issue 62 | winter 2024-25

healthcare manag

"Good leadership doesn't happen by accident"

Suffolk and North East Essex ICB chief Ed Garratt on trust, kindness and building communities

NHS REFORM SPECIAL

Darzi, the ten year plan, professional regulation: what's different this time?

Out of the box

Why the NHS needs to value and empower its data analysts

New rights at work

What's in and what's out of the government's employment bill

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The union for senior health & care managers

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healthcare manager

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Is it just me or is the new government trying to face a dozen different ways on how to reform the NHS in England?

We've had the Darzi diagnosis: in a nutshell, excessive central control, too few managers, not enough investment and too much focus on acute hospitals at the expense of community services. Now what about the treatment? The ten year plan is months away, but we've already had plenty of announcements, dropped hints and stern messages from ministers. So what's the direction of travel for this health and care system?

I don't know and I bet you don't either. We've been told cutting waiting lists and A&E waits is the number one priority, but so is the 'triple shift' to digital, community and prevention. In her Budget, the chancellor splashed the cash this year and next before turning off the taps again. Hospital league tables have been exhumed, performance-related pay is back in vogue and even Alan Milburn has made a comeback.

We've had promises of "devolution" at the same time as NHS England has tightened its grip on trusts, reversing its own proposal to share performance management with integrated care boards. And we've seen a series of announcements about managers spun off as manager-bashing stories in hostile newspapers despite ministerial promises to stop doing that sort of thing.

So far, it feels like a pick 'n' mix from the last 40 years of NHS reforms. Ministers seem to be trying to push every button at once, hoping that something will start working. Whether Sally Warren and her team writing the ten year plan can square all this off with Darzi's diagnosis remains to be seen. They certainly have their work cut out.

It's been a momentous year and no doubt we'll see a lot more upheaval in 2025. But before all that, a merry Christmas and a bright new year to every one of you. //

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headsup

analysis & opinion

features

regulars

healthcare manager

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headsup

News you may have missed
plus what to look out for

noticeboard

17-19 January 2025

UNISON National Black Members Conference

Venue Cymru, Llandudno

Annual conference for Black, Asian and minority ethnic members of UNISON (including MiP).

unison.org.uk/events/2025-nbmc

4-5 February 2025

King's Fund: Health and Care Explained

Online

Annual event where King's Fund experts try to explain how the UK health and care system works (and sometimes even succeed). Likely to focus on the upcoming ten year plan in England this year.

kingsfund.org.uk/events/health-care-explained

13-15 February 2025

UNISON National Women's Conference

Edinburgh International Conference Centre

Annual conference for women members of UNISON (including MiP).

unison.org.uk/events/2025-nwc

18-19 February 2025

Digital Health and Care Scotland

Dynamic Earth science centre, Edinburgh

Panel sessions, masterclasses and keynote speakers on the latest policy developments and advancements in healthcare tech. Topics include remote monitoring, e-prescribing, AI and cyber security.

mip.social/dhcs-2025

27 February 2025

NHS Employers conference: Reward in the NHS

King's House, Manchester

Free biennial conference for managers with responsibility for pay and benefits in NHS organisations.

mip.social/reward-2025

6-7 March 2025

Nuffield Trust Summit 2025

Windsor

Annual get-together of the venerable health and care think tank, bringing together NHS and care leaders with some "disruptors and innovators" to discuss current and future challenges.

nuffieldtrust.org.uk/summit/nuffield-trust-summit-2025

KEEP THE DATE

7-9 April 2025: UNISON Healthcare Group conference, Liverpool (unison.org.uk/events/2025-health-care-sg-conference)

23 April 2025: NHS Confed mental health conference, Leeds (nhsconfed.org/events)

15 May 2025: FDA Annual Delegate Conference, London (fda.org.uk/annual-delegate-conference)

11-12 June 2025: NHS ConfedExpo, Manchester (nhsconfed.org/events)

5-6 November 2025: King's Fund annual conference, London (kingsfund.org.uk/events/annual-conference)

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

Provider oversight

ICBs told to focus on commissioning as NHSE tightens grip on trusts

NHS England is to take over the performance management of trusts, leaving integrated care boards (ICBs) to concentrate on "strategic commissioning", prevention and developing a "neighbourhood" health service.

In a speech to the NHS Providers conference in November, NHS England chief executive Amanda Pritchard said new planning guidance and operating frameworks, expected to be published this winter, would "clarify" the relationship between trusts, ICBs and NHS England—something called for in Lord Darzi's recent review of NHS performance.

"This new way of working will be more coherent and less duplicative," said Pritchard. "Performance management will be more mature and more focused," she added, with "greater clarity" about oversight and support—which might include "turnaround teams for the most challenged" and "targeted improvement help for those in the middle."

The move is a significant U-turn by the national body, which produced draft guidance in the spring proposing joint performance management of trusts by ICBs and NHS England—with the best performing ICBs taking the lead.

Speaking at the same conference, health secretary Wes Streeting told ICB leaders he wanted them "to play a critical role in doing what we've never pulled off before". ICBs should "be responsible for one big thing: the development of a new neighbourhood health service," he said.

Executive pay

Performance pay could be counterproductive, say board-level members

The vast majority of board-level MiP members do not believe linking pay to performance will result in better standards, according to provisional results from the union's executive pay survey.

The survey is part of MiP's consultation with members at very senior manager and executive senior manager (VSM/ESM) level before the union gives evidence to the Senior Salaries Review Body (SSRB), which is due to make recommendations on VSM and ESM pay, including a new executive pay framework, in spring 2025.

The findings come after health secretary Wes Streeting announced plans to bar senior managers deemed to be "failing" from getting pay rises. The criteria for failure may include "failing to improve their trust's performance, preventing staff from doing their jobs, or letting patients down with poor levels of care", Streeting said.

MiP chief executive Jon Restell said board-level pay "has long needed an overhaul" but warned the government to "approach performance-related pay with caution".

"Linking pay to performance risks blurring the line between what's down to individual performance and what's down to wider contextual factors such as the system or policy. We urge government to consult MiP and other unions to ensure they get this right."

Respondents to MiP's survey described performance-related pay as a "blunt instrument" which could "prove counterproductive as it distorts decision-making and undermines teamwork".

Most survey respondents reported feeling unwell due to work-related stress within the last year, with many continuing to work despite not feeling well enough to do their job. At least half of respondents said they regularly worked more than 11 hours of unpaid overtime each week.

"Executive level staff continue to work under immense pressure and morale has been stubbornly low with this extremely important group of staff for some time," Restell added. "To ensure we can attract and retain the best leaders for the NHS more must be done to turn this around."

The full results of MiP's consultation on executive pay will be published on the MiP website in December.

New pregnancy and maternity guide for MiP members

Despite years of legislation and support for parents at work, poor practice on pregnancy and maternity issues are still a common feature of MiP's casework.

To help tackle this, MiP will be launching a brand new guide on pregnancy and maternity in the new year. It will help members, reps and managers navigate pregnancy and maternity rights and protections, NHS terms and conditions and the wider set of issues members can face including baby loss, breastfeeding at work and childcare.

The guide will be available from the MiP website and more details will be sent to members in the new year.

DAVE GOUDREAU/UNSPLASH

Politics

Edward Argar to shadow Streeting after Tory reshuffle

Former health and justice minister Edward Argar was appointed shadow health secretary in November as new Conservative leader Kemi Badenoch reshuffled her frontbench team. It marks a return to the health brief for Argar, who served as a junior health minister in Boris Johnson's government between 2019 and 2022.

Argar, 47, a former management consultant, was elected as MP for Melton and Syston in July, having been MP for the now-abolished seat of Charnwood since 2015. He served for just 11 days as chief secretary to the Treasury during Liz Truss's ill-fated premiership, and then as a justice minister under Rishi Sunak with responsibility for sentencing and victims' rights.

