issue 59 | spring 2024

healthcare manager

Caroline Lamb
Scotland's NHS chief on taking the plunge, healing the workforce and her "enormous" financial challenge

Care at the speed of thought
Could AI rescue NHS mental health services?

In place of fear
Why it's time to end the NHS blame game

Running on empty
The non-stop pressures pushing executive managers out of the NHS

mip managers in partnership
The union for senior health & care managers

There's more to life than work

That's why UNISON Living is here to help you get the most from your own time too.

Maybe you want to head off to the sunshine on a budget, or perhaps upgrade your car and you want a good deal.

Whatever your need, UNISON Living can connect you with a trusted partner.

We've used the huge power of our 1.3 million members to secure some of the best deals exclusively for you.

Take a look at benefits.unison.org.uk

Or call UNISON Direct on 0800 0 857 857

You'll see how your UNISON membership can benefit your everyday life too.

UNISON Living

healthcare manager

Published by:
Managers in Partnership,
Centenary House,
93-95 Borough High St,
London, SE1 1NL

I've recently spent time talking to people inside and outside the NHS about artificial intelligence in healthcare (*see page 19*). The possibilities are exciting but it's no quick fix. The safety, ethical and workforce challenges are huge. It will take time and money to capture the full benefits of this technology for patients and staff.

In his spring Budget, Chancellor Jeremy Hunt unveiled a £3.4 billion package of technology investment—some of it earmarked for AI projects. It sounds like a big number, but here's a bigger one: Hunt said this investment would "unlock" £35 billion in savings. His figures may be optimistic but the point is well made: investing money where it's needed now can save a whole lot more later on. Which begs the obvious question: why not do more of it?

In public finance terms, £3.4 billion over three years is small beer—less than 0.7% of NHS spending. The idea that this will pay for a significant extension of AI, new apps for staff and patients, electronic patient records for everyone and modernising all the outdated IT systems in England "so they're as good as the best in the world"—all of which Hunt claimed in his speech—is risible.

The British state is rubbish at investing for the long-term (*see page 8*). This is due partly to Treasury rules, which don't really distinguish between 'investment' and 'spending', and partly to straightforward political short-termism: politicians don't like spending money now when credit for the benefits will go to their successors in the future.

That makes long-term investment hard to do. Hard, but maybe not impossible. Other democratic countries seem to manage it better. And one home-grown example is the UK's climate change response, where a degree of political consensus about long-term goals, cross-departmental working and some independent scrutiny through the Climate Change Committee has led to real progress. We may not be doing anywhere near enough, but in our 'now-ist' political culture, it's a wonder we're doing anything at all. There are lessons there for healthcare and our other vital public services. //

Craig Ryan, Editor
c.ryan@miphealth.org.uk

headsup

News & noticeboard ---- 2

analysis & opinion

Home ground: It's time for a new public service paradigm! *Craig Ryan* delves into the 'New Localism' ---- 8

Leading Edge: *Jon Restell* on why the NHS's poor working culture can't just be blamed on managers ---- 10

features

Interview: Caroline Lamb Scotland's NHS chief talks exclusively to *Healthcare Manager*'s *Matt Ross* ---- 11

Running on empty: Board-level MiP members talk to *Rhys McKenzie* about burnout, political pressure and executive pay ---- 14

In place of fear: How do we end the blame culture in the NHS? *Jessica Bradley* investigates ---- 16

Care at the speed of thought: *Craig Ryan* explores the brave new world of artificial intelligence: could it transform struggling mental health services? ---- 19

regulars

Legal Eye: *Jo Seery* picks over the changes to employment law coming up in 2024 ---- 22

Tipster: Executive coach *Jane Galloway* gives her tips on building up your resilience at work ---- 23

Meet Your Reps: *Sue Glendenning,* York and Scarborough NHS trust ---- 24

healthcare manager

issue 59 | spring 2024

ISSN 1759-9784

Design & Production: lexographic.co.uk

Contributors: Jessica Bradley, Jane Galloway, Rhys McKenzie, Jon Restell, Matt Ross, Craig Ryan, Jo Seery.

Opinions expressed are those of the contributors and not necessarily those of *Healthcare Manager* or MiP.

Printed by Kind (kindagency.uk) on uncoated FSC-approved paper with vegetable-based inks. Please recycle when you're done.

Cover image: Gary Doak Photography

Managers in Partnership (MiP) is the trade union organisation representing health and social care managers in the UK. 020 3437 1473 // miphealth.org.uk // info@miphealth.org.uk // Twitter: @MiPhealth // Linked In: Managers in Partnership

headsup

News you may have missed and what to look out for

noticeboard

9 May 2024

FDA Annual Delegate Conference

One Great George Street, London SW1

Annual conference of MiP's parent union, with guest speakers and policy debates.

mip.social/fda-conference

14 May 2024

King's Fund Integrated Care Summit

King's Fund, London W1

"Inclusive and thought-provoking" discussions on how health and care leaders are tackling the key issues with integrating care.

kingsfund.org.uk/events/integrated-care-summit

10 June 2024

NHS Scotland Event 2024

SEC Glasgow

National conference for health and care leaders north of the border, focusing this year on "delivering health and care services through innovation and collaboration".

nhsscotlandevents.com

12–13 June 2024

NHS ConfedExpo 2024

Manchester Central

One of the largest conferences bringing together health and care leaders from across the UK. Run jointly by the NHS Confederation and NHS England.

nhsconfedexpo.org

18–21 June 2024

UNISON National Delegate Conference 2024

Brighton Conference Centre

UNISON's main national policy-making conference, with debates on motions from branches and the union's National Executive Council.

unison.org.uk/events/2024ndc

25–26 June 2024

King's Fund: Meeting the Productivity Challenge

Online

Two days of virtual discussions on what productivity in healthcare means, and how it can be improved for the benefit of patients and staff.

kingsfund.org.uk/events/meeting-productivity-challenge

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

A&E

Political meddling harms patient care, union warns

MiP has called for an end to "dangerous political meddling" in the running of NHS services following reports that some trusts were being pressured into diverting resources towards treating less sick patients to meet "political" targets.

The *Health Service Journal* reported in February that trusts were coming under pressure from NHS England regional teams "to focus energies on patients in their emergency departments who do not need to be admitted" in an effort to improve performance against the four-hour A&E target.

Some trust leaders told the *HSJ* they were ignoring the instructions because patients who needed to be admitted were more likely to suffer harm from long waits in A&E. It was unclear whether the NHS England teams involved were acting on their own initiative or passing on instructions from ministers, the *HSJ* said.

MiP chief executive Jon Restell said the union heard "too often" about local NHS managers being pressured to work to "political priorities"

rather than patients' needs. "Being scapegoated when politicians get it wrong" was one of the main reasons for senior managers leaving the NHS, he warned.

"Managers must have the autonomy to make decisions they know are best for patients," he added. "Political meddling in the day-to-day operation of NHS services is dangerous, it impacts the morale and motivation of staff and ultimately harms patient care."

Flexible working

‘Let’s talk about flex’: health unions launch NHS flexible working campaign

MiP and 16 other unions have launched a campaign to make flexible working in the NHS more accessible. ‘Let’s talk about flex’ calls on NHS employers to actively encourage and promote flexible working, which unions say helps to counter burnout and stress, improve morale and motivation, and gives workers a healthier work-life balance.

NHS unions argue that employers have failed to take full advantage of flexible working since NHS staff secured the right, in 2021, to request it. Dissatisfaction with flexible working arrangements was cited by 30,000 workers as a reason for leaving the NHS last year alone, unions say.

MiP chief executive Jon Restell said, with NHS staff under “immense pressure from rising workloads and dwindling resources, now is the time to embrace flexible working and the benefits it brings.

“Flexible working has proven to support staff wellbeing, combat stress and reduce burnout,” he added. “Crucially, it will help with the retention of staff at a time when many are leaving the NHS entirely over concerns about their work-life balance.”

Flexible working also benefitted patients, Restell said: “A healthy and happy workforce is more productive and will support the NHS in delivering the high standards of timely care the public expects of it. We encourage members and employers to engage with the campaign and promote flexible working in their workplace.”

The campaign will offer resources to staff and managers, highlight positive examples of flexible working in action and engage with employers to ensure flexible working requests are considered fairly.

To find out more about the Let’s talk about flex campaign, visit talkaboutflex.org.

NHS England

Back to office rule will damage productivity, MiP members say

NHS England’s new hybrid working policy requiring staff to spend at least 40% of their time in the office is more likely to damage productivity than improve it, according to a survey of MiP members working at the national body.

More than 600 managers—well over half of MiP’s membership at NHSE—took part in the survey, with less than one in five supporting the new policy. 73% of members said it would reduce their productivity at work, while only 6% said it would have a positive effect.

NHS England announced in January that all staff with office-based contracts must attend the office for at least 40% of their working week from April 2024. In a message to staff, NHS England’s executive group said: “Working together in person better helps us to solve common issues and have have a social conversation which can support our wellbeing, particularly among younger staff and new starters.” Office-based working would also help to “create the best possible inclusive culture, experience and environment”, NHSE claimed.

ANYA BERKUT @ISTOCKPHOTO

MiP was critical of the new policy, which it said was announced with no evidence or business case. The decision seemed to be based more on “politics rather than how it impacts staff and their ability to deliver value for the public”, said the union’s chief executive, Jon Restell.

NHS England has downsized its estate significantly since 2020, posing significant logistical challenges to the new policy. Half of those taking part in MiP’s survey said their office could not handle the increased use due to a lack of space, desks and dedicated areas for online meetings. Survey participants also cast doubt on NHS England’s claim that office working “helps us to solve common issues”: around three-quarters reported that their immediate teams were based at different locations to their own.

Some members also raised concerns about the impact of the hybrid working policy on those affected by NHS England’s ongoing organisational change programme, with some staff now unable to seek suitable alternative employment at bases far from where they live. MiP national officers have raised these concerns and others brought to light by the survey with NHS England’s management team.

VSMs/ESMs

NHS England unveils new fitness tests for NHS directors

NHS leaders in England will expected to show how they are driving service improvement, delivering transformation, promoting equality and developing a just culture as part of new "competency framework" for directors published by NHS England.

The framework, which applies to trusts, Integrated Care Boards and NHS England itself, sets out six "domains" within which board-level managers must assess themselves. Each domain contains a series of "competency statements" for directors to mark themselves on a sliding scale from "almost always" to "no chance to demonstrate". These assessments will then be discussed with chairs or chief executives as part of the annual appraisal process.

The six domains, which NHS organisations have been instructed to include in all board-level job descriptions from April, are:

- Driving high-quality and sustainable outcomes
- Setting strategy and delivering long-term transformation
- Promoting equality and inclusion, and reducing health and workforce inequalities
- Providing robust governance and assurance
- Delivering a compassionate, just and positive culture
- Building a trust relationship with partners and communities

The competencies strongly emphasise equality and inclusion, with requirements to "speak up" against racism, bullying and sexual harassment, challenge unsafe or unfair practices and ensure a "safe culture" for staff who want speak up.

"Competency frameworks underpin good management practice, but they don't make management good by themselves," commented MiP chief executive Jon Restell. "Good culture and do-able jobs are just as important, if not more so. The present drive to make the executive management overhead go further, coupled with micro-management and too much regulation, will eat the framework for breakfast," he warned.

For full details of the new framework, visit mip.social/nhse-competency.

