change. That meant encouraging the whole team to reflect on the culture of their previous organisation and decide what they wanted to bring forward and what they wanted to leave behind.

The NHS is full of success stories but, like many big organisations, it can be "terrible at celebrating its own successes", James says. But if you can "do something that's going to make the health service a little better, a little faster at treating someone", then that's something to celebrate. | RM

MISHA IMTIAZ
HEAD OF DEMENTIA & MENTAL HEALTH POLICY INNOVATION
NHS ENGLAND

"At NHS England, things move slowly but we can have a massive impact"

Any new policy in the NHS needs to pass three tests. Does it improve patient care? Can it be scaled? And, crucially, is it affordable?

As Misha Imtiaz, head of dementia and mental health policy innovation at NHS England, explains, designing good policy means first working closely with clinicians, patient groups and frontline staff. The next step is to secure government funding, which requires a good business case, the design of complex models and lots of negotiation. But after months of work the most common response is, "Okay, but what can you do with half the funding?"

"So it's back to the drawing board, consulting and co-producing ideas with healthcare professionals and voluntary sector organisations, then whipping up those models to see what can be done within Treasury budgets," Misha explains. "There's a lot of skill in developing policy and thinking about what you can do with the envelope you're given."

Misha and her colleagues in NHS England's mental health policy team relish such challenges. As as example, she talks about her team's role in funding pilots for a new community pathway for dementia diagnosis, which could speed up the process and ease pressure on other services.

Despite steady improvement, rates of dementia diagnosis in England are "still not good enough for us", Misha says, especially as many people with advanced dementia don't have a formal diagnosis. The traditional pathway involves a GP referral to a memory assessment service, which often have long waiting lists. While investigating alternatives, the team learned about one NHS service that was successfully diagnosing dementia by going directly to care homes.

"Looking into it, we found that up to 70% of care home residents could have dementia. It became clear that this local model could potentially be scaled up," Misha says.

Misha's team worked with government to secure funding, which they distributed to 14 pilot sites, each based on the original model but with a fair level of local autonomy. "We don't mark our own homework, so we hope to get an external organisation to carry out an evaluation," Misha says. "After that, we will know the impact of the funding — is this best value for money? Only then would we make the case for a national roll-out."

While still awaiting that evaluation, the early signs are positive, says Misha, who is keen to give the credit to the "fantastic work" of her frontline colleagues for delivering the pilots. But without her team's work—identifying impactful local initiatives and putting forward a compelling case for funding—such pilots would never get off the ground. Convincing various layers of government to support these projects is no mean feat.

Despite these challenges, Misha finds reward in the positive effect these new programmes can have on patients. "In a national policy role, even if you can only move things an inch, it can have a massive impact," she says. | RM

TIM SIMMANCE
ASSOCIATE DIRECTOR OF SUSTAINABILITY & GROWTH
BEDFORDSHIRE, LUTON & MILTON KEYNES ICB

"If people get jobs, it improves their health. We've got lots of jobs in the NHS, so we can join those dots together."

"Employment and prosperity lead to better health," says Tim Simmance, associate director of sustainability and growth at the Bedfordshire, Luton and Milton Keynes Integrated Care Board, and one of the driving forces behind a scheme helping social housing tenants into employment. "If they get a job, it improves their health. And we've got lots of jobs available in the NHS, so we can join those dots together," he explains.

Tim is working with NHS colleagues, a local housing association and the local public health team to build a "supported pathway into employment" for local residents, many of whom have already "ruled themselves out" of careers in health and care, Tim says. The health and housing team and recruitment staff from the local trust now take part in regular hub events, sharing information and advice on careers and how to apply for NHS jobs.

It's early days, but seven people have already benefitted from the scheme, Tim says, either by getting a job in the NHS or social care, connecting with employability support or acquiring new skills.

One resident who spoke but couldn't read English was helped to apply for a cleaning job, he explains, while another was a qualified midwife who, as a single mother, was unable to work shifts. "We connected her with the recruitment team, to see if they could find some flexibility," Tim explains.

"People feel it's difficult to apply to the NHS if you're not familiar with it or don't have clinical qualifications," he adds. "One of our biggest messages is that there are 350 career paths in the NHS, and roughly 50% of them are not clinical. That opens the door to a huge number of people."