In his first Commons speech in the job, Argar said the Conservatives would hold health secretary Wes Streeting to his pledge to link additional NHS funding to reform. "The opposition support that condition, because it is only with reform that the NHS can sustainably continue to look after us for years to come. Yet I fear that this risks being another broken promise," he said.

IAN DAVIDSON / ALAMY STOCK PHOTO

Argar was joined in the shadow health team by Hinkley and Bosworth MP Luke Evans, 41, a qualified doctor who worked as a Midlands GP from 2013 to 2019.

Budget 2024

Chancellor boosts NHS spending but funding for reform still in doubt

SEAN AIDAN / ALAMY STOCK PHOTO

MiP and NHS leaders welcomed a significant boost to NHS funding in the October Budget but warned that much of the new money could be swallowed up by existing commitments such as staff pay, rising maintenance costs and trust deficits.

In her first Budget on 30 October, Rachel Reeves announced a £22.6 billion increase in day-to-day NHS spending in England and £3.5 billion in additional capital investment for this year and next. The spending increases, funded by a mixture of higher borrowing and new taxes, mean NHS spending is set to grow by 3.8% in real terms—close to the long-term average since the 1950s, but well above the levels seen over the last 15 years.

MiP chief executive Jon Restell said: "While these funding increases will not solve the NHS's problems overnight, MiP believe it's a step in the right direction and provides a good foundation leading into the ten year plan due in the spring." But it remained unclear, he added, how much of the new investment would go to meeting "existing commitments such as staff pay".

Reeves described the funding package as a "downpayment" on the ten year plan, hinting that further investment plans may be unveiled in next year's spending review. "This is the largest real-terms growth in day-to-day NHS spending outside of Covid since 2010," she said.

The 11% boost to NHS capital spending announced by Reeves will take investment to a record £13.6 billion by the end of 2024-25. It includes an extra £1 billion earmarked for hospital repairs and a £100 million pot for refurbishing GP premises, as well as £2 billion more for investment in technology.

But with the maintenance backlog for NHS buildings approaching a record £14 billion and many NHS organisations expected to be in deficit this year and next, experts warned that much of the new money could be swallowed up by existing commitments. Staff pay increases are also expected to be higher than NHS England has budgeted for—partly due to the chancellor's increase in the minimum wage above the entry level for NHS pay—and it remains unclear how the government will fund its long-term ambitions to shift care from hospitals to community services and to invest more in prevention.

"The NHS is facing rising financial deficits, a growing and aging population, rising cost pressures, and endemic staffing shortages and performance woes," said King's Fund policy director Siva Anandaciva. "This is a Budget that will help keep the show on the road for health care services and deliver some improvement, but it is unlikely to deliver a step change in access or quality of care."

Much now depends on the spending review, expected in spring 2025, which will set spending levels for 2026-27 and beyond. "The end of the chancellor's speech is rarely the final word on health and care funding," Anandaciva added.

The Conservatives criticised the government not keeping its promise to tie additional NHS funding to reform. Commenting on the Budget, the then shadow health secretary, Victoria Atkins, said: "This eye-watering budget has no plans for NHS reform, for winter preparedness or for social care. GPs and dentistry are glaringly absent. Taxpayers have been saddled with the highest tax burden in our country's history with no idea what we're paying for."

Page 8: Sticking plaster or turning point: are we investing enough in the NHS?

Statutory regulation

Government moves to introduce professional regulation for managers

YUI MOCK / ALAMY STOCK PHOTO

Wes Streeting with NHS England chief executive Amanda Pritchard (right), during a visit to the Abbey Medical Centre, London.

The government announced plans to regulate NHS managers in England to ensure "they follow professional standards and are held to account" and end what it called the "revolving door" that allowed poorly performing managers to carry on working in the NHS.

Under the proposals, which are open to public consultation until mid-February, "NHS managers who silence whistleblowers or endanger patients through misconduct could be barred from working in the NHS," a spokesperson for the Department of Health Social Care (DHSC) said.

Ministers are considering a range of options for professional regulation, including a voluntary accreditation register, statutory barring mechanisms and full statutory registration. Any regulatory framework would apply "at a minimum" to all board-level directors in NHS trusts, arms-length-bodies and integrated care boards, the department said.

Professional regulation would build on the government's promise "to reform the NHS so it rewards success and acts decisively on failure," said health minister Karin Smyth. "To turn around our NHS we need the best and brightest managing the health service, a culture of transparency that keeps patients safe and an end to the revolving door that allows failed managers to pick up in a new NHS organisation."

Jon Restell, chief executive of MiP, said the union's previous surveys showed most members support statutory regulation in principle, but many "lacked confidence that it will be applied proportionately, fairly and openly, and that the process will be truly independent".

He added: "Managers must be accountable for the decisions they make, but they need clear responsibilities and the right tools to do their work well. It's vital that regulation comes with a fully resourced package to develop, train and support NHS managers as seen in other professional regulatory frameworks." Regulation was not a "silver bullet", he said. "It can only play a part in improving the capacity, capability and culture of NHS management."

While welcoming the consultation, NHS chief executive Amanda Pritchard also called for more professional support for managers to go alongside new statutory responsibilities. "It is right that NHS managers have the same level of accountability as other NHS professionals, but it is critical that it comes alongside the necessary support and development to enable all managers to meet the high quality standards that we expect," she said.

Health secretary Wes Streeting also confirmed that the government will consult on whether NHS managers should included in the 'duty of candour' for senior public servants being introduced under its proposed 'Hillsborough Law'.

MiP "will engage with an open mind" in the government's consultation, Restell added. "We hope by listening to our members' concerns and designing processes in partnership with managers, the government can build the trust required to ensure its plans are effective."

MiP launches first Black Members Network

MiP's newly-founded Black Members Network held its inaugural meeting in November. The network provides a safe space for MiP's Black members to meet, discuss workplace issues and influence MiP policy and campaigns.

The network is still in its formative stages and is working with members to develop priorities and objectives heading into 2025. MiP encourages all Black members to join the network and help shape its development.

The network has agreed to meet monthly initially and will review the frequency of its meetings next year.

If you are interested in joining the network, please contact info@miphealth.org.uk for details of the next meeting.

MiP is a national branch of UNISON and the network's purpose aligns with UNISON's definition of Black members: In UNISON 'Black' is used to indicate people with a shared history. Black with a capital 'B' is used in its broad political and inclusive sense to describe people in Britain who have suffered colonialism and enslavement in the past and continue to experience racism and diminished opportunities in today's society.

Boost to workers and unions as government unveils new employment laws

Rhys McKenzie explains what's in and what's out of the government's employment bill, which promises new rights for millions of workers and a fairer deal for trade unions.

The government unveiled its Employment Rights Bill in October, promising to deliver "the biggest upgrade to rights at work in a generation". The bill proposes 28 changes to employment law aimed at boosting protection for workers and making it easier for unions to organise in the workplace. But some key promises from Labour's election manifesto—including the right to 'switch off' outside working hours—have been left out of the legislation.

Commenting on the bill, MiP chief executive Jon Restell said: "Action to improve the lives of working people is welcome, and, if delivered in full, this bill will give a much needed boost to workers across the country."

Christine McAnea, general secretary of UNISON, described the bill as a "sea change" in industrial relations, which brought to an end "years of worsening industrial relations and unnecessary hostility towards unions".

Most of the new rights in the bill, which has also been endorsed by the Trades Union Congress, will not come into force until 2026 due to lengthy consultation periods and the time needed to pass legislation through parliament.

Day one rights

The bill includes a significant extension of rights for new staff, who would be protected from unfair dismissal from their first day of employment. Under current laws, other than in exceptional circumstances, staff with less than two years' service can be sacked without reason, as long as they are paid for their contractual notice period.