NHS staff survey

Staff morale improves, but one in five still want to leave

The 2023 NHS staff survey showed modest improvements in staff morale, job satisfaction and levels of burnout, but found NHS workers were facing record levels of discrimination from the public and a significant proportion still plan to leave their jobs in the near future.

More 700,000 of the NHS's 1.4 million workers took part in the survey at the end of last year, answering dozens of questions of every aspect of their working lives, including questions on sexual harassment for the first time.

NHS England's chief workforce officer, Navina Evans, said it was "good news" that "staff are happier at work than last year" but admitted "there is still more to do". The high levels of sexual harassment and discrimination from the public revealed by the survey were "distressing" and "should not be tolerated in the NHS", she said.

Commenting on the survey, MiP chief executive Jon Restell warned that despite some signs of improvement "the overall experience of working in the NHS today is still well below what it was before the pandemic."

Following last year's 5% pay rise, satisfaction with pay rose slightly to 31%—but this was still the second lowest level recorded since the survey began in 2003. More than one in five staff want to leave the NHS within the next year, with almost one in six wanting to go as soon as possible.

"As two in every three staff are still not satisfied with their pay, it's easy to understand why so many are considering leaving the health service this year," added Restell. "The government have an opportunity to reverse this trend as staff are due a pay rise from April, but ministers have yet to put anything on the table."

He said positive results for line managers—73% said their immediate manager valued their work and was supportive—were "to be celebrated especially given the pressure on staff and services".

NHS staff reported more than 58,000 incidents of "unacceptable and unwanted" sexual behaviour from patients, relatives or other members of the public during 2023. Overall, 10% of staff experienced sexual harassment from the public, and 4% from colleagues. Levels of discrimination remain high: only 56% said the NHS treats staff fairly over career progression and promotion, and nearly one in ten said they had personally experienced discrimination at work.

Restell described the level of violence, discrimination and sexual harassment staff were facing from the public as "truly shocking" and warned that a comprehensive strategy to reduce violence, agreed by NHS employers and unions in 2020, would need "sustained leadership and investment to make a difference".

Sarah Woolnough: "staff are feeling undervalued, stretched and unwell"

Commenting on the survey results, Sarah Woolnough, chief executive of the influential King's Fund think tank said: "There are some positive improvements across various indicators, but we can't ignore the main message from this survey: that NHS staff are feeling undervalued, stretched and unwell and there is still work to do to make health and care a more attractive career."

For the survey data and a briefing on the national results, visit nhsstaffsurveys.com.

Budget 2024

Extra cash for tech but NHS spending squeeze set to bite after election

Unveiling his March Budget, Chancellor Jeremy Hunt announced a £2.4 billion increase in day-to-day NHS spending in England, a real terms increase of around 1.5%, and a £3.4 billion package of capital investment in technology spread over the next three years. But the Chancellor also set out plans to restrict spending growth in public services to 1% during the next parliament, and offered no new investment in adult social care.

The funding settlement showed "this government is here for the NHS", Hunt told the Commons on 6 March. "It will allow the NHS to continue its focus on reducing waiting times and brings the total increase in NHS funding since the start of the parliament to 13% in real terms," he said.

Critics say the settlement isn't as generous as the Chancellor claims. Budget documents reveal that the £2.4 billion spending boost will partially be used to cover the ongoing cost of the 2023 pay deals for NHS staff, and Hunt's additional tech investment comes with a big string attached: a requirement for 2% NHS productivity growth for the next five years—more than twice the historic average.

The additional funding was "welcome", said Health Foundation chief executive Jennifer Dixon, "but no-one should be under any illusion that this will significantly reduce the long waiting times currently being experienced by patients. Social care was notable by its absence from the Chancellor's speech."

Responding to the Budget in the Commons, shadow health secretary Wes Streeting said per-person funding for the NHS was still set to fall in 2024-25 and warned the Budget would do nothing to help the NHS which was "going through the worst crisis in its history".

In his Budget speech, Hunt claimed his £3.4 billion technology investment would "modernise NHS IT systems so they are as good as the best in the world". But it remains unclear whether the package will be fully funded or partly financed from other government capital budgets. The £2.1 billion NHS technology budget announced in 2021 was later cut by half as funds were diverted elsewhere.

Specifically, the Chancellor promised to invest in replacing outdated IT systems, extending the use of artificial intelligence in NHS services (see page 19) and revamping the patient-facing NHS App, which has largely fallen into disuse since the pandemic. Hunt also set out plans to develop a new NHS staff app for electronic rostering, and for all trusts to have an electronic patient record by 2026—despite several previous deadlines being missed.

Chancellor Jeremy Hunt: "This government is here for the NHS"

CLICKPICS/ ALAMY STOCK PHOTO

NHS England chief executive Amanda Pritchard said the new investment "means the NHS can now commit to deliver 2% annual productivity growth in the final two years of the next parliament, which will unlock tens of billions of savings."

But some experts cast doubt on the feasibility of this target. In a King's Fund blog, the think tank's chief policy analyst, Siva Anandaciva, wrote: "Will these NHS productivity ambitions be realised by 2029–30? I'm not so sure." Productivity improvements depend not only on technology, but also on "better infrastructure and changes to how staff are trained and retained", he said. "The missing pieces of the puzzle then are big ones, including where the capital funding will come from to improve increasingly worn-out NHS buildings and equipment."

NHS staff in Northern Ireland back 5% deal after months of strikes

After months of industrial action, NHS workers in Northern Ireland have voted to accept a 5% pay offer for last year from the Department of Health. Negotiations had been stalled for months due to the breakdown of the power-sharing Northern Ireland Executive, which finally returned to office in February.

As well as a 5% consolidated pay rise for all Agenda for Change staff, the offer includes a one-off payment of £1,505 for all staff regardless of grade. If accepted in a ballot, the offer will bring health workers' salaries in Northern Ireland into line with those in England. The pay award will be backdated to April 2023.

Jamie Briers, MiP's national officer for Northern Ireland, said the "long-overdue" offer showed "staff that their efforts throughout this extremely challenging period have been recognised". Maintaining pay parity with staff in England would "be welcomed throughout the workforce", he added.

Briers said MiP "appreciated" that the flat-rate lump sum offered to members was designed to help lower-paid staff, but said members would be "disappointed" that, at £1,505, the one-off payment was lower than those paid to staff in England, Wales and Scotland.

MiP members in Northern Ireland were balloted on the offer during March. Full details of the ballot result will be sent directly to members from UNISON.

'Put NHS pay right': MiP and UNISON launch 2024 pay campaign

MiP and UNISON have launched a joint campaign, 'Put NHS Pay Right', aiming to bypass the lengthy, unreliable pay review body process and press for direct pay talks with government, *writes Rhys McKenzie.*

NHS staff are due a pay rise from 1 April 2024, but government delays mean it's unlikely the uplift will be received until later in the year. Informed by the results of the recent survey of MiP and UNISON members, the unions are asking the government to negotiate on three key areas:

- A proper pay rise
- The right banding
- A shorter working week

"Action to address these areas is vital if the NHS is to recruit and retain the workforce it needs to deliver on its commitments, bring down waiting lists and improve access to services,' said MiP chief executive Jon Restell.

A proper pay rise

A majority of members in every type of role and every pay band said that increasing pay is the number one priority. A decade of pay decline means NHS staff at all levels are paid less for their work in real terms than in 2010. As inflation did not fall as expected last year, the 2023 award—despite being significantly better than the government's initial offer—failed to reverse that trend.

Improving pay also means making sure that experience and promotion are fairly rewarded. Currently, there is little incentive for Band 7 staff to go for promotion to Band 8A. With a very modest increase in base pay, often offset by the loss of terms and conditions like overtime pay and unsocial hours payments, it's no surprise that NHS employers struggle to fill these posts from within their organisations.

The arbitrary five-year wait to reach the top of Bands 8 and 9 is another disincentive to seeking promotion. The time it takes to reach the top of a pay band should not be based solely on length of service, and it should be no longer than needed for staff to become competent, trusted and confident in their jobs.

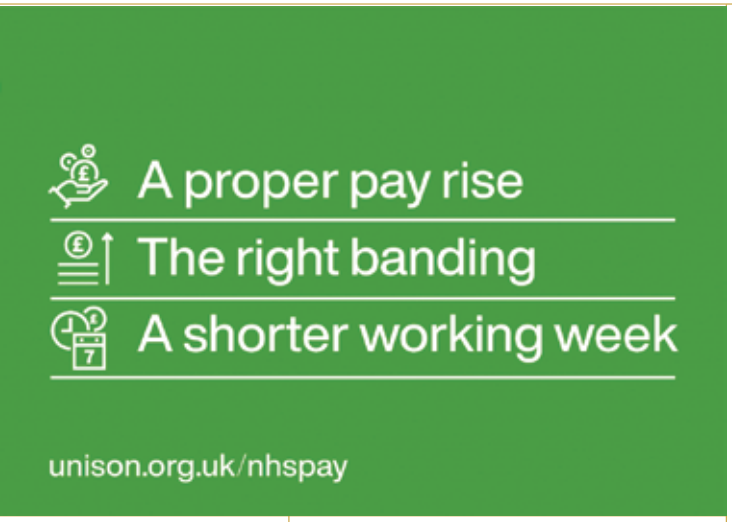
The right banding

All staff should be entitled to role and pay band reviews to ensure they are being paid the correct wage for the job. Thousands of NHS workers routinely go above and beyond their job spec, but are not being paid for it. This is demotivating, drives burnout and ultimately results in staff leaving the NHS.

The government must ensure that NHS employers have the resources to modernise job evaluation processes, and can evaluate and band jobs properly so staff get paid for the work they actually do.

A shorter working week

The campaign is also aiming to obtain a shorter working week for NHS staff without loss of pay. Better work-life balance improves morale, reduces burnout



// Improving NHS pay and working conditions isn't just about NHS staff. It's about all of us who use services and the benefits that come from a fully resourced and highly motivated NHS workforce. //

and can lead to more productive working, helping to reduce the NHS's dependency on paid and unpaid overtime and costly agency workers.

Reducing working hours was the third highest priority in our members' survey. Just under half of NHS staff reported feeling exhausted after the working day and a similar proportion said they have felt unwell due to work-related stress.

Staff in both administrative and clinical settings have already identified a number of ways to enable a shorter working week while still delivering on their job commitments. So far, government mandates to improve NHS productivity have focused only on cutting staff numbers, meaning those who remain are asked to do more with less. This is counter-productive as staff quickly become burnt out due to the increased workload and relentless pressure. If ministers are serious about improving productivity, then exploring ways to implement shorter working hours should be their priority.

Commenting on the launch of the campaign, Jon Restell said: "Improving NHS pay and working conditions isn't just about NHS staff. It is about all of us who use services and the benefits that come from a fully resourced and highly motivated NHS workforce. We will make this case to government and will keep members updated on the progress of campaign."

Rhys McKenzie is MiP's communications officer. Visit the campaign page on the UNISON website: mip.social/pay-2024.

Separate pay system for nurses "divisive", union says

MiP has criticised as "divisive" and "time wasting" proposals in a government consultation paper to introduce a separate pay spine for nurses in England, removing them from the national pay framework covering most NHS staff.