Tim's job is to spot and develop opportunities like this. ICBs have a big role in supporting local economic development and mobilising the NHS's power as an 'anchor institution' in communities. "We really try to squeeze those partnership opportunities," he says, citing the work of Liz Parsons and the local public health team as "instrumental" in getting the scheme off the ground. "I work as a connector. I get that strategic agreement to do something and then bring together the people who can make it happen," he explains.

It's a big challenge for the "historically insular" NHS to adapt its approach "so it lands well with partner organisations," Tim says. "We turn up, wanting to talk about economic development, but local government colleagues have been doing this for years." Some initial conversations were "a bit spiky", he admits, "because people thought we were telling them how to do their jobs."

A research chemist by background, Tim has worked in most parts of the NHS since joining the management training scheme 15 years ago. But his latest job seems like a perfect fit. "All along, I knew something was missing, and it was that wider determinants of health aspect," he says. "This job is strategic, but close enough to the ground that you can actually see the difference you make." | CR

Only managers themselves can tell these stories. Get involved by telling MiP about something you or your team have done that you're proud of. Visit mip.social/our-story to get started. It only takes a few minutes.

Above and beyond: why so many NHS jobs aren't graded fairly

JAMES SPARLING/MIDJOURNEY AI

Agenda for Change, introduced 20 years ago, was supposed to put an end to inconsistency and unfairness in how NHS staff are paid. But staff shortages and tight budgets mean many staff are now graded below the level of the work they're doing. It's time to modernise the system, says Rhys McKenzie.

Equal pay for work of equal value. It's the enduring mantra of Agenda for Change (AfC), the pay structure that was designed to bring NHS terms and conditions into the 21st century. By harmonising pay and conditions for fairly evaluated jobs, AfC would bring an end to pay variation for staff doing the same or similar jobs at different employers.

Yet, in a survey of MiP and UNISON members on AfC, carried out ahead of the 2024 pay round, the second highest priority for members was ensuring staff were in the correct pay band for their role—an issue that AfC was meant to resolve.

Trade unions and health staff won a huge victory when AfC was introduced in 2004. But the framework hasn't evolved with the jobs people do. Without modernising AfC, staff risk being graded for their jobs as they were twenty years ago, not as they are now.

Mission creep

The root cause of these problems can be traced back to workforce shortages and funding constraints. When overall numbers are too low, staff end up taking on more complex work, often above their AfC grade.

"You have these additional duties creeping onto your job description," says Sam Crane, MiP national officer for London and the East of England. "Staff portfolios get bigger and bigger, and as the organisation is under pressure, staff are expected to deliver."

This creep can happen slowly as staffing becomes stretched, or it can happen almost immediately following an organisational change process. Either way, staff end up going far beyond the requirements of their role and it isn't reflected in their pay.

As the MiP/UNISON survey shows, grading issues exist from the top to the bottom of the system—they aren't exclusive to a single staff group or AfC pay band.

Healthcare assistants, originally graded at Band 2 on AfC, have steadily been taking on more clinical responsibilities as hospitals struggle with staffing. Supported by UNISON, thousands of healthcare assistants have won the battle to have their jobs 'rebanded'—receiving up to five years of back pay in the process (see page 3).

In the middle of the AfC scale, nurses have also demanded action on grading. UNISON is leading the Nursing Profile review, which aims to update the 'job matching profiles'—short summaries of common NHS roles used for comparing with other jobs—for nursing. The previous government even opened a public consultation on removing nurses from AfC altogether, in a desperate bid to appease nurses calling for a grading review. MiP argued that, rather than fragmenting AfC, we should ensure that job descriptions and grades reflect the modern demands of the job for all staff groups.

'Work doesn't just disappear'

Grading issues go all the way up to managers and senior leaders. The steady fall in manager numbers relative to other staff since 2010 and the sharp rise in demand for care mean bigger and more complex workloads for today's managers.

The IPPR's 2023 report, *Finding Hope* (ippr.org/articles/finding-hope), found that, compared to 2010, the NHS is "missing" 10,000 managers, and clinical staff are "desperate" for more managers to reduce their non-clinical workloads. "The work these managers were doing doesn't simply disappear. Someone has to pick up the slack," says Claire Pullar, MiP's national officer for Scotland and North East England, "and as clinical numbers have remained relatively steady, more and more of these management tasks are falling on them."

This squeeze on management is most noticeable following organisational change processes, which generally target managers. Staff given a job in the new structure often find their workload has increased, Claire explains. "They're doing their own job and delegated parts of their line manager's job because the manager doesn't have time to do it. They've got posts left unfilled for colleagues who would support them, but these are being held for savings. And before you know it, the employer says, 'Actually you're doing very well carrying that extra work, so we'll let you keep it.'"