Alongside this, the government wants to introduce a new statutory probation period, the length of which is currently open to consultation. Ministers have suggested it should not exceed nine months—more than the six months or less currently required by most employers. Workers would still be able to claim unfair dismissal during their probation period if they were dismissed unlawfully.

Parental rights

The bill would remove the 26-week qualifying period for paternity and parental leave, giving new parents these rights from day one of employment. Parental bereavement leave will also be replaced by a more general right to bereavement leave. Although details have yet to be confirmed, the government says its intention is to extend statutory bereavement leave to more workers. Ministers have also promised to review the parental leave system, although this is not addressed in the bill.

The bill also proposes further protections for pregnant workers and returning mothers, who already have additional rights in redundancy situations, such as priority access to suitable alternative

employment. The new laws—expected to be enacted through secondary legislation—will make it unlawful to dismiss employees during pregnancy and within six months of their return to work except in specific limited circumstances.

Flexible working

Flexible working is hugely popular with the public—TUC research has found that four out of five workers in the UK want to work flexibly. Due to legislation passed by the previous Conservative government, flexible working has been the default option for all workers from day one since April 2024.

Labour's bill would make it slightly harder for employers to refuse a flexible working request. While they will still be able to turn down a request due to very broadly-defined 'business reasons', the new laws mean employers will only be allowed to refuse flexible working requests if it is "reasonable to do so" and will have to provide an explanation to the employee. How this will affect the outcome of flexible working requests, if at all, remains to be seen.

Labour's promise to introduce the 'right to switch off'—allowing workers to refuse to engage with work though emails, phone calls or messages outside of their contracted working hours—is not included in the bill. Ministers say this right will be enshrined in a statutory code of practice, and subject to consultation during 2025. The government hopes this will encourage employers to agree policies with employees, although it's unlikely there will be any specific sanctions for breaching the code.

Social care staff

The impact poor pay and conditions for social care staff has on both health and care services is well known, and in a bid to tackle this, the bill includes provisions to establish a Fair Pay Agreement for the whole social care sector. The bill gives the secretary of state significant powers to establish a negotiating body made up of unions and employers to determine pay, terms and conditions and other matters relating to employment. The scope of this body will include all adult social care workers including agency staff.

Other measures in the bill include:

- statutory sick pay to be paid from the first day of illness rather than the fourth
- more rights for staff on zero-hours contracts, including an entitlement to a limited number of hours
- closing loopholes that permit employers to 'fire and rehire' staff

Strengthening trade union rights

In addition to strengthening rights for individual staff, the Employment Rights Bill will restore and enhance some trade union rights.

The bill would repeal in full the Strikes (Minimum Service Levels) Act 2023 which allowed employers to break lawful strikes by ordering staff back to work.

It will also roll back most of the 2016 Trade Union Act, which made it extremely difficult for unions to operate and organise members. Under new laws, workers will be able to take industrial action if a simple majority of staff vote for it. It also removes the requirement for paper balloting, so workers will be able to vote digitally in strike ballots, ensuring more members can have their say.

New measures included in the bill will also improve workplace access for trade unions and provide more protection for activists. Employers will be required to inform all new staff of their right to join a union, and will have further obligations to grant workplace reps 'facilities time'—time off work to carry out trade union duties.

Many of the measures outlined in the bill are subject to consultation and may change as the legislation passes through parliament. Some NHS organisations are already asking staff for their views on aspects of the bill—including the arrangements for partnership working with trade unions. MiP strongly encourages members to engage with their own organisation's consultation processes for the Employment Rights bill.

MiP chief executive Jon Restell added: "The NHS has a proud tradition of partnership working with trade unions, the results of which have brought benefits to both staff and the many employers in the NHS. The strengthening of workers' rights to engage with their unions will help modernise industrial relations in the NHS and beyond."

Rhys McKenzie is MiP's communications officer.

PHOTO BY SHAUNAK DE ON UNSPLASH

Sticking plaster or turning po

The NHS has been starved of investment for more than a decade, with results that are plain to see. Is Rachel Reeves's boost to public investment enough to stop the downward spiral and deliver the government's ambitions for health and care?

Let's not get carried away. In her October Budget, chancellor Rachel Reeves announced a big increase in capital investment in the NHS in England—around 11% in real terms over the next two years. Great. But here's a sobering fact: even if the entire capital budget of £13.6 billion for next year was spent on NHS buildings, it wouldn't even cover the maintenance backlog, let alone pay for any new hospitals or all the investment in medical equipment, technology and training the NHS so badly needs.

So this a good stride in the right direction, but not a game changer. In his recent report, Lord Darzi said that being "starved of capital" for 15 years was one of the big reasons for the "dire state" of the health service. But NHS leaders can't even use all the meagre investment funds they do have, thanks to continual raids on capital budgets. That hasn't stopped. Budget documents reveal that £876m has already been diverted this year from long-term investment to fund day-to-day IT costs and staff pay.

This historic lack of commitment to investment has left us with a record £14 billion maintenance backlog for NHS buildings. "Vital bits of the NHS are literally falling apart," says Saffron Cordery, deputy chief executive of NHS Providers, "putting quality of care and sometimes the safety of patients and staff at risk".

She welcomes the new government's commitment to capital investment but, "after years of under-investment and severe staff shortages", she warns "we must be realistic about the speed of progress."

With almost limitless demands, how the new investment funds are targeted will be critical, says Anita Charlesworth, chief economist at the Health Foundation. As a recent report from the Institute for Government (mip.social/ifg-capital) shows, capital budgets have "not always been spent well or in full", she says. "Politicians tend to be attracted to centrally dictated, big new projects over maintaining existing assets or investing in smaller local projects."

But she sees "encouraging signs" in the Budget announcement of a £1.5 billion investment in surgical hubs and diagnostic scanners, and a £2 billion fund earmarked for new NHS technology.

There was also a welcome nod towards investment in primary care, with a £100m pot for renovating GP surgeries. Darzi was particularly critical of the government's failure to invest in primary care services; figures produced for the review show that the share of NHS capital spending going to primary care fell from 6% in 2018 to just 2% last year.

With more than 6,300 GP surgeries in England, £100m might seem like small beer. But when the existing pot is so small, it marks quite a change. "Our members working in primary care have been raising concerns about their estate for months with us now, so this specific capital funding for primary care is incredibly welcome," says Ruth Rankine, the NHS Confed's director of primary care.

GP surgeries are already seeing a record number of patients, Rankine says, and with winter approaching, she urged ministers to make sure the funding process did not leave surgeries "bogged down with bureaucracy". She sees the move as a "down payment" on the investment needed to realise the government's ambition to shift NHS resources from hospitals to primary and community care.

int?

"The government still lacks a strategy for funding the shift from treatment to prevention in the NHS. This is unfinished business for the spending review."

But that will demand a much bigger shift in attitudes to investment, comments Jennifer Dixon, chief executive of the Health Foundation. The UK has become an "an international outlier", she says, with levels of healthcare capital investment well below those of EU countries. "If the government is serious about its commitment to prevention, it should follow the changes to its fiscal rules by strengthening the fiscal framework to boost and protect prevention spending," she says.

The changes Reeves did announce in the Budget fall far short of this. The new "Persnuffle" target for government debt (see opposite) has given the chancellor some much-needed headroom for borrowing in the short-term, enabling her, among other things, to find that extra £25 billion for the NHS. In the longer term, it's unlikely to make much difference to the NHS because borrowing to invest in new buildings and equipment, as well as prevention and public health programmes, will be subject to the same constraints as before.

This leaves the government without a clear strategy for funding the shift from treatment to prevention in the NHS, adds Health Foundation chief economist Anita Charlesworth. "Like capital spending, prevention is a form of investment, delivering benefits long into the future with the added challenge that often the benefits are diffuse—spread across multiple public services," she explains. Developing a fiscal framework to protect prevention spending is "unfinished business" for the government's spending review, now expected in the spring, she says.