The consultation paper, published in January, outlines two alternative proposals. One is to introduce a pay spine exclusively for nurses within the current Agenda for Change framework, meaning most terms and conditions would remain the same as for other staff groups, with only pay set differently. The second is to negotiate a new contract for nursing staff, removing them entirely from Agenda for Change. This could mean changes to other terms and conditions as well as pay.

Health minister Andrew Stephenson claimed the consultation had been launched in response to "union concerns" and would explore both "the risks and benefits" of a separate pay structure for nurses, "ultimately helping to make the NHS a better place to work."

MALCOLM PARK / ALAMY STOCK PHOTO

Health minister Andrew Stephenson: exploring "the risks and benefits" of a separate nurses' pay system

But MiP chief executive Jon Restell warned the proposals would "fragment" the NHS pay system, "pitting different staff groups against each other", and would not lead to the improvements needed for all staff.

"Nurses, alongside all other NHS workers, rightly expect the government to pay them fairly for the work they do for the public," he said. He warned that a separate pay spine "would only diminish team morale and consign employers to years of legal disputes on equal pay claims".

He added: "MiP recognises there are issues within Agenda for Change, with levels of pay as well as grading and career progression. These issues should be the focus of the government—not wasting time and resources on a divisive proposal that risks undermining the hard-won terms and conditions of the entire NHS workforce."

Go long and go local

A growing army of academics and local leaders say thinking long-term and giving power to local people and staff is the key to saving the NHS and the UK's other ailing public services. But are national politicians listening?

In a gloomy end-of-year report for 2023, the Institute for Government (IfG) warned that UK public services are trapped in a "doom loop" where "perpetual crises" pile pressure on staff, undermine performance and focus ministers' attention on survival and news management rather than solving problems. Government policy has become "erratic and unpredictable", the influential think tank complained, making it impossible for public service leaders "to plan or implement performance-enhancing reforms".

Nevertheless, both Rishi Sunak and shadow health secretary Wes Streeting insist that "reform" will "save" the NHS—although neither have been upfront about how. In the mouths of ministers, "reform" often sounds like a threat and adds up to little more than political stunts like ordering staff back to offices or cutting equality jobs. But Labour's reform plans aren't much clearer, and with little money to spend it's hard to see how Labour ministers will break out of that doom loop.

Britain (or England at least) hasn't had a public service reform strategy since the Lansley NHS reforms burned up on contact with reality a decade ago. Lansley now looks like the last gasp of New Public Management (NPM), which emphasised choice, competition and importing management practices from the private sector, and underpinned the reform efforts of the Blair, Brown and Cameron governments. Even according to Aveek Bhattacharya, chief economist at the pro-market Social Market Foundation, "there seems little appetite to continue down the same path".

Ben Glover, head of social policy at independent think tank Demos agrees. "We've seen a retrenchment of marketisation, choice and competition in public services," he says. "The scorecard is not good in the UK. It's been very hard—maybe impossible—to build genuine competition in public services and it's increasingly questionable whether choice is what people want."

With the prospect of a Labour government later this year, both Demos and the Institute of Public Policy Research (IPPR) recently published reports sketching out a new strategy for public services. They reach similar conclusions: the future of public services is local and long-termist. A sustainable recovery demands a transformation in the relationship between the state, citizens and local communities, and a complete shift in the way politicians operate—away from short-term, politically driven policies imposed from Whitehall towards long-term investment, workforce empowerment and local control.

These reports bring together clutch of related ideas that have gained currency recently, often as a grass-roots response to cuts in local services. Sometimes known 'the New Localism' or 'the Community Paradigm', these draw on thinking by the American Nobel-Prize-winning economist Elinor Ostram, who argued that local communities could resolve social problems better than central government or the market, and the British social entrepreneur and author Hilary Cottam.

Cottam's influential 2018 book, *Radical Help*, set out a new model for welfare systems based on "deep participation", "building capabilities" and "fostering human connections". It's the thinking behind council programmes like the Wigan Deal and East Ayrshire's Vibrant Communities, and the work of the National Lottery Community Fund and New Local, a network of reform-minded councils.

If NPM was driven by financial incentives, New Localism is all about relationships. Enthusiasts, like Demos chief executive Polly McKenzie, talk about replacing the "transactional model" of public services, focusing on "actions done to people", with a "relational model" where services collaborate to build people's capacity "to resolve their own problems in their own ways". She quotes Sir Robert Peel's original vision for the police: "the police are the people and the people are the police". For the NHS that could mean a lot more community engagement, delivery partnerships, collaborative service design, supporting volunteers or "simply friendly outreach", she writes.

The thinking behind Integrated Care Systems—focusing on collaboration, prevention and tackling the social causes of health—"is also part of this movement even if they're not really working that way in practice," Glover says.

The logic of ICSs is that devolution and integration go together. "It's easier to

"Sustainable recovery demands a complete shift in the way politicians operate—away from short-term policies imposed from Whitehall towards long-term investment, workforce empowerment and local control."

join up services at local level", says Chris Thomas, the IPPR's head of health, because "you can get real political leverage" over how services are run. He cites "good results" in Greater Manchester, such as mayor Andy Burnham's negotiation of NHS funds for homelessness initiatives. Thomas also points out that while the health secretary isn't particularly powerful within the cabinet, "the NHS is very powerful at local level."

The IPPR also wants to see public service managers and staff empowered to make decisions based on local needs and circumstances. "You have to give power away", says Thomas. "A lack of ability to act on things they realise are going wrong and a lack of leadership capacity were probably, alongside pay, the biggest complaints when we researched with staff."

This would mean ending national targets and frameworks that "dictate processes and take away autonomy, stifle innovation and redirect energy away from genuine leadership," he explains. While there's plenty of evidence from around the world that more "gold-standard modern management capacity" reduces mortality, he adds, "the NHS tends to insource capacity through management consultants, who are literally linked to declining efficiency."

An approach like this would demand "a bigger contribution" from staff, adds Glover, who, rather than "just being told what to do", would have more responsibility and scope "to experiment and be creative". The lack of such freedoms "is one of the reasons why we have a workforce crisis in public services," he says.

But where does all this leave central government? The key ask–and it's a big one–is to shift what Thomas calls "the short-termism baked into the system".

The IPPR's proposal to replace Whitehall targets with "national missions" is more than a rebranding, he insists. Missions are "wide, ambitious societal goals" which go beyond any one service, department or even government itself. "They're challenges that we don't know the answer to completely," he explains.

For the NHS, this could mean a single health mission—Thomas suggests "making the UK the world leader in healthy life expectancy over a 30-year period"—with mission goals "embedded across departments" so other services like social care, schools and housing play their part. Crucially, funding settlements would be long-term and based on the metrics set out in the missions, rather than the outcome of an annual hagglefest between the Treasury and spending ministers.

To overcome the short-termism inherent in five-year parliaments—and the even shorter shelf-life of most ministers—Thomas points to the way Britain's net zero targets were enshrined in the 2008 Climate Change Act, with progress monitored by the independent Climate Change Committee.

"You'd need something similar for health," Thomas says. "If you hold some accountability outside and make sure political capital is invested in it, I think you can sustain progress." Proposals for cross-departmental "mission boards", reportedly being considered by Labour leader Keir Starmer, look like a step in this direction.

Does some of this have a familiar ring? The first politician I interviewed as a young-ish journalist was David Clarke, a Cabinet Office minister in the first Blair government. Clarke proudly showed me his 'digital' red box (a normal red box with a clunky laptop inside) and talked enthusiastically about "breaking down silos" and something called "joined-up government". But more than twenty-five years later we're still talking about it.

"That's because it's really hard to do!" says Glover. The Demos report argues that any serious attempt to devolve power and join up services needs cross-party consensus, which looks unlikely in today's polarised political climate. But there are grounds for optimism, he insists. This agenda can appeal to both the centre-right, who like the localism and the emphasis on self-reliance and cutting bureaucracy, and the centre left, attracted by ending marketisation and the focus on respecting and empowering public service workers.

"If your vision for joined-up government is getting Whitehall departments to work together, you'll probably fail," Glover concludes. "You will only get joined-up public service working at place level, so you need to devolve. Once we've tried that for 15 years in England, you can come back and tell me this is impossible." //

Find out more

- ***Recovery Through Reform: the launch paper of the Future Public Services Task Force,*** **Demos, January 2024 (mip.social/reform-demos)**
- ***Great Government: public service reform in the 2020s,*** **IPPR, December 2023 (mip.social/reform-ippr)**
- ***Radical Help,*** **Hilary Cottam, Little Brown, 2019 (mip.social/cottam)**
- **The Community Paradigm: further reading, podcasts and videos from the New Local network (mip.social/new-local)**

Would the NHS really be a worker's paradise if we just had the right managers?

Every now and then, my colleagues—our amazing national officers and equally amazing workplace reps—and I look up from our individual casework and ask what it says about the workplace culture of the NHS. Sadly, the answer often leaves hearts in boots. As Sam Allen once told our summit, the NHS is one of the wonders of the world, but it's far from perfect. The day-to-day experiences of too many members bear that out.

Bullying and harassment, race discrimination, sexual safety, flexible working, overworking, and psychological and physical safety are big issues on which the NHS does badly compared to other employers. Granted, the NHS staff survey is a more public soul-bearing exercise than other sectors would tolerate, but it clearly shows the NHS has a problem with workplace culture. Staff either hate it and stay or hate it and leave. Neither is good for patients. The evidence for the problem litters the place, from staff surveys, workforce statistics, union casework and legal judgements to the former paramedic bringing a Tesco delivery to your door.

Management is often blamed for the NHS's poor culture. But that's quite a stretch. Take bullying. Researchers say too much demand and too few resources create the pressures on people and systems that are the main cause of bullying. Other research suggests bullying may be endemic in healthcare throughout the world, particularly in certain settings like emergency departments or within clinical hierarchies. To cap it all, the UK's four national health services must contend with the pressures created by short-term political demands (see our member surveys for the effect these can have), micro-management, demanding and often-contradictory regulation, and endless re-organisation.

When managers succumb to these pressures they contribute to the negative culture, but it's missing the point to say they're the root cause. To put it another way, how credible would it be to say that if only we had managers with the right values, training and regulation, the NHS would be a worker's paradise – despite the huge waiting lists, staffing shortages, death by template, political diktats and continual structural upheaval? In my view, not credible at all. Yet politicians and others—inside and outside the NHS—perpetuate this convenient myth because it's simply too hard to fix the root causes of our problems.

> *// Politicians perpetuate the myth that managers cause poor culture because it's simply too hard to fix the root causes of our problems. //*

Some root causes will not be fixed any time soon. The next parliament will not see a Blair-style funding boost. The intrinsic pressures of healthcare will remain. Politicians will demand greater productivity. So the pressures will build, producing strong headwinds against which good culture will struggle to progress. But management can be a powerful mitigation. The latest NHS staff survey found satisfaction with line management back to pre-pandemic levels. It should be a priority—for the good of staff and patients—to support and develop managers.

No one wants to work for decades in a poor management culture. As a managers' union, MiP's contribution is to improve the working lives of managers so they can improve the lives of other staff and the care of patients. So what do our members and reps think can be done?

First, system leaders and managers themselves should accept that day-to-day behaviour and experience in the NHS is shaped by forces beyond the direct control of staff and employers. This will help bust the myth that managers cause poor culture. Instead, good managers mitigate pressures and need investment and support.