When a manager asks to be moved to the correct grade for the work they're doing, employers will often refuse due to constraints in staffing budgets or the targets set in the organisational change process. Staff doing the same work at one NHS employer will then be graded and paid differently from staff at another.

Promotion can be a hard sell

Exacerbating this variation, in Claire's experience, is that some employers are willing to offer higher wages to plug gaps in their workforce, or retain existing staff. "It shouldn't be possible under AfC, but the reality is some parts of the country will pay more for the same work," she says.

The 2024 report from the NHS Pay Review Body (PRB) highlighted this as an issue leading to an inconsistent application of AfC. This is compounded, the PRB says, by the requirement for staff at Bands 8A and above to wait five years before they become eligible for pay progression—most other bands receive a pay rise after two. With pay bands, especially Bands 7 and 8A, so compressed, it can be a hard sell asking staff to take on more responsibility for so modest a pay increase.

To begin tackling this issue, the PRB recommended introducing an intermediate pay point that staff move to after two years, bringing Bands 8A and above in line with most other AfC grades (see page 7). It's a welcome step, which MiP has campaigned for and will support, but more needs to be done to tackle grade variation across the NHS.

Opportunity to modernise

MiP has called for the government to modernise the AfC framework in partnership with unions and employers. This would include ensuring that job descriptions for all roles, reflect the modern demands of the job and that staff are being paid fairly for the work they do.

MiP believes all staff should have a right to request an annual band review, but this requires strengthening the job evaluation capacity in the NHS. Job evaluation work has to be adequately funded and managers must be trained and supported through the evaluation process.

Ensuring promotion and progression is well rewarded will incentivise staff to continue their development and progress up the pay scale. Addressing specific pressure points, such as between Bands 7 and 8A, should be prioritised.

There's no overnight fix for grading issues in the NHS. But MiP were encouraged by the new health secretary's commitment to address structural issues within AfC, as recommended by the PRB this year. This work will be conducted through the NHS Staff Council, the body that brings together government, employers and trade unions, with funding underpinning it. It will take time, but it's a great opportunity to begin modernising AfC. Action on accurate and fair banding for managers will be top of MiP's agenda.

But to stop these grading issues from coming back in the future, we need to tackle the root cause of 'grade creep': the NHS must be able to recruit and retain the workforce it needs to be safely staffed, without needing people to work above their agreed job descriptions. This requires funding and long-term workforce planning—and not just for clinical roles. If the new government are serious about addressing the structural problems in AfC, then they must back that up with action on staffing. //

Rhys McKenzie (R.McKenzie@miphealth.org.uk) is MiP's communications and policy officer.

A brief guide to race discrimination law: indirect discrimination

In the second part of our guide, Jo Seery explains how the law deals with indirect race discrimination and the evidence you need to build a case.

Unlike direct discrimination, which is when someone is treated less favourably because of their race, indirect discrimination happens when an employer applies a rule or practice which, although not directed at a particular racial group, puts some workers at a disadvantage because of their race. With indirect discrimination, it's the rule or practice that causes the disadvantage, not the protected characteristic of race itself.

How is indirect discrimination defined?

Section 19 of the Equality Act 2020 states that indirect race discrimination occurs when an employer's policy, criterion, or practice (known as a 'PCP') applies equally to everyone but puts, or would put, one racial group at a particular disadvantage compared to others. There's no requirement to show *why* the PCP causes a disadvantage but, to bring a successful claim, a worker must, be able to:

- identify a PCP which the employer applies to everyone; and
- show that it puts a racial group at a particular disadvantage compared to others; and
- show that they personally are put at that disadvantage

Proving particular disadvantage

A PCP can include workplace policies, rules, and informal practices that, while applied uniformly, result in a disadvantage to a particular group. For example, requiring staff to pass a skills test for promotion might disadvantage employees of a particular race if there is evidence that Black and minority ethnic (BME) candidates are more likely to fail the test. This establishes group disadvantage.

An individual would also need to show that they are personally disadvantaged. Someone of the same racial group who failed the skills test could show individual disadvantage; but someone who did not take the skills test because they were late, for example, could not.

Employer justification

Even if a PCP disadvantages a racial group and the worker can show personal disadvantage, their claim will not automatically succeed. The employer can try to justify the PCP by showing it's "a proportionate means of achieving a legitimate aim".