That fiscal framework—the set of rules the government uses to measure and target spending, taxation and debt—has often been blamed for the UK's poor record on both private and public investment. The UK has had the lowest investment in the G7 for 24 of last 30 years, and many economists see this as the major cause of the low economic growth we've seen since the financial crisis of 2007-8.

Former cabinet secretary Sir Gus O'Donnell and a group of eminent economists wrote to the chancellor before the Budget, calling for a "step change in levels of the public investment" and blaming the fiscal framework for "creating an inbuilt bias against investment". Underinvestment, the letter says, "has resulted has resulted in a vicious circle of stagnation and decline", leading to "both a weaker economy and greater social and environmental problems, which themselves require greater investment to solve."

This Budget won't turn all that on its head. But the chancellor has at least reversed years of decline and signalled a fresh attitude towards public investment. Let's hope this is the beginning of the end for the cheeseparing, short-term thinking which has dogged the NHS and other public services for as long as most of us can remember. //

Persnuffle and the golden rule

Government tax and spending decisions are governed by two 'fiscal rules'. One is the so-called 'golden rule': that day-to-day spending must be covered by taxes over the medium term (five years). In short, this means the government should only borrow to invest. The second rule is that the government's 'net debt' should fall as a proportion of GDP within five years. It's this second rule that Rachel Reeves has changed in her bid to boost public investment.

You might think that 'net debt' means everything that you owe minus everything you own. But government accounting doesn't work like that. The old 'net debt' measure only sets off a few assets—basically cash and foreign exchange reserves—against government borrowings. Reeves's new measure, Public Sector Net Financial Liabilities (nicknamed 'Persnuffle' by economists) widens that to include financial assets. If the government borrows to lend money to someone else, or to buy a stake in a private company, it can net off the value of those investments against debt.

But Persnuffle doesn't include physical assets, so the new rule won't allow the government to borrow more to spend on hospital buildings, scanners or IT equipment without adding to debt.

Office of Budget Responsibility chair Richard Hughes called the move "an innovation in the UK and relatively novel internationally", warning that it could create "a strong incentive" to invest in financial instruments "when it would be more efficient to invest directly in infrastructure".

So why do this? One reason could be that the new measure is in better shape than the old one—giving the chancellor scope for extra borrowing over the next few years (about £50 billion reckons the OBR). Another reason could be that it will allow government projects like the National Wealth Fund and GB Energy to acquire assets without adding to government borrowing.

Oxford economics professor and leading fiscal policy expert Simon Wren Lewis sees little value in the new rule. "Counting financial assets but ignoring physical assets still makes little economic sense, so the new debt rule run alongside the golden rule still has no purpose other than to suppress public investment," he says.

The NHS is one team: giving managers legitimacy is the key to making reform work

Wes Streeting's big speech to NHS Providers in November, expertly sifted by Rhys McKenzie in this issue (*page 18*), was part gear-change and part business-as-usual—a combination of tea and terror. I won't dwell on the manager-bashing or the risks and gaps in his plans for building management capacity and capability. This was all normal, with the usual foreboding that the terror will be white-hot and the tea lukewarm.

But the health secretary deserves credit for what he said about accountability and clarity of responsibility. Here was a combative, sharp politician saying something we haven't heard before: "I'm prepared to make an unpopular argument with the public about the value of good leaders." If he follows through, the NHS may get somewhere.

For decades, governments have caged themselves in the fake trade off between the frontline and everybody else. Politicians have failed to talk about what the NHS actually is: a complex system which needs all its different interdependent functions working well. A skilful politician would know how to get this idea across. So Wes Streeting's "unpopular argument with the public" would be different and politically brave. My hunch is that the cage door is unlocked, if not yet open.

The think tanks and Lord Darzi have shown the value of management and given managers a bit of a morale boost too. More importantly, politicians may be lagging behind the public, who see every day what underinvesting in capital, systems and management means for them, their loved ones and friends. Early themes from the ten year plan consultation suggest the public have a good idea about what's needed. Among the top priorities for change are communications with the public, the supply chain, shared digital health records, automated systems for patient registration and appointments, and more flexible working patterns. These challenges fall mainly to people in the 'everybody else' end of the NHS trench—particularly managers.

Streeting may find making this case to NHS staff an even tougher nut to crack. Sadly, many staff groups share the views of the public. Just listen to any phone-in about what's wrong with the NHS! The 'frontline vs everybody else' trade-off has become a deep-seated belief in a two-tier workforce. You see this when the mere idea of redundancies or outsourcing among clinical staff is met with horror, while there's barely a murmur when it actually happens to clerical workers or facilities management staff. Managers, especially, get 'othered' by staff as a whole, often seen as malfunctioning magicians or hard-hearted mill owners. They are neither. Managers are skilled workers in a team of skilled workers.

> *Here was a combative, sharp politician saying something we haven't heard before: "I'm prepared to make an unpopular argument with the public about the value of good leaders." If Streeting follows through, the NHS may get somewhere.*

Two things will be important if the health secretary is to win over staff.

First, language. It's his to choose. Headlines about "failing managers" and "protecting the frontline" undermines the legitimacy of managers and all non-clinical staff. No-one goes on to read the balanced remarks about the hard work and skill of most of managers. The term 'manager' also travels wider and deeper than politicians think. Andrew Lansley was shocked to learn that matrons thought he was talking about them when he attacked managers. He thought everyone understood he meant the men in suits at the top of NHS organisations. Leave aside that the 'men in suits' were mostly women, he'd only made the job of managers, clinical or non-clinical, harder. Anyone wanting to block change—led by managers—thought the health secretary was on their side. Streeting runs the same risk.

Secondly, managers must be allowed to get on with repairing, or re-creating, the social contract with staff: junior doctors for whom endless payroll errors are the final straw; staff with out-of-date job descriptions stuck in the wrong grade; and people feeling let down, frightened and demoralised by bullying, sexual harassment, violence, racism and inflexible working. These problems have management solutions. Give managers the permission, encouragement and tools to deliver them.

If managers are to get the legitimacy they need, ministers must start talking and planning around a unified workforce'—giving equal value to managers, clinicians and everybody else. Without that, productivity and reform—unloved concepts at the best of times—as well as the ten year plan itself will hurtle over the cliff. //

“Showing kindness and trust creates a virtuous circle—people respond well to that”

As chief executive of Suffolk and North East Essex, one of the England’s most highly rated integrated care boards, Ed Garratt has pioneered a radically different approach to leadership—one based around kindness, trust and putting down deep roots in local communities. He talks to *Healthcare Manager’s* Matt Ross.

Early in Ed Garratt’s career, he recalls, he encountered “a view that I might be too kind to be an effective leader: that you’ve got to have a more punitive style, a tougher style.” For many years, he adds, “a pacesetting, performance-management style was fashionable: a competitive, harder edge.”

That approach to leadership is, Garratt believes, “one-dimensional” and counter-productive. “If you want to deliver sustainable results, if you want to generate genuine followship, you’ve got to treat people with respect,” he argues. “What people really respond to is leaders rooted in their local communities, who are giving clarity of purpose and building a sense of belonging.”

Garratt’s leadership style is inspired by that of James Timpson, the business leader and, since July, peer and prisons minister—who sees “kindness and trust” as the best ways to build organisational performance. “Showing kindness and trust towards your staff creates a virtuous circle, because people respond well to that; and then they show those qualities with their staff and across organisational boundaries,” Garratt explains.

Inspiring staff to meet a shared goal, Garratt believes, is far

more effective than herding people forwards with individual performance targets. "Establish a focus on the outcome for the community, rather than focusing on the mechanics of how you get there," he advises. "The importance is in developing the commonality and the culture; that will develop its own virtuous circle, and propel you forwards."