Second, in managing the managers, we should stop relying on values—horses that seem to fall easily at the first hurdle—and focus more on actual behaviours. Good practice in managing change, performance and concerns should be essential rather than optional. Endless suspensions, repeating investigations until they come to the 'right' conclusion, sham and shambolic change consultations and harsh treatment are all behaviours towards managers that other managers can stop right now without needing a shift in the tectonic plates.

Third, we need effectively co-produced codes of practice and competencies to underpin management practice; these are essential if statutory regulation comes in. MiP stands ready and able to support such change.

But, finally, codes and training will be sandcastles facing the incoming tide unless there are enough managers doing doable jobs. I get why a head of midwifery, for example, might cut management to get more midwives in the delivery suite right now. But long-term under-management creates conditions from which staff want to escape and in which mums and babies suffer harm. Leaders need to talk openly about the safe management levels needed in all healthcare settings. //

in at the deep end

Joining the Scottish health department just weeks before the pandemic struck, Caroline Lamb found herself as head of NHS Scotland within a year. She tells Matt Ross **about the "intense and scary" experience of managing through the Covid crisis, her plans to integrate services and tackle staff shortages and why Scotland needs more money for health and care.**

"It was very intense; at times it was quite scary, and quite upsetting," says Caroline Lamb, recalling those terrible months after the Covid pandemic erupted in March 2020. "I remember looking at the projections for how many people we could have [arriving] in ICU, and thinking, 'Oh my God!' Fortunately, that's not where we ended up—but it was a really tough period."

Lamb, who is both the chief executive of NHS Scotland and the Scottish Government's director-general for health and social care, found herself going over those uncomfortable memories earlier this year, as she prepared to give evidence to the Scottish Covid-19 Inquiry. The experience brought back "that fear of not knowing whether you were doing the right thing," she says—and no wonder: not only was Lamb dealing with a brand new disease, she'd only joined the civil service "about four weeks before everything started kicking off; so that was amazing timing!"

After a career in public sector finance jobs and a stint as chief executive of NHS Education for Scotland (NES), Lamb had moved into central government in December

2019—initially in a secondment role, as director of digital reform and service engagement for health and care. As Covid spread, her digital skills and relationships with health board chief executives—built up during 14 years at NES—brought many of the fresh challenges presented by this novel virus to her desk.

She first rolled out the 'Near Me' remote consultation service, then turned to expanding ICU capacity. "When it became clear that we probably weren't going to be overwhelmed in ICU, we'd just announced our 'Test to Protect' strategy, so I led the contact-tracing bit of that," she recalls. "Then the vaccination programme." In the midst of all this, Malcolm Wright, then NHS chief executive, stepped down due to ill health and in January 2021, just 13 months after entering government, Lamb succeeded him. "It was quite a journey," she says with some understatement.

Lamb says her most important mission in the job is "engagement across Scottish Government". That's because "80% of the determinants of poor health have nothing to do with what we do in health and social care: it's all about employment, housing, social conditions," she explains. "If health stands on its own, then we will forever just be the repair shop.

"The way to move to a more sustainable system is to reduce some of the demand," she continues. "And we'll do that through playing our part in better employment, better education attainment, greener communities and working with partners around areas like housing and the economy." Health boards and social care organisations must make full use of their roles as major employers and anchor institutions in their local communities, she adds. Meanwhile, she encourages other civil service leaders to promote public health within their own policies.

Collaboration is equally important in Scotland's Integration Joint Boards (IJBs)—which bring NHS boards together with local authority social care services—and in the broader, place-based community planning partnerships (CPPs). Progress here accelerated when Covid arrived: "The pandemic was awful, but it did simplify the world a little bit. For that period, we had one thing to focus on," says Lamb. "The pandemic built closer working relationships, and demonstrated the value of integration to the system more broadly."

To pursue this agenda, the next generation of health and care leaders will need to be "supportive of staff, supportive of innovation," and able to work "with partners in ways that benefit the population in your area, in an environment where you don't have all the levers to pull," says Lamb. "As the financial climate gets tougher, it's even more important that we're working across the piece."

That also entails close collaboration between employers and unions in local area partnership forums. "When we do annual reviews with health boards, we sit down with the area partnership forum and hear from them about what's working, what isn't working; and what we would be expecting to hear is that those relationships are robust," she says. Senior NHS leaders are expected to work in partnership with union representatives and engage them in decisions about services, she adds.

Scotland's success in avoiding the pay strikes seen in England has, Lamb says, "helped to preserve and maintain those relationships" with unions. In 2023–24, the Scottish Government agreed an Agenda for Change deal for giving those earning under £57,769 a lump sum payment and a 6.5% rise, comfortably topping England's 5% settlement. Averting strikes has been hugely beneficial, "not just because it has prevented us from having to cancel operations and appointments, but also because it reflects the fact that we value the workforce": making a relatively generous offer, she believes, sent an important signal to staff.

However, more senior staff saw their rise capped at £3,755, generating significant real-terms pay cuts for many MiP members. Is Lamb concerned about the risk of losing highly-skilled people to the private sector? "I guess it depends on the extent to which people are motivated by that bit of the overall package," she replies, emphasising the NHS's strong employee benefits and the chance to "improve people's lives". Public/private pay differentials for technical professionals are becoming unsustainable, I suggest: "There are absolutely some aspects—and digital would be a key one—where it's not only that we're in competition, but also that there aren't enough good people out there," she concedes. "And that's a challenge."

Indeed, NHS Scotland is not short of challenges. Winter performance against the A&E four-hour wait target has hovered around 60–65% for the last two years, way below the 95% goal: "2021–22 was a really hard winter; 22–23 wasn't great either," says Lamb frankly. "23–24 feels a bit calmer, but that might just be because we've normalised working at very, very high levels of pressure." On elective treatments, "all health services have built up a backlog as a result of the COVID pandemic," she adds. "We're also dealing with a population—particularly the elderly population—that got deconditioned during the pandemic."

To close those gaps, Scotland must address recruitment and retention problems—particularly acute in social care—that mirror those in other parts of the UK. "The impact of Brexit has reduced some of the access to labour markets in social care," comments Lamb. "So that challenge across the system—being able to keep flow through the hospital, and having people exiting the back door as well as managing demand at the front door—has become quite difficult."

She does, however, argue that Scotland moved early to tackle the problem. Referring to NHS England's Long Term Workforce Plan, she says: "What England is trying to do is—I'm not being complacent here—a lot of the things we've been doing for the last few years". Unlike England, she adds, Scotland isn't trying to "eliminate international recruitment"—but it has been working to build "strong, secure pipelines for recruiting into healthcare", increasing the numbers of undergraduates, postgraduates, nursing training places and apprenticeships.

Lamb's team has also been trying to

improve the employment offer in the care sector, which loses a stream of staff to better-paid NHS jobs. "We're moving towards paying £12 an hour for social care from the 1 April. That's additional funding that's gone in to try to make sure there isn't such a big gap," she comments.

Lamb acknowledges, though, that the social care sector faces huge problems—with margins for providers so tight that some local authorities are struggling to let contracts. "A more collaborative approach to commissioning" can help by, for example, cutting the staff travel required, she says, but acknowledges that "there are some real questions around areas where we have a predominantly private model." These locations tend to be "much more challenging in terms of sustainability," she adds. "So having that core capacity in the public and third sector is really important."

The Scottish Government had hoped to solve these problems with a National Care Service, but in December it announced a three-year delay and abandoned plans to take control over services from local authorities. Lamb sounds relieved to have avoided that battle: "We have always been clear from the outset that we wanted to work with local government," she says, explaining that she and COSLA, the Scottish councils association, have been looking for "points of consensus. What are the things that we can do together, rather than getting into a fight over what's the best thing to do?"

This sounds sensible: government cannot both expect IJBs and CPPs to rebuild services around local needs, and at the same time create a monolithic, uniform national care service. The National Care Service (Scotland) Bill's stated aims, which include ensuring that services "are operated in the same way and at the same standard throughout Scotland", receive less than wholehearted support from Lamb. "To the same standard," she says pointedly. "We want equality of access; we would like to move towards a single way of assessing people's needs; and we would like services to be operating to consistent standards."

The project is not dead, Lamb insists, but altered: "What matters is that we continually improve. And that's challenging when you don't have additional resources to put into problems." The National Care Service was expected to cost upwards of £650 million over five years, while Audit Scotland's latest assessment estimates that NHS boards will face a combined £500 million deficit by 2025–26—and that's if they hit their ambitious savings targets.

"We had a number of boards with underlying financial problems going into the pandemic," comments Lamb. "The pandemic blurred that, because of the level of additional funding. Now the pandemic funding has gone, but we've been left with the backlog and with the impact: we've still got people being admitted to hospital with Covid."

Here, as with NHS performance and the state of social care, Lamb is open about the problems facing Scotland's health and care systems. "There's an enormous financial challenge," she says. Speaking before UK Chancellor Jeremy Hunt's March Budget, she makes a plea for additional resources: "You've heard what the IMF have said about the need to think less about cutting taxes and more about investing in public services, and I couldn't agree more with that," she says.

NHS Boards are "busily preparing their draft plans, with some really, really challenging savings targets," she adds. But Lamb also calls for further Barnett 'consequentials'—meaning additional funding from the UK government: "There is a requirement for us to see more consequentials from England that help us to fund health services".

Caroline Lamb has really been through the mill since she joined NHS Scotland—walking straight into the worst pandemic in a century. Within weeks of her arrival, she recalls, thousands were dying. Civil service and NHS staff "worked so, so hard: people were working unbelievably ridiculous hours" to protect and care for the public, she says. Now she's struggling to repair services, reduce waiting lists and heal a battered workforce. I have to ask: does she ever regret taking that secondment back in December 2019? "No," she replies without hesitation. "I'm passionate about this. It's a tough gig, but it's an absolute privilege." //

Sticking it out: blunt instruments, own goals and quick fixes

Under pressure from political demands and relentless organisational change, many board-level NHS managers are feeling the effects of burnout and contemplating leaving the NHS. Rhys McKenzie **reports from MiP's 'Sounding Board' of senior members and on the union's evidence to the pay review body.**

"One step forward, two steps back" was how MiP chief executive Jon Restell summed up the sentiments coming out of MiP's Sounding Board of executive level members, which met in February to reflect on the past year and inform the union's evidence to the Senior Salaries Review Body (SSRB). Board members agreed the progress made last on pay year was offset by a number of unresolved issues and the emergence of new pressures on senior staff.

While an increase of 5% in base pay and changes to pension tax rules in 2023 had a "morale boosting effect", according to board members, reorganisations, cuts driven by productivity programmes and increased political pressure had all contributed to increased burnout among board-level NHS managers.

Each year, the SSRB makes recommendations on the pay of very senior managers (VSMs) working for NHS trusts and ICSs in England, and executive senior managers (ESMs) working for arm's-length-bodies such as NHS England. As with the pay review body for Agenda for Change staff, the government may accept, reject, or amend the SSRB's recommendations. MiP, as the trade union for senior managers, contributes evidence to the review body.

Reflecting on last year's award

A series of 0% awards for executive staff was finally ended in 2022 by a 3% pay rise, followed by the much welcomed 5% award last year. Changes to pension tax rules, introduced in 2023, were also received well. Our Sounding Board felt that these changes have helped slow down, although not completely stop, the stream of executive grade managers considering early retirement or leaving the public sector due to the potential impact on their pensions. Several participants were concerned that the problem would resurface if an incoming government restored punitive annual allowance levels or the lifetime allowance.