There is no statutory definition of a legitimate aim, but the employer must provide evidence that justifies the PCP. Examples of legitimate aims often relied on by employers include business efficiency, health and safety, maintaining workplace standards, protecting patients or providing an efficient service. But case law has established that cost alone is not a legitimate aim.

Even if the employer's aim is "legitimate" the means of achieving it must be proportionate, balancing the employer's reasonable needs against the discriminatory impact on the worker. For instance, the skills test requirement might be justified based on promoting the best candidates for the job, but if it means fewer BME workers are promoted, the employer must consider if there is a less discriminatory way to do this.

Same disadvantage

Since January 2024, workers can claim indirect discrimination even if they don't share the protected characteristic of workers who are disadvantaged – provided that they are put at "substantially the same disadvantage". In a recent case, it was argued that non-British nationals were disadvantaged by a change in working schedule, because they were less able to comply with the schedule than British nationals. A British national brought a claim of indirect race discrimination, arguing they were put to the same disadvantage. This aspect of indirect discrimination is a new and developing area of the law.

Gathering evidence

Evidence is crucial in proving indirect discrimination. Consider the following key questions:

- What is the PCP, and whom does it affect?
- Is the aim legitimate?
- Is the PCP proportionate, or is there a less discriminatory way of achieving the legitimate aim?

Evidence of whether BAME workers are, or would be, put at a particular disadvantage can come from equality statistics, policy impact analyses or other comparative evidence showing how the group is negatively affected or disadvantaged compared to others. Public sector employers like the NHS also have a specific duty to publish equality-related information. This can be useful evidence when establishing whether a new policy or practice is indirectly discriminatory.

Proving indirect race discrimination can be complex and understanding your rights and what's required for a successful claim is crucial. If you believe you are being subjected to indirect discrimination, seek advice from your MiP rep or national officer as soon as possible. //

Jo Seery is a senior employment rights solicitor at Thompsons Solicitors, MiP's legal advisers. For more information visit: thompsonstradeunion.law.

Legal Eye does not offer legal advice on individual cases. Members needing personal advice should contact MiP by emailing MemberAdvice@miphealth.org.uk.

How to manage in a crisis and come out stronger

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Leadership coach and former senior detective *Andy Cribbin* offers his tips for managers on how to prepare for a crisis, manage calmly and deliver results that people will remember.

After years of austerity, Covid and industrial unrest, even a normal day in the NHS can feel like you're going from one crisis to the next! But when a crisis does strike, which it will, making sure you and your team are well prepared will help you to get through the incident and recover in a much stronger position.

1. Get to know your risks

Read and understand your organisation's risk register. It will help you to identify the threats you could face, the likelihood of them occurring and their potential impact on the organisation. Understanding the risk enables you to plan how to respond when a crisis happens.

2. Test plans to destruction

Understand the role that you and your team are expected to play in any crisis. Attend relevant CPD events and training. When engaging in table-top exercises, test your plans to destruction; it will help you to think 'outside the box' if the unthinkable happens. The alternative solutions may be impracticable or impossible but it's better to consider them in a safe environment rather than in the middle of a crisis.

3. Use your experts

You may only have a basic working knowledge of some problems and potential solutions. Identify the experts in these areas and embed them in your team. The final decision lies with you, but use your experts' knowledge and experience to guide your thought processes and support an evidence-based approach to problem solving.

4. Think about resilience

Know your own resilience levels and the fact that everyone's will be different. At the onset of the crisis, will you and your team be in the 'right mindset' to take on the challenge or is somebody else best placed to do it? It's better to highlight any personal issues before taking control rather than mid-crisis, when a change of leadership or staff will be more difficult. Allow individuals to decline the role without losing face.

5. Don't reinvent the wheel

Being in crisis mode doesn't mean you have to stop using the people and processes you'd ordinarily use. You may just have to flex your response according to the scale of what you're dealing with. Recognise that staff may not be used to the pace and urgency required, but with support and encouragement you'll enable them to deliver beyond their expectations

6. Surround yourself with a trusted team

Who are your go-to people—the people you trust most, who deliver results and complement your strengths and weaknesses? They may include your current staff or people you've worked with before. Bring them into your team at the earliest opportunity. The familiarity and bonds you share will help you successfully navigate all the challenges.

7. Document key decisions

Start a decision-making log and record the 'key' decisions. Note the decision, when you made it, when you recorded it and what you knew at the time. By recognising and recording the complex decisions, you'll be able to learn from your responses and defend your decision making at any subsequent review.