As chief executive of Suffolk and North East Essex Integrated Care Board (SNEE) since 2019, Garrett has built the organisation around these beliefs. "One of the organising principles of our system is showing kindness—both to our communities and the people we serve, and to our staff," he comments.

It seems to be working. As chief executive of the three clinical commissioning groups (CCGs) that merged into SNEE, Garratt secured 'outstanding' ratings for each of them. His early work leading the integrated care system (ICS) earned him an OBE in 2023; that same year, NHS England's review of ICSs' digital maturity put SNEE in top spot. We are currently awaiting the results of NHS England's ICBs performance appraisal, in which—*Healthcare Manager* understands—SNEE is expected to do extremely well.

Garratt can't confirm his ICB's place in these rankings, but sounds optimistic. He's come a long way since 2004 when, studying for a PhD in English literature at Cambridge, he "ran out of money and started temping" for the NHS. "I really, really loved the health service and saw so many opportunities in management—then I got offered a job as an administrator, and built it up from there," he recalls. "It wasn't planned, but I felt a passion for it."

Garratt identifies three key factors in developing his management skills: learning from an "outstanding" chief executive in his first job; working on the NHS constitution in 2009; and going through an "aspiring directors course" early in his career. Such courses are thinner on the ground now, he comments, "but good leadership doesn't happen by accident: you need to develop and support it in the same way as other disciplines in the health service. Greater investment in structured ways of developing people is really, really important."

What factors explain SNEE's high performance? Consistency is one key plank of its success, he says. A lack of churn in senior roles across the ICS has provided the "continuity to see things through". Equally valuable is "stability of organisational structures": Garratt helped to develop the 2021 NHS White Paper that overturned Andrew Lansley's 2012 reforms, and plainly now wants to avoid further top-down changes. "Having a period of stability organisationally allows people the headspace to develop, which I think would be exceptionally helpful," he comments.

The ICB has also enjoyed a "consistency of purpose," he says. "We set our system up around tackling health inequalities and being very community-based in the way we've organised our workforce: we have a set of neighbourhood teams, joint arrangements for many services, and colocation of staff".

Alongside these commitments to tackling inequalities and rooting staff in communities, says Garratt, SNEE is "passionate about working across organisational boundaries and leveraging partnerships"—collaborating with universities, local authorities and voluntary organisations as well as NHS bodies. With the University of Suffolk, he explains, the ICB has established an Integrated Care Academy where health, care and voluntary sector staff "develop an understanding of system working, build relationships and work on practical challenges in their community."

SNEE also supports staff to do local voluntary work and build relationships with community leaders, Garratt says: "You get so much more effort and commitment if people feel that they belong in their community and are making a difference." This collaborative, locally-focused approach is now producing clear results, he adds, citing improvements in life expectancy, inpatient numbers and hospital deaths among people with learning disabilities. This is that virtuous circle in action."It's incredibly rewarding for staff to see the difference that collaboration between the different agencies is making," he adds.

Garratt also sees the unions as key partners: close collaboration with Sam Crane, MiP's national officer for the East of England was, he says, key to the ICB's maintenance of morale and forward progress while making the 30% savings in running costs demanded by government during this year and next.

"One of the first things I did was to sit down with Sam to say, 'Our ambition is that we will not make anyone [compulsorily] redundant during this process, and I want to work with you pragmatically to find a way to deliver that outcome'," he recalls. The ICB and unions co-developed a programme for voluntary redundancies, reshaping the organisation around them, and "the outcome was that we saw an improvement in staff satisfaction during the year we were making these changes," says Garratt. "We came through a difficult time smoothly, and were able to continue making progress. Partnership working is key if you want to maintain organisational delivery and performance; it's a false economy to work without those strong partnership foundations."

Garratt's concentration on building partnerships also pays dividends in digital services, where improvements require organisations to share IT systems and information. Here, the engagement of clinical leaders is critical: "Digital is as much about winning hearts and minds as it is about technical implementation," he says. "We've linked datasets between primary care, community services, mental health services, social care and acute—so we've got amongst the most developed datasets of anywhere in the country. And that achievement has been driven through clinical leadership around our digital agenda."

Effective digital reforms, he adds, "invariably involve moving from a more hierarchical culture to a flatter, more collaborative culture, where you're trying to get the best use of all your skills mix—and where that's happened, we've seen significant improvements in patient satisfaction and experience,

in staff satisfaction, and ultimately in outcomes."

Some of those improvements in outcomes are generated by using population health information to better target services: work to support people with frailty, for example, is reducing the number of falls and hospital admissions. Others come through better information exchange: SNEE has "the highest use of the shared care record in the country—and a third of poor quality outcomes are a result of poor communication in the health service," he comments. "So we're seeing improvements in outcomes as a result of actively using shared care records."

In dentistry, too, SNEE is forming unique and powerful partnerships. The area has "traditionally been a dental desert", Garratt comments, so the ICB had an underspend. This offered the "potential to think differently and innovatively—and that's absolutely what we've done."

With the University of Suffolk, SNEE has launched a community interest company (CIC) to provide dental training and services: the university has built and staffed a new dental centre, which the ICB commissions to treat under-served groups such as the homeless, people with learning disabilities, and children in care. Staff are salaried, and the CIC is paid per session rather than per treatment—incentivising a preventive approach.

Over time, Garratt hopes, the flow of qualified dentists, hygienists and dental therapists graduating from the university will water SNEE's dental desert. Meanwhile, "12,000 more patients within our ICB have had access to dentistry compared to the year before; and in terms of benchmarks amongst the ICBs, we've gone from being one of the worst in the country in terms of access—particularly for children's access—to about the middle."

"That's the benefit of an ICB: you've got local relationships and partnerships that you can leverage in a way that you couldn't if you were commissioning from a distance," Garratt says. The same holds true in capital investments, he believes: asked whether a

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"I'm clear that spending a greater proportion of capital in primary care and community would deliver better outcomes."

relaxation of the national rules governing ICBs' use of capital budgets would improve results, Garratt replies that "we would be spending a greater proportion in primary care and in community services—and I'm clear that that would deliver better outcomes for the population."

Reorientating capital spending towards primary care "would be a game-changer in terms of integrating more services locally and decompressing systems generally," he adds. "It's a huge and important shift that we need to make in terms of financial strategy."

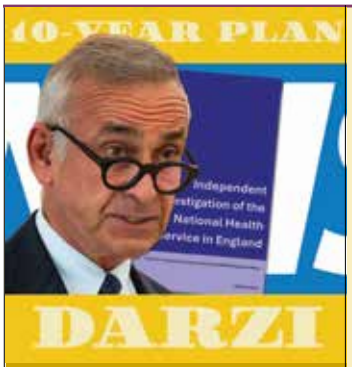
Given his track record in CCG leadership, his focus on primary care and his ICB's success in digital, Garratt was an obvious choice to lead a new NHS England pilot programme testing ways to improve general practice. "We're working with 22 primary care networks [PCNs] in seven different integrated care boards to baseline the community gap within those PCNs, and provide a 10% uplift in resource," he explains: the money will fund work to integrate primary, community and secondary services; introduce technology to improve productivity; make better use of skills across the workforce; and better understand and address demand.

The programme was conceived under the last government, Garratt explains, but Labour ministers are "very, very interested—and I think if we can demonstrate evidence-based outcomes, it has huge potential to be considered seriously and for learning to be scaled up and improvements to be made."

Garratt hopes to demonstrate that reforms and investment in primary care can reduce illness and improve health outcomes—taking the pressure off acute services. In his view, ICBs will prove most effective if they shift care provision forwards and down into local communities, using their local relationships and expertise to mobilise public and voluntary organisations—both within and beyond the ICS—around a common purpose.

"Keeping ICBs on task around delivering better outcomes through collaboration, through leveraging all the partnerships they've got available to them, is where we need to be: that's got to be the consistency of purpose," he says.