Despite these positives from last year, the focus group were concerned about the delay in implementing the pay award. This has become a theme in recent years and there was no sign of improvement last year. We heard that most executive managers did not receive their pay uplift, due in April 2023, until November. Whether the delays arose in the Department of Health Social Care, NHS England or both, they were an "own goal", said Restell, especially as the government had accepted the SSRB recommendations in July and Agenda for Change colleagues had received their pay rise in April.

In recent years, the SSRB has recommended protected funding to deal with pay overlaps between VSMs/ESMs and Agenda for Change Band 9 staff, which mean some executive level managers are paid less than staff they're managing. MiP has previously welcomed this funding, but our focus group could offer no insight on how the funding is accessed or what impact, if any, it's having. We need clarity on how this funding is being used to ensure it's having the desired effect.

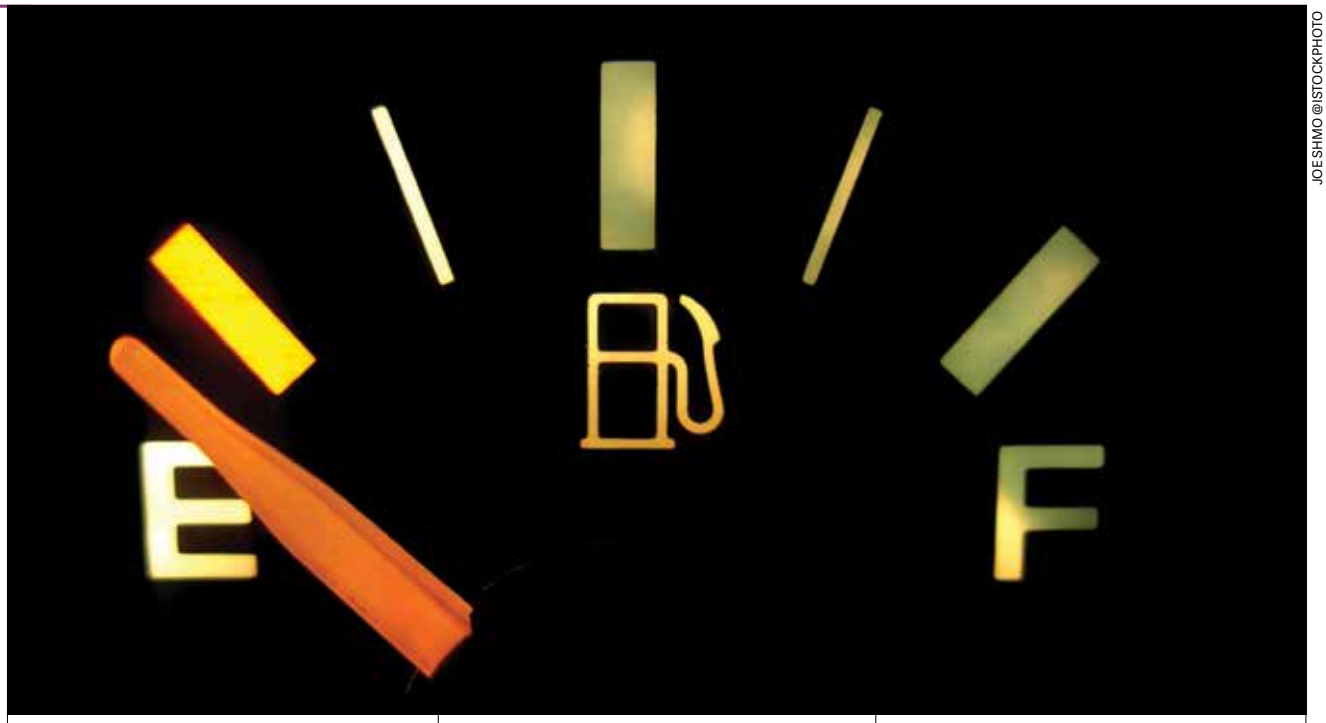
"Brutal and demoralising"

We asked our focus group to reflect on levels of morale, workload and capacity during 2023. They told us the relentless pressure to deliver "more with less", driven by efficiency programmes and organisational change is being felt throughout providers and arm's-length bodies.

Vast swathes of the NHS in England have been dealing with some form of organisational change in the last year. NHS England has slimmed down drastically, ICBs are going through similar processes and many trusts have merged with neighbours creating single leadership structures.

But there is no let up on the priorities demanded of these slimmer organisations, our Sounding Board told us. MiP supports work to make the NHS more productive and efficient, and believes that managers and leaders have a crucial role to play here, but government-mandated efforts to improve productivity seem to be about asking staff to increase workloads rather than exploring how to deliver work more efficiently. As Jon Restell puts it: "You can't cut your way to a productive NHS".

One ESM told us that reorganisations are "brutal and demoralising" and most staff feel happy just to "survive it". Some executives told us how they have taken



JOE SHMO @ISTOCKPHOTO

on a whole new portfolio which they fear they they won't be able to deliver on with their existing priorities: staff will often take on extra work in the hope that it puts them at less risk of redundancy, we heard. It's another short-term fix, one that Restell describes as a "blunt instrument" that will probably "have the opposite effect on productivity in the long run".

Executive staff are also under intense political pressure, the board told us. Many feel they are working to political cycles and in many cases, political priorities, limiting their ability to plan for the long term. This has a huge impact on morale, especially as staff feel they are often made scapegoats for problems caused by politicians themselves.

Burning out

Our focus group reported increasingly high levels of burnout among colleagues as the efficiency drive ramped up over the last year. "A lot of younger staff are leaving", said one VSM working in a trust, often at a critical juncture in their NHS careers—just below executive level. As demands get more intense and the terms on offer are less attractive, the pipeline of talent below deputy director level seems to be dwindling. "We need to make it attractive for the next generation of staff coming through," if we're to avoid "massive recruitment challenges in the future," our VSM said.

Another VSM told us that older, more senior staff, are "sticking it out" but still feeling the effects of burnout: many are considering flexible retirement options, at least to cut down their hours, while others are contemplating retiring from the NHS entirely.

The board also warned that a lack of clarity over government proposals for professional regulation were fuelling concerns that any new framework could become another cause of burnout.

"It's not the principle of management regulation. Many of our colleagues are already regulated through their clinical and professional qualifications," said one senior manager working for a trust. "It's about being put in impossible positions where you're being regulated to unreasonable standards without having the tools to do the job."

Many executive staff fear that regulation could become another blunt instrument to hold them to unrealistic demands from politicians. MiP suggests that any new regulatory framework is designed with managers and senior leaders to ensure it's transparent and that people being regulated see it as fair, proportionate and independent. Building trust will be key if regulation is to have the desired effect.

Building on small successes

Drawing on these insights, MiP's evidence to the SSRB recommends tackling delays in the payment of awards, action on growing levels of burnout and consideration of the impact organisational change is having on the morale, motivation and capacity of executives. The union has also asked for clarity on how the funding set aside to tackle pay anomalies is being used and for senior managers to be engaged on the design and implementation of any future regulatory framework.

Summing up MiP's evidence submission, Jon Restell said: "Let's build on the small successes of last year and deliver a meaningful pay rise for VSMs and ESMs, ensuring the total reward package is at least in line with Agenda for Change to prevent further pay overlap issues. By doing this and addressing the shortfalls highlighted by our Sounding Board, we can take a real step towards tackling the ongoing recruitment and retention challenges for this extremely important staff group". //

In place of fear

The enduring tendency to point the finger when something goes wrong in the NHS can fill clinicians with fear and hamper managers trying to solve problems. Jessica Bradley **looks at alternative approaches and asks why the NHS is still struggling to shake off its blame culture after decades of trying.**

During the trial of neonatal nurse Lucy Letby last year, it emerged that senior managers at the Countess of Chester Hospital had failed to respond to doctors' concerns linking Letby to the unexplained deaths of several babies in the hospital's neonatal unit.

According to Rob Behrens, the health service ombudsman, the doctors' suspicions were ignored for so long because the NHS's "defensive culture" puts reputation before patient safety. Too often, he added, clinicians are stigmatised, bullied and threatened when they voice concerns about patient safety.

Charities like Patient Safety Learning have warned that this, along with clinicians' fear of being blamed if they admit to mistakes themselves, means important lessons are ignored and mistakes get repeated.

Many experts agree that a 'blame culture'—where attention is focused on blaming individuals when things go wrong rather than fixing system failings—has been ingrained in the NHS for decades. One BMA survey of almost 8,000 doctors found that 95% were "occasionally" or "often" scared of making a medical error. But it's far from clear how—or even if—this culture can be changed.

Scared and powerless

A blame culture discourages staff from reporting problems, admitting to mistakes or asking for help because they feel scared or powerless, warns Chris Frerk, a consultant anaesthetist and chair of the Clinical Human Factors Group, a charity which campaigns to improve how the NHS learns from mistakes.

"Fear can lead them to avoid culpability by missing out bits of information in their statements, or saying they don't know what happened—meanwhile, [they're] feeling terrible," Frerk says.

"When they see something that doesn't seem safe, people on the ground generally don't feel they have the authority to change it. If they've not done something deliberately wrong, they need to develop trust that they won't be punished before they will start being honest about what's happened," he adds.

But silence and inaction can be very dangerous, warns Jayne Chidgey-Clark, national guardian for the NHS. The latest NHS Staff Survey responses "show us that there's a growing feeling that speaking up in the NHS is futile," she says. "If people speak up, but don't feel heard, they might stop talking."

Unsurprisingly, working in a blame culture can also do psychological harm to both clinicians and managers, and is often linked to bullying, says

MiP chief executive Jon Restell. "Most academics who study bullying would say that, if an industry is characterised by overwork, high demand, high risk operations, understaffing and bullying, a blame culture is more or less guaranteed to emerge.

"A lot of managers accused of bullying would say they didn't want to do it but had no choice, or they don't have enough time to be kind to people—they're struggling in a difficult environment," he adds.

A fair balance

Despite the toxic impact of blame culture, an entirely 'no-blame' approach isn't an ideal alternative, experts say, as it could allow staff to evade responsibility for deliberate wrongdoing.

The widely preferred alternative—recommended by both the Francis and Williams reviews into NHS patient safety—is a 'just culture'. This approach aims to understand the systemic reasons why something goes wrong and free staff from the fear of being punished for human error. Frerk says a just culture aims to strike a fair balance—so people can still be held to account for deliberate or malicious acts.

It's 24 years since a review by the then Chief Medical Officer, Liam Donaldson, publicly acknowledged that most errors in the NHS are caused by systemic factors, which the blame culture prevents the service from identifying (see mip.social/donaldson-2000). But the NHS is still struggling to implement a just culture.

NHS England's Patient Safety Incident Response Framework (PSIRF), published in 2022, is the just the latest in a long line of initiatives aiming to shift how the NHS responds to incidents by emphasising what can be learnt and improved upon. According to the 2019 NHS Patient Safety Strategy, such initiatives are often thwarted by the widespread fear of blame among staff.

Worse still, willingness to tackle culture change in the NHS seems to have been dwindling since the pandemic, warns Rosie Benneyworth, interim head of the Health Services Safety Investigations Body (HSSIB). "While people understand the importance of just culture, the circumstances under which they're working make it quite difficult," she says.