8. Identify key decision makers

Understand the hierarchy among partner agencies and who has the authority to make decisions within each one. You'll only have time to brief key stakeholders once, and will need answers and agreement at pace. By identifying the right level from the outset, you'll avoid repetition and having to constantly update interested parties as opposed to the actual decision makers.

9. Look after your team

Make sure that you have a robust policy to manage the physical and mental wellbeing of your staff during and after the crisis. Don't forget to include yourself: who's looking out for you, supporting your welfare and being your critical friend?

10. Hold your nerve

It's imperative to show that you are calm, measured and in control—even when you're feeling the exact opposite. You're in charge because of your proven ability. Follow your training, stick to tried and tested processes and don't panic. You will regain and maintain control. The satisfaction you feel from delivering in the most challenging circumstances will be one of the defining moments of your career. The stress is short lived, but the pride of success lasts forever. //

Andy Cribbin, a former detective superintendent with Lancashire Police, provides leadership training and coaching for a range of private and public sector organisations. For more info email andycribbin@icloud.com

meetyour**reps**:**David Williams**

"MiP reps have a unique role: we know how the system works"

New MiP rep David Williams explains how he brought his management experience and risk management skills to the aid of MiP members facing a major restructuring at one of England's most troubled ICBs.

"My job as a rep is to support members who are experiencing challenges at work and also to support the organisation to do better, by working collaboratively with management and feeding back the voice of our members," says David Williams, MiP rep at Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (ICB)—commonly known as BOB. David has his work cut out: BOB could be doing a lot better and there are plenty of MiP members needing support from David or the wider union.

After becoming an accredited rep only in February this year, David immediately found himself in the deep end. A restructuring in 2023 had left the ICB facing a 40% cut to operating costs—potentially putting many jobs at risk among its 400-odd staff. A consultation, launched in April, failed to provide staff with enough information, David says—a view shared by most members. "They came up with an operating model that fundamentally wasn't fit for purpose... You couldn't see the rationale for why some roles were removed rather than others, and staff were asking questions and not getting any feedback," he explains.

David brought together the seven unions at BOB to agree a response. "We needed to be co-ordinated and work with the organisation in a positive but challenging way to get them to do the restructuring properly," he explains. "One of the basic principles of consultation is that staff have sufficient information to ask questions and inform their decisions, and they weren't able to do that."

The ICB "relaunched" its consultation in early July, this time proposing to expand its workforce to over 560 posts. "The problem is that they've repeated many of the mistakes from the first consultation, but we've continued to feed back members' views, with input from the other unions," David says. The consultation has now closed and the ICB is now working on the feedback from staff before going to the board for approval.

> *// I like identifying a problem and working with people to find a solution, That's the bit I enjoy the most. //*

MiP taking the lead during the negotiations has "worked naturally quite well", David says, because as a senior manager he knows how the system works. He adds: "I feel the MiP rep's role is quite unique in that you can use your management experience to bring some shape to the discussion."

In his day job as associate director of quality, "I tend to get involved when things have not gone so well," David says. "I work with teams to see what's gone wrong and what we could do differently—the aim is to design the problem out of the system." He also supports the commissioning of services for patients who don't fit into traditional care pathways and supports colleagues to identify good quality services and work with organisations on quality improvement.

Collaborative working and building relationships are key to David's work as a manager, union rep and co-chair of the ICB's LGBT+ network. "I like identifying a problem and working with people to find a solution," he explains. "That's the bit I enjoy the most. My background is in risk management and I can use those skills to unpick the problem with them."

In a small union like MiP, local reps have a lot of autonomy, and David says it can be difficult knowing how far he can take decisions for the union. "I often think, I'm going to challenge them on this, but you need a bit of a sense check when you're talking about putting yourself into a dispute." He's been able to draw on support from MiP national officer Rosie Bartram and a national network of ICB reps set up by the union's national organiser Katia Widlak. The group now meets regularly to discuss common issues and share experiences and best practice.

When the restructuring is over, David would like to spend more time recruiting members. "People need union support because these things aren't going to be a one-off," he warns. And he would also like more opportunities for MiP reps and members to meet as a collective. "It would be really nice to see some of the people I've talked to face-to-face," he says. " //

If you're interested in becoming an MiP rep, contact MiP's organiser, Katia Widlak: k.widlak@miphealth.org.uk.

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