For him, the first task is to tackle the worst outcomes: "The health inequality agenda is absolutely at the heart of that." And the most powerful levers lie in the healthcare frontline, where staff operate within the communities they serve. "The challenges in secondary care are important, but if they overly dominate then I think that's a huge missed opportunity," Garratt concludes. "If ICBs' attention is on communities and neighbourhoods and places, they can deliver really positive, long-term legacy changes." //



Darzi's defence of NHS managers offers a fresh start

With his blunt dismissal of those who blame managers for the NHS's troubles, Lord Darzi drew a line under decades of manager-bashing and scapegoating. It's time to move on and for managers to work hand in glove with clinicians to tackle the real problems facing the NHS, writes *Rhys McKenzie*.

When the newly appointed health secretary, Wes Streeting, announced that ex-Labour health minister and current independent peer Lord Darzi would be conducting a "raw and frank" assessment of the NHS in England it left many managers with a strong sense of *deja vu*: another hastily arranged, 'independent' insight uncovering what most NHS managers could tell the government in a five-minute phone call. It was met with a fair amount of apathy in the health system: how many more times do we need to diagnose the problem before we start to treat it?

The review was conducted, written and published in just one month, adding to the sense that this was more about politics than policy. But while Darzi's findings bought the government some much needed time while it figured out what 'NHS reform' actually meant, it was Darzi's ardent defence of managers that really caught them by surprise.

While laying out all of the NHS's struggles over the past 14 years, Darzi was categorically clear: "some have suggested this is primarily a failure of NHS management. They are wrong," he wrote.

This should not really be a revelation. Many reports and reviews on our healthcare system have drawn similar conclusions. But the way in which Darzi tears apart this notion of management failure after being given free rein by government to "uncover the hard truths" plaguing the health service, should convince us to accept it.

Lansley and the 'lost decade'

Darzi's key finding was that the NHS is in "critical condition but its vitals are strong". A slightly more optimistic prognosis than the health secretary's blunt top line that the "the NHS is broken". The critical condition the NHS finds itself in, Darzi says, is caused in large part by reforms that were intended to save it.

Every good story needs a strong antagonist. Enter Andrew Lansley, the reforming Conservative health secretary whose plan to "liberate the NHS" almost destroyed it. His reforms were eviscerated by Darzi who called them "a calamity without international precedence".

Darzi's scathing verdict on the Health and Social Care Act 2012, a piece of legislation that was three times the size of the 1946 act which founded the NHS, should serve as a cautionary tale to reforming governments.

Its "scorched earth" approach to management structures resulted in a permanent loss of management skills and capacity, the effects of which are still felt today. Lansley opted to abolish three tiers of management at the same time, dissolving the entire management line of the NHS. It resulted in the creation of over 300 new NHS organisations in a five-year period, in a completely new structure and operational environment. With even the most talented managers in the world, no health system could be expected to build up such a large number of organisations in such a short period.

As managers struggled to make sense of this nonsensical move, they became the scapegoats for ministers looking for someone else to blame. The reforms were "a political decision, that not only condemned the NHS to a lost a decade, but condemned its managers to a decade of finger-pointing and political attacks," says MiP chief executive Jon Restell.

23. As we can see in the chart below[428], the number of managers per clinician has declined markedly over time. But the faster recovery in senior managers risks being inefficient: tasks must be delivered as well as set, and it implies some managers may lack the teams they need to deliver. Moreover, many clinicians take on managerial responsibilities, such as service directors. They find themselves lauded in one capacity and demonised in another. This is counterproductive.

Figure IX.2.3: Change in managers per NHS employee since September 2009

24. The problem is not too many managers but too few with the right skills and capabilities. International comparisons of management spend show that the NHS spends less than other systems[429]. This has often been observed as source of pride; but it may well be a failing, since it suggests that the NHS is not employing enough people whose primary responsibility is that its resources are used well, and the talents of its clinicians are focused on delivering high quality care. We need to invest in developing managerial talent and creating the conditions for success.

Too much oversight

Lansley was also the driver for a near-constant reorganisation of the headquarters and regulatory functions of the NHS. The number of staff employed in central and regulatory functions of the health service has expanded massively compared to providers. The size of the Department for Health and Social Care (DHSC) has increased by over 50% since 2013 and the number of staff working in regulatory roles is now more than 35 per trust, up from just five in 2007.

Darzi is quick to point out, and MiP agrees, that this is not a criticism of the people working in these roles. But the increase in oversight undoubtedly puts a strain on the managers and leaders further down the system. Accountability is important. But too many people holding each other to account, rather than focussing on delivering, can be counterproductive.

"When you're looking up, you're not looking out," says Restell. "The NHS as a national health system requires a strong centre to operate effectively, but many managers in providers spend too much time on internal management duties rather than using their skills to improve services locally. A few targets can focus the mind and ensure each part of the system is working towards a common objective, but too many can make it difficult to remember who you are there to deliver for—the patient."

Darzi argued that "the problem is not too many managers" but too few in the right parts of the system to be as effective as they can be. But with NHS England, ICBs and a large number of trusts going through organisational change in the last few years, there is no appetite for more reorganisation. MiP understands how costly and distracting these exercises can be, and how they demoralise and demotivate staff.

Darzi, thankfully, says that reorganisation is neither "desirable nor necessary", especially as our health system is beginning to resemble a more sensible structure after the 2022 Health and Social Care Act. But in lieu of restructuring, MiP agrees with Darzi that government should do more to clarify roles and accountabilities throughout the system.

Managers drive efficiency

Darzi's review also highlighted how the loss of managers has reduced the efficiency of the NHS. Manager numbers fell at an annual rate of 4% between 2010 and 2015, and only began to grow from that low base in the last two years. The number of managers per clinician has also fallen, putting more of the management burden on clinical staff.

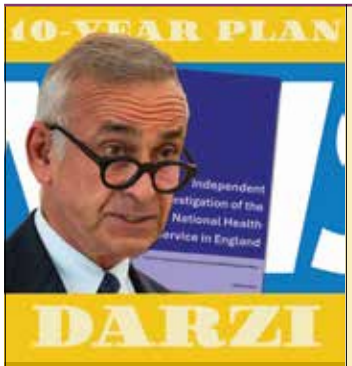
Clinicians taking on more management responsibilities to plug this gap then find themselves in the strange position of being "lauded in one capacity and demonised in another". The irony was not lost on Darzi.

Senior manager numbers are recovering at a faster rate than managers generally, although Darzi highlights how this resource could be wasted: "tasks must be delivered as well as set," he writes, "and it implies some managers may lack the teams they need to deliver'. It may be uncomfortable for the government, but Darzi is taking on the elephant in the room: can we really get away with ignoring manager numbers for much longer?

Darzi's review pointed out what all of us knew for some time. The NHS is struggling due to an unprecedented and wholly unnecessary top-down restructure in 2013, a lack of funding, especially in capital, going back 14 years, a pandemic we were woefully unprepared for and a failure to shift resources from the hospital to the community. Its analysis of the problems will be used by government as a mandate to conduct its reforms. But in its identification of fault, it has also set out one of the most compelling rebuttals of NHS manager-bashing in years.

We must move on now. As Darzi has highlighted, the NHS will only recover because of managers, not in spite of them. They need support and need a government who sees them as partners rather than an opportunity to score quick political points.

If the new government only gleans one piece of wisdom from Darzi's review, let it be that it was disastrous government reforms that last put the NHS on its knees—not its dedicated staff. Let's not repeat the same mistakes again. //



It ain't what you do, it's the way that you do it…

The government's upcoming ten-year plan will try yet again to shift the NHS in England towards community, digital and prevention. The big question is how, writes *Craig Ryan*. Try honesty, patience, focusing on what matters and empowering staff and local managers—that's what gets results.