Pointing the finger

Restell argues previous attempts to tackle blame culture have failed because of a widespread belief that errors are caused by poor management and bad individuals, rather than the environment, culture and political imperatives within which the NHS operates. This is compounded by persistent underinvestment in management functions, he adds.

"We pride ourselves on how few managers we have in the NHS, but if we've got a manager covering what used to be two jobs and working 12-hour days with 25% clinical staff shortages, they're not going to be working perfectly in terms of how they treat people," Restell says.

While changing an organisation's culture inevitably takes a long time, some rapid change is possible, Restell adds: "If there could be a sense that mindlessly cutting management costs isn't a great policy response, the environment would become better and behaviour would improve."

The way the NHS investigates incidents also perpetuates blame culture, Frerk says. Most hospital staff haven't got the training or experience to understand scientific investigation methods, and those who do don't get enough support during investigations.

Benneyworth argues that a just culture also needs to be embedded into staff training from the start. "We need to be educating people around the importance of speaking up when things aren't going well at the beginning of their careers, as well as being able to talk about things that have gone wrong without feeling like a failure, and the importance of creating time to reflect on things that go wrong," she says.

Just culture in the skies

The UK's aviation industry has made huge efforts to move away from a blame culture over the last fifty years. Following the 1972

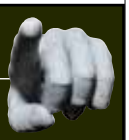
Freedom to Speak Up guardians

NHS Freedom to Speak Up guardians provide an additional way for clinicians, managers and other staff to raise concerns in confidence. Staff may talk to a guardian if they fear the consequences of speaking up or because they feel the right action hasn't been taken on concerns they've raised before. There are more than 1,000 guardians across England; together they handled more than 25,000 cases last year.

"[Guardians] also challenge and support leadership to foster an effective speak up culture in the organisation, because they cannot be effective in isolation," says national guardian Jane Chidgey-Clark. "This needs leadership and management commitment to listen and act on concerns raised."

While all NHS organisations in England were supposed to have adopted the new NHS England Freedom to Speak Up policy by the end of January, Chidgey-Clark says there is still a lot of work to do to ensure staff who speak up are treated fairly and consistently. And access to a guardian remains limited for staff outside NHS trusts. "We're working with NHS England to see how we can better support people who work in primary medical services to have access to a guardian," Chidgey-Clark adds.

From 'who did it?' to 'what happened?"



Before 2016, Mersey Care trust had a high volume of disciplinary investigations—more than half of which resulted in there being 'no case to answer'.

In 2017, the trust changed the basis for deciding whether a formal investigation was needed, and introduced template documents that encouraged managers to consider alternative approaches. The idea was to shift the emphasis from 'who did it?' to 'what happened?'. And where possible, staff who were the subject of potential investigations were also able to provide information at this early stage.

As a result, in one of the trust's four clinical divisions the number of disciplinary cases fell by almost two thirds between 2016 and 2017.

Find out more about Mersey Care's just culture approach at mip.social/merseycare.

// People go to work to do a good job, they don't intend to mess up...we need to understand how we inadvertently set that person up to fail, so hopefully it won't go wrong again. //

Staines air disaster which killed 118 people, it emerged that all the contributing issues had occurred before—in isolation—but hadn't been resolved, says Sean Parker, safety reporting lead at the UK Civil Aviation Authority (CAA).

"If something had been done about these individual problems when they first happened, we would've avoided it," explains Parker, who says he has been having conversations with the NHS about open reporting and a just culture for almost two decades.

The mandatory occurrence reporting system, introduced in 1976, enables staff to self-report safety incidents or concerns while giving them legal protection from any detriment. Aviation professionals who are aware of something that went—or nearly went—wrong, can safely report it to the CAA so it can be learnt from, Parker explains.

A 'no-blame' culture was also included in agreements between aviation trade unions and employers, ensuring that staff reporting an incident in this way wouldn't face any adverse consequences. This no-blame culture subsequently evolved into a 'just culture' when it became apparent that some individuals could abuse the system, Parker says.

"People go to work to do a good job, they don't intend to mess up. There's no benefit in punishing them, because they beat themselves up enough when things go wrong," he adds. "We need to understand how we inadvertently set that person up to fail, so that hopefully it won't go wrong again."

Safe care is cheaper care

While the culture shift in aviation has undoubtedly been successful, some experts argue there are limits to how far the lessons can be applied to healthcare.

"The culture of speaking up and taking action when people have spoken up" is a vital lesson, says Benneyworth, but a crucial difference is that healthcare can't simply be stopped if something goes wrong. "You can ground a fleet of aircraft across the world within minutes but it can take years for learning to be shared in healthcare. We need to get much better with sharing learning internationally," she explains.

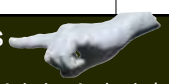
Another reason why the NHS has struggled to adopt a just culture is money, suggests Parker. As a publicly-funded service, the NHS isn't able to spend money fixing a problem in the same way that airlines and airport operators can.

But in the long-run, it's more expensive not to implement a just culture, Benneyworth argues. Safe care is cheaper care, she says, while unsafe care can lead to lead expensive litigation claims and poor retention of staff. "If you're going to look at financial efficiencies, you have to look at safer systems and processes, which will develop efficiencies," she says.

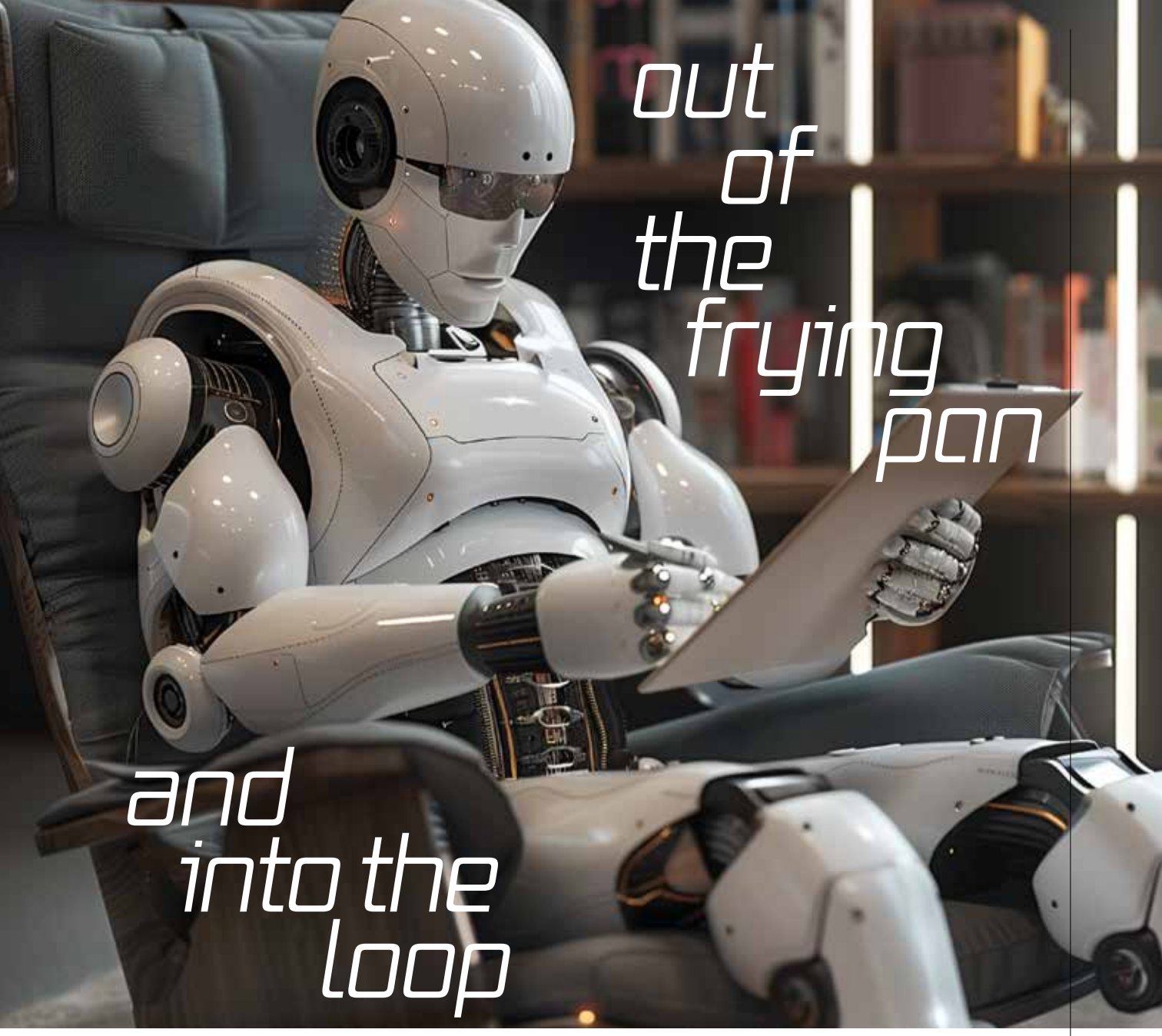
"If organisations prioritised safety, they'd be far more likely to manage the other demands and challenges facing the NHS. Quite a lot of demand is a result of things not being treated properly the first time," she adds.

For national guardian Jane Chidgey-Clark, managers have a vital role in shifting the NHS away from a blame culture, but she warns that without adequate support and training they may feel vulnerable, personally criticised or undermined when people do speak up. "Line managers may often be the first port of call that people turn to. In this way, they have a central role in fostering a workplace culture where speaking up, listening and following up are part of everyday life," she says. //

Read more about this



- More information on the Civil Aviation Authority's just culture policy is available at mip.social/caa-just-culture.
- *Fatal Solution*, by Jan M. Davies, Carmella Steinke and W Ward Flemons, Routledge (2022). The inside story of how a Canadian health system used a tragic error to transform itself and redefine just culture (mip.social/fatal-solution).
- NHS England, *A Just Culture Guide*: guidelines for managers on implementing a just culture, with case studies and evidence from staff surveys (england.nhs.uk/a-just-culture-guide).
- Insights from a Just Culture in practice focus group, NHS England (2021). Report from a focus group of staff from NHS organisations with a successful record of implementing just culture practices (mip.social/just-culture-practice).



out of the frying pan and into the loop

Thinly-staffed NHS mental health services are under intense pressure with patients facing interminable waits for diagnosis and treatment. Could artificial intelligence and chatbots be part of the answer? What are the risks and what does this largely-unregulated new technology mean for patients and staff? *Craig Ryan* investigates.

Mental healthcare is intrinsically human. We're dealing with the workings of the human mind, with intuition and emotion, and how humans relate to other humans. Can artificial intelligence (AI)—machines that try to think and communicate like us—really help deliver this kind of care? Many experts think so, and NHS mental health services are among the first to use AI directly in patient-facing care.

We need to do something. Mental health services are under huge pressure, with spiralling waiting lists and a chronic shortage of all almost every kind of mental health professional. And everyone knows demand is only going to grow. "It's bad enough already," one NHS clinician told me, "but we haven't got a clue how to cope with what's coming down the track."

According to Dr Anna Moore, a child psychiatrist at Cambridge University Hospitals, a fifth of all children in the UK have a diagnosable mental

CREATED BY MIDJOURNEY BOT

health condition that would benefit from treatment, but 70% of those get no help at all. Waiting lists have doubled in the last five years and some children with lesser needs receive treatment while more serious cases are "missed" by the system.