Here we go again. Another big NHS reform for England is just around the corner. Following Lord Darzi's hard-hitting "diagnosis", the treatment comes next May with the government's ten year plan—"the biggest reimagining of the NHS since it was founded in 1948", says Kier Starmer. No pressure, then, on the small team of officials drafted into the Department of Health and Social Care (DHSC) to write the damn thing.

Thanks to Darzi and the drip-feed of ministerial statements since, we know the plan will be built around the so-called 'triple shift': moving effort and resources from treatment to prevention, from analogue to digital, and from hospitals to community and primary care services. That's nothing new—these shifts have been talked about for decades. The imaginative bit will be devising a plan that can be effectively implemented and delivered. The track record on this is patchy to say the least.

We're already halfway through a ten-year plan, which began in 2019, subsuming the 'Five Year Forward View', which in turn had started unpicking the chaotic Lansley reforms of 2013. Further back, Frank Dobson's 1998 modernisation plan was upended within three years by Alan Milburn, who introduced foundation trusts and more competition. Funnily enough, Milburn's blueprint was called the 'NHS Ten Year Plan'.

So we've been round these houses before and we're still talking about starting that triple shift. What needs to be different this time?

"The first thing is you have to be absolutely honest with the public that this involves trade offs," says Siva Anandaciva, chief policy analyst at the King's Fund and a former DHSC official. "Investing in the community and prevention might mean we have to wait a little longer for hospital care or even get poorer quality hospital care."

Then you need time. We've seen how previous long-term NHS plans run out of steam: "the money goes away, the acronyms change, the focus shifts to something else," Anandaciva says. "I was a big fan of the Five Year Forward View... but we just didn't let it stick. So let's pick something and stick with it for five or ten years." The third key element, he says, is to "focus on implementation and do it well".

Achilles heel

Delivery and implementation is usually the "Achilles heel" of NHS reforms, says Sir Chris Ham, emeritus professor of health policy and management at Birmingham University. Ham was part of the team that produced Milburn's plan in 2000—widely seen as more successful than your average NHS reform.

"Much more thought needs to be given to how change and improvement are going to happen," he explains. "Who are the leaders and what are the mechanisms? Nobody will really scream about the three shifts, but what do they mean in practice? You need to be very specific about how you're going to bring those shifts about."

He sees "a real risk" of conflict between action to tackle the immediate crisis and longer-term ambitions for reform. "Quite rightly, there will be pressure on the government to show it's making a difference quickly—they can't afford to wait six months—but that's not what a ten year plan can realistically do," he says. Promises of a "blitz" on waiting lists and waiting times through extra cash for hospitals and using more private capacity are hard to square "with a shift to putting more emphasis on primary care and community services," he says.

There's a danger, Ham warns, that ministers will reach for what they know and "we'll end up with another very centralised, very-top down approach, very much based on targets. And I don't think that's the right way to go about it."

Instead, ministers should think about "how to make hundreds if not thousands of small changes and improvements," he says. "We've never been very good at linking up challenges with solutions, so this is an opportunity to draw on the expertise that already exists in the NHS and the energies of 1.4 million staff. That needs to be at the heart of the plan."

Nirvana never comes

Some experts, Anandaciva included, are sceptical about the traditional approach to NHS reform: stablising the service with extra cash before moving on to transformation. "The stabilise-to-transform narrative just leaves you waiting for a nirvana that never comes," he says. "I struggle to see how you can flip the health service on its head and still meet all these constitutional targets. I think something's got to give."

That means recognising both the limitations of targets themselves and that we may be targeting the wrong things, he explains. "We could focus on a smaller range of targets or change what good looks like... because how long you wait for care is not all that matters. Nothing magical happens to you after four hours in an A&E department."

Measuring people's actual health outcomes rather than hospital activity would "cover more of the care pathway" and but raises tricky issues with accountability, Anandaciva explains. He recalls a recent meeting, where some ambulance service directors indicated they would be willing to take responsibility for an outcome target—such as survival to discharge rates for heart attack patients—despite not controlling the whole care pathway. "One said, 'This is what matters. So, I'll do my bit and make sure the rest of the pathway does its bit.' At least that way we'd be measuring the right things," says Anandaciva.

Forces for change

For change like that, you need heavyweight political cover. It would give him "more belief and more confidence," says Ham, if Starmer, Rachel Reeves and Wes Streeting could "show the same joint commitment to reform and investment and, crucially, to seeing it through in the long term," that Tony Blair, Gordon Brown and Milburn did 25 years ago.

The idea of taking politics out of major NHS reform is "both unrealistic and the wrong way of looking at it", Anandaciva says. "A politician's focus can be an incredible lubricant and force for change." It may be significant that, unlike the last round of reforms, the ten year plan is being driven by DHSC rather than NHS England. It may also be significant that Milburn is advising Streeting on the plan.

But the NHS is under much greater financial pressure today than in 2000, when, Ham says, extra funding "was never in question". Anandaciva doubts that Reeves's October Budget stumped up enough cash to recover all the NHS performance targets and deliver the transformational changes the government expects. This leaves ministers with an ugly choice between another "massive cash injection" further down the line, or "a very different dialogue... about how we can spend the existing money differently," he says.

But investing in prevention and community services, even at the expense of activity targets, "may not be as [politically] risky as we've been framing it," Anandaciva adds, because we may be at the limit of what can be achieved by pouring in more money. "Yes, hospitals may be doing 25,000 more hip operations, but you're still waiting five months for a referral," he says. "People's lived experience of the NHS won't feel very different."

As the huge response to the government's consultation exercise on the ten-year plan—70,000 responses in the first week—shows, there's no shortage of ideas about how to reform the NHS, And the mixed and sometimes contradictory messages coming from ministers, the Darzi report and NHS England about ICS powers, managers, league tables, incentives and targets suggests the government doesn't yet know it's own mind.

Perhaps spare a thought for Anandaciva's old boss from the King's Fund, Sally Warren, who now leads the team developing the ten year plan. This shows how hard government can get: the issues are complex, the trade-offs are difficult, there's no money and the cost of failure is very high. "I'm glad she's doing it, but I really don't envy her at all," Anandaciva says. //

What should be in the ten-year plan? Tell the government what you think at: change.nhs.uk

Labour's reforms: a mixed bag for managers

Ahead of the ten year plan, Wes Streeting and NHS leaders have been sketching out some ideas for NHS reform. *Jon Restell* and *Rhys McKenzie* explain what these early proposals could mean for managers.

Since Labour's election victory in July, we've heard regularly that there will be no more money for the NHS without reform. After an injection of cash in October's Budget, the NHS knew the first of these reforms would soon follow. Health secretary Wes Streeting duly delivered two weeks later, setting out the first package of what he described as "tough" reforms.

While nowhere near on the scale of what's expected in spring's ten year plan (see page 16), these reforms are still wide reaching and will have a significant impact on managers and leaders. That they were announced during a speech to healthcare leaders at the NHS Providers annual conference gives an indication of the intended audience.

In his speech, the health secretary made a point of reassuring NHS managers that he won't bash them for the sake of it, telling his audience that they can "expect a grown-up break from the past" and that he's "prepared to make an unpopular argument with the public about the value of good leaders".

These sentiments might have gone down much better if Streeting hadn't trailed his speech with talk of "rotten apples" and threats to "sack failing managers" in the media.

Performance and accountability

As part of his reform package, the health secretary announced key changes to very senior manager (VSM) pay — confirming that the long-awaited new pay framework would be published by April 2025. MiP believes the current VSM pay framework is well out of date. It has significant overlap issues with Agenda for Change, and the only metric used to determine the pay range for senior leaders is the financial turnover of their trusts.