"At the moment, we identify unsystematically and then refer everything to CAMHS [Child and Adolescent Mental Health Services]," says Moore. She is leading a major research programme looking at "whether we can streamline that process using AI... and create a preventative, early intervention pathway for children with mental health problems."

Moore, who has secured £2.5 million in government funding from UK Research and Innovation, wants to combine the vast amounts of information routinely collected about children with research data to create AI tools that improve and speed up identification and diagnosis. Work is due to start this summer on large regional databases bringing together data from the NHS, schools, social care, housing and other services. The idea is for AI to support decision making by spotting things a human clinician may not—or may not spot quickly enough.

A multi-disciplinary team within an ICB could, for example, use the tool "to identify the kids the most at risk", Moore says, and pull together what's known about them—"are they already in the system, on a waiting list or have they not popped up at all?"—before alerting the next practitioner who sees them that "there's something they need to look at".

It's an exciting prospect, but the work involved in identifying and accessing the data needed, building the AI models, developing use pathways and managing the many ethical issues is huge. Moore doesn't expect a prototype to be ready for testing for three or four years.

According to Dr Rishi Das-Gupta, chief executive of the NHS Health Innovation Network for South London, which works with industry partners to implement new healthcare technology, AI could help to relieve pressure on mental health services by speeding up triage and diagnosis, offering new forms of treatment, and by helping clinicians work more effectively. But many of these technologies are in their infancy, he warns, and many important ethical and regulatory issues have yet to be fully explored.

Offering AI tools to patients on waiting lists "might help to identify and triage who we should be seeing," Das-Gupta says. Some may also benefit from AI therapy tools while they're waiting, but that's "incredibly contentious", he warns. "We haven't diagnosed those patients yet, we may not have even seen them, but we'd be offering them something. But is it better and safer to offer something rather than nothing?"

Many patients are already using AI-powered chatbots and apps to access NHS mental health services. Systems like Limbic Access and Wysa, developed by cutting-edge AI firms in partnership with mental health practitioners, provide an "intelligent front door" for patients, replacing the often-unsatisfactory traditional routes via GP appointments, phone calls or daunting website forms.

These chatbots are nothing like the often frustrating chat functions that pop up on bank and utility company websites. Behind the conversational interface of Limbic Access, which is used by more than a third of local NHS Talking Therapy services, is a powerful clinical AI—what the firm's chief executive Ross Harper calls "a clinical brain". Trained "on hundreds of thousands of data points from a clinical environment", it tries to understand what's most likely to be the problem and decide where the chatbot should probe further, he explains. When a human clinician picks up this information "there's already been an intelligent analysis to help them make a high-quality clinical decision and identify the correct treatment pathway," Harper says.

Limbic has already been used by 270,000 NHS patients, and independent research found it reduced waiting times and therapy drop-out rates, and

AI in action: *Ambient Voice Technology*

Ambient Voice Technology (AVT) is an AI-driven technology being trialled in some NHS organisations in London. Enthusiasts hope it will reduce clinician burnout and speed up patient flow by taking over much of the admin work involved in clinical consultations. Like most successful innovations, it's a blend of old and new technologies, combining cutting-edge AI with audio recording and speech recognition, which have been around for decades.

"It listens into the conversation, with the patient's consent, and then processes all that information in a secure environment," explains Rishi Das-Gupta *(pictured)*, chief executive of the NHS Health Innovation Network for South London. "Then it can, for example, produce a clinical note, dictate a letter, book appointments or suggest medication."

He stresses that human clinicians remain in charge. "What's exciting for me is that it's a supervised use of AI. It generates something for the clinician to check. It's quite helpful to have something that's 95% done," he says.

Doctors in America are already using AVT, with the Microsoft-backed Dragon Ambient eXprience the first big-scale product out of the blocks. Other big tech firms like 3M are developing similar tools, while smaller ones like Ditate.it already offer healthcare-specific products.

Some hurdles still need to be overcome before AVT can be widely deployed in the NHS. There are fears that easier ordering could lead to more waste, that clinical notes could become longer or that clinicians may be tempted to talk more to the AI than the patient. Some doctors are also anxious about having their every word recorded in case patients fixate on something they didn't mean or which wasn't important.

If these can be ironed out, cutting down on paperwork isn't the only potential benefit of AVT, Das-Gupta says."The experience of the patient and the clinician is qualitatively different. In a simulation with GPs, not having to take notes also led to a much more natural patient-facing interaction."

Find out more

Dr Anna Moore and the Timely Project (children's mental health): mip.social/timely

Wysa app: wysa.com

Limbic Access chatbot: access.limbic.ai

Lindus Health—using AI in clinical trials: lindushealth.com

Ambient Voice Technology—report from the South London Health Innovation Network: mip.social/avt

Large language models and generative AI, report by the House of Lords Communications and Digital committee: mip.social/lords-ai

significantly increased access, especially for hard-to-reach groups. Most importantly, recovery rates more than doubled. Harper says the tool has already saved 50,000 hours of clinician time and cut recovery costs by 90%.

Far from feeling fobbed off with a second-rate service, many patients—especially young people—prefer accessing support through an app, says Ross O'Brien, a former NHS mental health commissioner who is now European managing director of software firm Wysa. Research among 6,000 UK youngsters found most would turn to their smartphones for mental health advice rather than have a "potentially embarrassing" conversation with a GP or mental health clinician. "We weren't surprised by that," says O'Brien. "But a majority said they would go to TikTok for support, and from a clinical perspective, that's scary."

Rather than fight this, Wysa says it offers a safe, clinically-validated gateway that's available 24/7, offering initial support as well as triage. "We wanted to build a single tool that could take the pressure off throughout the care pathway," O'Brien says. "The beauty of AI is that it guides you towards understanding your presenting problems in an interactive way. It keeps your attention but also validates that you're going down the right path. It helps you towards the right support and information immediately."

With six million users worldwide, Wysa is used by NHS adult services in Dorset and by CAMHS in Northamptonshire, among others, and functions as the sole gateway to mental health services in Singapore, where it recently caught the eye of shadow health secretary Wes Streeting. In a recent trial, Wysa was also distributed to Scottish schoolchildren, with impressive results: 82% accessed the app five times or more.

Mention AI in any context and the question "will it take our jobs?" inevitably follows. Limbic's Ross Harper says conversations about AI "too often go down the route of substitution" and that tech companies, keen to bang the drum about savings, can be the worst offenders. "I think that's ignorant. Our job is not to reach human levels of performance and then substitute for clinicians. It's to reach the highest level of performance and then hand that over to a human professional."

Das-Gupta says "supervised" or "blended" AI tools—like the Ambient Voice Technology he is trialling with NHS providers in London (see opposite)—aim to "improve the reach of what we can do as clinicians and managers", not replace them. "History shows that new technology often promises to be immensely labour-saving, but actually we use the time saved to do something more valuable. We should expect AI to change our jobs but not to replace them," he explains.

The key ask for managers is "being thoughtful" and designing "valuable" jobs that don't treat staff as "automatons", he adds. With many routine tasks automated, those jobs could become more, not less, demanding, he says, as clinicians focus on more complex tasks that, at least for now, only humans can do.

Meri Beckwith is co-founder of Lindus Health, which develops AI tools to improve and speed up clinical trials. By drafting documents, protocols and patient-facing materials, AI can already shave "at least a month" off most clinical trials, he reckons, and the savings will only get more significant. "But it's definitely not about replacing people, it's more about helping managers and medics extract more signal from data, rather than being overwhelmed with all the data produced in a clinical trial," he says.

Beckwith says innovations like Woebot, a AI-driven chatbot already approved by the US Food and Drug Administration for offering Cognitive Behavioural Therapy (CBT) to patients, "give us more resource to deal with mental health challenges and potentially free the time of clinicians to focus or more severe or complex cases". While AI has already shown it can have a "significant impact" on broad, common conditions like anxiety and depression, it's not yet proven safe for more high-risk conditions like schizophrenia, he adds. "But do I think it will get there? Yes, definitely, based on the huge progress we've seen in a short time".

One threat to that progress is what a recent House of Lords report called "digital turbulence". The association of AI with deep fake images, online abuse, electoral manipulation, espionage and fraud has led to widespread mistrust and even fear, while reports of 'hallucinations' by popular AI tools like ChatGPT and Google Gemini undermine faith in its effectiveness. The lack of a regulatory framework also feeds the perception of AI as a 'wild West' technology fraught with risk, especially in a high stakes environment like healthcare.

Like any healthcare innovation, building clinician and patient trust is the key to unlocking the potential of AI. Mistrust and nervousness "is not misplaced, but it needs to morph into scrutiny", says Harper. That means only using clinically validated tools which have been shown to work elsewhere. He sees the clinical validation of Limbic, awarded Class II medical device status by the MHRA, as crucial to its future development.

While we need "guardrails" to ensure AI is used safely and responsibly, the risks shouldn't blind us to the possibilities, says Rishi Das-Gupta: "If we were as risk averse in road technology as we are in healthcare AI we'd never have let cars on the roads in the city". In developing a regulatory framework for AI, he sees driving laws as a possible model, with a graduated response for "careless AI", "dangerous AI" and "high-consequence AI". Investment and regulatory action could then be targeted where the risk is greatest—just as we put traffic lights at dangerous corners and invest more in safety features as cars get faster. Of course, his means that humans must be in control of how AI develops—something that might be easier to achieve in a heavily-regulated, safety conscious industry like healthcare than in other sectors like the media.

Far from resisting new technology, NHS organisations are "much more innovative than people think," concludes Harper. "They're mission-driven people who care about real value and impact. If you can show you understand their challenges and have ways to solve them, people are very willing to change their thinking and try something out." However the tech develops, it's those "mission-driven" humans—managers and clinicians working together—who will make AI work in mental health. //

Employment law: what's new in 2024?

Our legal correspondent, Jo Seery, explains some of the many changes in employment law coming into force this year.

The start of 2024 has seen a stream of employment law reforms. Some of these result from the Retained EU Law (Revocation and Reform) Act 2023, which ended the supremacy of EU law and gave the government new powers to reform existing EU-based employment laws. Other reforms implement private members bills.

Changes from January 2024

The government has amended the Working Time Regulations 1998 to introduce changes in holiday pay and entitlement from 1 January. These changes, which put existing EU case law into UK law, require employers to pay the statutory four-week holiday entitlement at "normal" rates of pay and set out how and when workers can carry over unused holiday.

A number of amendments to the Equality Act 2010 (EqA) also came into force on 1 January:

- **A new definition of disability:** the definition has been widened to include workers who can show that their physical or mental impairment has an adverse effect on their ability to participate fully and effectively in working life on an equal basis with their colleagues. The previous definition required disabled workers to show that they were adversely affected in their ability to carry out "normal day-to-day activities" (e.g. household tasks, taking part in social activities etc.).

- **Indirect associative discrimination:** this definition has been extended to cover people without a protected characteristic (e.g. age, sex, race, disability etc.) if they are, in practice, put to the same disadvantage because of their association with a person who has a protected characteristic. For example, a male worker caring for his disabled mother would experience the same disadvantage as disabled workers if the employer requires workers to be office-based.

- **Breastfeeding mothers:** Women can now claim direct discrimination if they are subject to less favourable treatment than other workers because they are breastfeeding.

Changes from April 2024

From 1 April, employees with irregular working hours or who work for only part of the year will accrue holiday on the last day of each pay period calculated at the rate of 12.07% of the hours they actually worked, effectively pro-rating holiday entitlement.

From 6 April, employees will have the right to request flexible working from day one of their employment. The right to take paternity leave will also be extended, so that fathers and partners will be able to take up to two weeks of paternity leave any time in the first year. The right applies where the expected week of childbirth or the expected date of placement for adoption is on or after 6 April.

New rights for carers also come into force on 6 April, with workers gaining the right to request one week's unpaid leave in any 12-month period to provide or arrange care for a dependant with long-term care needs.

There are also new protections for pregnant workers and those taking parental or adoption leave. From 6 April, protection from pregnancy discrimination will be extended to workers who are subject to unfavourable treatment because of pregnancy and/or pregnancy-related illness during the protected period (from pregnancy until a woman returns to work).

Employees who are pregnant or returning to work from maternity, adoption or shared parental leave will also have increased protection from redundancy. Employers must offer such workers a suitable alternative vacancy (if one is available) for a period of 18 months after birth or the placement of a child for adoption. The protection applies to anyone whose maternity or adoption leave ends on or after 6 April and fathers and partners who take six consecutive weeks of shared parental leave starting on or after 6 April.

Looking Ahead

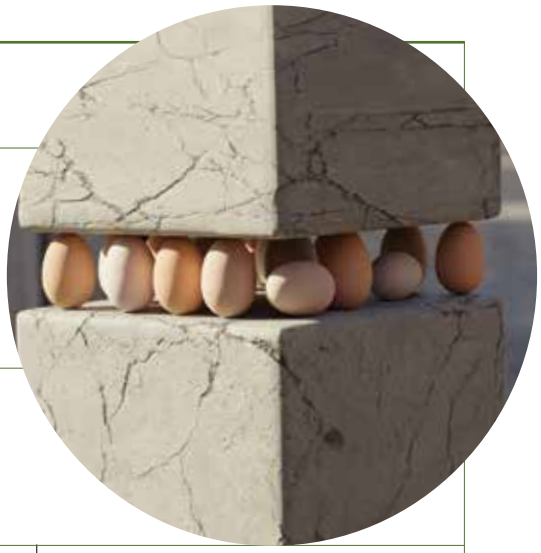
New rights for employees and agency workers to request a predictable working pattern are expected to come into force in September 2024. Finally, from 26 October, employers will be required to take proactive steps to prevent employees from being sexually harassed at work, with clarification expected to be published by The Equality and Human Rights Commission in the near future. //

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

tipster /Jane Galloway

Building resilience for you and your team



MARCOVENTURINIAUTIERI

Resilience helps us to cope with stress, setbacks and challenges, and promotes engagement and satisfaction at work. Executive coach Jane Galloway gives her tips on how to build resilience for you and your colleagues.

Resilience is like a leaky bucket. It's constantly dripping and being dipped into, so it's vital to keep refilling it rather than waiting until it's completely empty. Resilience focuses on proactive strategies that help you to avoid stress or be better equipped to deal with it. It's not a magical power. No one feels resilient all the time, so don't be hard on yourself when you don't. Luckily, most experts agree that resilience can be learned (see mip.social/resilience).

Research shows that resilient teams are higher performing, more engaged and collaborative, better prepared and more adaptable, and are more likely to overcome challenges. But with constant change, scrutiny and pressure, working in the NHS can drain resilience. As a leader you can support colleagues to find and grow their own resilience—but you need to look after yours as well. Here are 10 ways to refill your bucket and help your team do the same.

1. Find your people

You know who lifts you up and who brings you joy and strength. When your resilience is low, ask for help from people you know will give it unquestioningly, in whatever form you need (an ear, a shoulder, a glass of wine).

2. Find meaning and purpose

A sense of purpose supports self-esteem, wellbeing and mental health, and contributes towards resilience. Creating goals can help you to focus on your 'true north'. By identifying what's really important to you, you can acquire a sense of what you need to focus on and avoid sweating the small stuff.

3. What makes you happy?

This one is simple: things that make you happy give you energy and strength, and enhance your resilience. Create a list of every small thing that makes you happy. Highlight a couple to do this week and diarise them.

4. Notice what's going on for you

Take time to notice and reflect on what you're feeling. Listen to your body: if it tells you to rest or walk away, pay heed. Be aware of what happens when your resilience is falling so you learn your own early warning system.

5. The magic triangle: be active, eat well and sleep well

Resilience comes from looking after your physical needs as well as your mental wellbeing. Move your body daily, especially when you feel lethargic and least want to! Exercise releases endorphins (the happy chemical). Good food choices give your body the raw materials to generate the energy you need. Wine, chocolate and crisps may fill a gap, but they don't fulfil your needs. And resilience requires rest: adults need seven to nine hours sleep. Practice good sleep hygiene by avoiding alcohol before bed, creating a calming bedroom and switching off your phone an hour before you go to sleep—try reading or meditating instead.

6. Let it go

Don't dwell on the negative and replay mistakes over and over in your head. Grudges weigh you down. You can't always control what happens to you, but you can control how you respond and whether you let it define you. Can you see the opportunity in a situation? Can you flip a mistake so it becomes a development experience?

7. Take Action

Taking decisive action on problems reminds you that you have agency even when times are difficult. Consider what's within your control or your sphere of influence. Start there.

8. Lead by example

As a leader, you can model and support resilience at work. When you look after your own wellbeing and talk about the impact it has, you give colleagues permission to do the same. Being open about the challenges you face and how you tackle them will help others to be honest too.

9. Contribute to the positive experience of work

In a pressured workplace, we often focus too much on what's wrong and who's at fault. Take time to appreciate your team. Celebrate wins, big and small. Say thank you and recognise contributions. Encourage and value difference in your team. Create a resilient work culture where people feel safe talking about failures and mistakes—and how to learn from them.

10. Build connection

Get to know your team and their drivers. Help them to reach their potential, and work towards goals that feel meaningful and align with their values. A sense of togetherness and belonging fosters resilience and helps people to tackle challenges and overcome adversity. Check in with your team and encourage them to look after their emotional, psychological and physical wellbeing. Research suggests that the biggest drain on resilience at work is managing difficult relationships and workplace politics, so try to resolve any conflicts quickly and impartially. //

Check out our recommended resources on resilience at mip.social/resilience. Jane Galloway is an award-winning coach and founder of Quiet the Hive. For further info, visit: quietthehive.com.

meetyour**reps**: Sue Glendenning

It's a worry that people consider the NHS can be run without managers

TOM CAMPBELL

MiP National Committee member Sue Glendenning is proud to be a nurse, midwife, senior NHS manager and a union rep. She talks to *Healthcare Manager* about supporting staff, staying close to the frontline and why it's important to stand up for managers.

"You can never take the nurse or midwife out of a person—it runs through me—but I'm proud to say I'm an NHS manager," says Sue Glendenning, associate chief nurse at York and Scarborough Foundation Trust and a newly-elected member of MiP's National Committee. "It's a worry that people consider services can be run without managers," she adds. "In the NHS, you need that synergy from everyone working together—clinical, operational, finance, estates and all the valuable back-office support—because ultimately it's all about the patient."

Sue is responsible for supporting the nursing workforce within the trust's family health care group, comprising gynaecology, children's, neonatal, sexual health and HIV services. It's a key role which requires visibility and an understanding of the support staff need. During tactical on-call commitments, it can be very much a hands-on job: Sue spends time on the wards, in the emergency department and with the bed management team, talking to staff and sometimes helping with patients. "As clinical managers, I think it's absolutely pivotal that we're close to the frontline," she says.

Sue is enthusiastic about the Back to the Floor initiative, implemented by the trust's chief nurse, which encourages senior clinical and non-clinical managers to spend time working with frontline colleagues. Every Friday, she and other senior leaders go onto wards, and into departments and community services, "not as part of an inspection", but "to support staff, see how it is for them, ask questions, be part of the team and support quality initiatives." It's an important part of her leadership practice, she says. "I know it from my on-call work, but it really brings home that the NHS is a very busy place."

The best part of the job is supporting staff, she says, "helping them to deliver their objectives, to progress, to enjoy coming to work and then working together to deliver a good patient experience." As a trained coach, Sue also helps staff from different professional backgrounds to work through problems and develop their careers. "I love coaching. It's a really positive experience, because it's not about instruction, it's about having conversations that help someone come to their own place and [get] the support they need," she explains. "And it can spark something in yourself. When you see someone have that lightbulb moment because of something you've said, that's quite amazing."

As a child, Sue was a St John's Ambulance cadet and "always wanted to be a nurse". After training as a nurse and a midwife in Leeds, she spent most of her career in midwifery, with spells in Norfolk, Lincolnshire and Teesside before returning to Yorkshire. "But I've always kept up nursing and undertook secondments to support both registrations," she says. "I've enjoyed a varied career and made many friends along the way."

Sue joined MiP about 12 years ago. "I've always found it a really supportive union, and I think managers do need support," she says. She admits it took time for her to feel comfortable with being an MiP rep and be accepted by other unions at the trust. "If you're in a senior NHS role—particularly a clinical role—people don't necessarily perceive that you should be a rep," she explains. "I'm really enjoying being part of the union representation group and we're working together really well. I feel that collaboration helps me in my role and other unions can see that managers are reasonable and are here to support people."

As a National Committee member, Sue says she wants to help change what she sees as the NHS's "unfair" investigations process, which can be "a bit draconian" and "doesn't focus on learning in an open and transparent way". Managers are often held responsible for failings elsewhere, she says: "Yes, we get things wrong sometimes and there has to be consequences for that, but we don't necessarily look for the truth. We look for the easy way, saying the manager got it wrong when maybe they didn't." She also wants investigations to be completed faster. "They go on and on, and it's just very distressing for everybody involved," she says.

"You definitely need resilience to be an NHS manager – it's a challenging arena," Sue concludes. "I know I've got that, but there comes a point when you think you shouldn't need to have all this resilience. There should be enough support to do this job." //

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

Our pledge to you

THOMPSONS
SOLICITORS

STANDING UP FOR YOU

Thompsons Solicitors has been standing up for the injured and mistreated since Harry Thompson founded the firm in 1921. We have fought for millions of people, won countless landmark cases and secured key legal reforms.

We have more experience of winning personal injury and employment claims than any other firm – and we use that experience solely for the injured and mistreated.

Thompsons pledge that we will:

- work solely for the injured or mistreated
- refuse to represent insurance companies and employers
- invest our specialist expertise in each and every case
- fight for the maximum compensation in the shortest possible time.

The Spirit of Brotherhood by Bernard Meadows

www.thompsons.law.co.uk 0800 0 224 224 *Standing up for you*

Managers are vital to the NHS, but does anybody actually know why?

At MiP we're launching a campaign to change perceptions by showing how managers, right at the heart of the NHS team, are ideally placed to make it work and to ***make it work better***.

Inspirational stories about real people

We're doing this by launching a documentary style campaign based on interviewing inspirational managers and publishing their stories backed up with key statistics and evidence from independent research.

Recognition and support for the work managers do

Because managers do a great job in challenging circumstances they need recognition and support from their colleagues, politicians, the media and from the public.

Get involved today by scanning the QR code

Nominate an inspirational colleague, a manager or even yourself to be featured in the campaign. It's happening throughout the UK on social media and in the press.

Help us make change happen!

Jon Restell
Chief Executive, MiP

MANAGING our NHS