Under the new framework, pay will be linked to performance. Senior managers deemed to be failing will be barred from pay rises, while those performing well will be rewarded. At this stage, it's not clear how performance will be measured, but the health secretary has said the trust's levels of both patient care and financial discipline will be taken into consideration.

MiP thinks accountability is the key question here: Put simply, what's down to the personal performance of the manager and what's down to the system and policy? The government risks blurring the two, achieving nothing more than giving people another reason to leave or not become a manager in the first place. The framework needs to be able to value a manager in a struggling organisation who may be cutting the deficit while keeping more staff and upholding care standards.

Regional variation in demand, the complexities of care required and available staff could all play a role in performance. If such factors are not taken into consideration, it will become impossible to convince talented managers to take on roles in struggling organisations.

The devil will be in the detail, but the principle of updating VSM pay is welcome. By engaging with MiP and other health unions, there is a lot the health secretary can get right here.

Y2K again

If you thought low rise jeans and Oasis were the only things making a comeback from the year 2000—think again. Former health Secretary Alan Milburn is back in Victoria Street and he's brought his league tables with him.

Providers are once again to be ranked in order from best performing to worst in a very public league table. The NHS Oversight Framework, which sets out how trusts and ICBs are currently monitored, will be updated by April 2025, with the first tables being published around the same time.

Streeting says senior managers in the best performing trusts will be rewarded with more autonomy and freedom over budget surpluses. Managers in the worst performing organisations will face more central oversight, less financial freedom and could be sacked.

The NHS already has vast amounts of performance data available to the public; in reality, since they were introduced by the last Labour government nearly 20 years ago, league tables have never gone away. It's the throwback to the 'name and shame' culture of the time that is causing concern among NHS leaders.

It is right for the NHS to use performance data to improve standards, identify failings and allocate support. But naming and shaming will only serve to demoralise, not only managers, but

PETER BYRNE/ALAMY

staff throughout the organisation. And while it's unlikely the public will bother to check how their hospital is doing in the league before a trip to A&E, there's a risk that it will gradually erode patient confidence. If a trust's services are exemplary but it is ranked low purely because it runs a deficit, is that really something patients need to take into account?

It is impossible to create a framework that takes into consideration every nuance of hospital performance. A struggling trust could be facing staffing shortages, financial constraints and overwhelming demand. Yes, this should be identified, but the instinct should be to support the leadership to turn things around, not to publicly humiliate.

It may also prove counterproductive to the health secretary's admirable aim of getting the best leaders to take on most struggling trusts. With plans to link pay to organisational performance and restrict managerial freedoms in struggling organisations—why would any leader take that personal risk?

Carrot and stick

If league tables are the stick, than management professionalisation must be the carrot. Amanda Pritchard has set out plans to develop a new NHS management and leadership framework with a single code of practice, set of competences and national curriculum. Implementation is expected to start in summer 2025. She appeared to confirm that it will be mandatory—"it won't be an option", she said—and linked the framework to the statutory regulation of managers.

Streeting has also announced a new college of executive and clinical leadership to "train and develop excellent NHS leaders". Sir Gordon Messenger will be brought back to advise on the leadership and management needed for the ten year plan.

Wes Streeting: "Expect a grown-up break from the past. [I'm] prepared to make an unpopular argument with the public about the value of good leaders".

Although it wasn't mentioned in this speech, Streeting has subsequently announced a consultation on statutory regulation for managers (*see page 5*). MiP supports moves to develop and professionalise management and believes that managers themselves should own their professional standards.

Both Streeting and Pritchard agree, for now at least, that no one wants another major reorganisation. But they do want more clarity about which parts of the system do what.

Streeting wants to move to a system where "freedom is the norm" and central grip would be limited to poorly performing providers. NHS England, not ICBs, will be responsible for performance managing trusts to let ICBs focus on strategic commissioning.

On first look, Labour's NHS reform agenda is certainly a mixed bag. No one knows their local health systems better than the managers working in them and more autonomy and freedom will go a long way in the right hands. Releasing the grip of central oversight could enable more managers to look out rather than up. But the rebrand of league tables could result in organisations focussing on the arbitrary metrics needed for a higher rank, not necessarily better standards of care.

It seems Streeting is starting to understand that he will need the support of managers if his reforms are to have the desired effect. But when he says he won't bash managers for the sake of it—he must stay true to his word. Darzi was clear in his analysis of the state of the NHS: it was not that there were too many managers, but too few. Let's not attempt to rewrite this story. //

Voice, value and vision: what data professionals need from the NHS

Data analysts play a vital role in an NHS which is increasingly data-driven and focused on public health trends. But the NHS faces fierce competition for skilled analysts and many feel the health service fails to value them or fully use their talents. *Alison Moore* reports.

"We need to double the pay we're offering good analysts," says Steve Black, a former NHS data analyst and management consultant who still works closely with the health service.

While some analysts would disagree, pointing to other benefits of the job, there's no doubt the NHS faces a highly competitive market for data analysts. Many can earn far more in the private sector, especially in finance. "We do lose people to the private sector for less responsibility but £20,000 more," says Ruth Holland, director of regions for the Association of Professional Healthcare Analysts (AphA) and deputy chief information officer at Imperial College Healthcare Trust.

This disadvantage is made worse by the vagaries of the Agenda for Change pay framework. Starting salaries and pay progression can be variable, depending on where analysts are working, leading some to argue that analysts need to be moved to a different pay scale altogether.

AphA's director of policy, Neil Morgan, says entry level jobs—which can be graded as low as Band 4 or 5—usually get a reasonable range of applicants, but attracting analysts for more senior jobs is harder, especially those that require specific, highly-prized skills such modelling, AI, machine learning and data prediction.

"We could lose out if we can't match the pay in the commercial sector," he warns. "People get more excited by the thought of working for Google, Amazon or IBM. This is one of the areas where NHS England needs to be on the front foot."

No one joins for the money

But, as Shevon Licorish, an NHS data architect and AphA's branch lead in the north east and north Cumbria, points out, no one joins the NHS for the money. There are other satisfactions to the job, he says, such as feeling you're making a difference and improving care—but it's also vital that people feel valued and empowered. As analysts often work in small teams, the culture of that team is also important for how they feel, he explains.

"We have too many managers and managers masquerading as leaders with their heads down on controlling resource and optimising processes, and not enough actual leaders who share their vulnerabilities, passion and as much of their authentic self as possible," he says. The NHS needs leaders who can sell the virtues of the NHS

The golden thread: why the NHS needs more analysts

There's a "golden thread" connecting the work analysts do to the benefits for patients and staff, says Ruth Holland, deputy chief information officer at Imperial College. As an example, she points to how, during the pandemic, data analysts helped to calculate hospitals' likely needs for oxygen and critical care beds.

Analysts work in all parts of the NHS—trusts, integrated care boards, commissioning support units and arm's length bodies like NHS England—and their day-to-day work varies from place to place. But most will be pulling together data from different sources and helping to interpret it. This can improve productivity, support clinical processes and clinicians, and give insights into how an organisation is performing.

But analysts also spend a lot of time working on regular data submissions to bodies like NHS England—"feeding the beast", as one analyst calls it. Data collection has ballooned in the NHS since the service started compiling statistics on things like bed occupancy in 1980s. And this time-consuming work is, of course, replicated many times over in trusts and ICBs across the country. While it may be possible to automate some of this work using large language models and other forms of AI, it hasn't happened yet.

The demand for data analysts is set to soar in the coming years. Based on NHS England's own findings, the Association of Professional Healthcare Analysts (AphA) suggests numbers could rise from 13,000 to 35,000 by 2030. But last year's NHS Long-term Workforce Plan failed to mention analysts and consideration of the digital workforce was relegated to an addendum to the main report.

Growth areas for data analytics include health inequalities, service redesign and population health. "There's an opportunity for analysts to come in and build subject matter expertise in these areas," says Neil Morgan, AphA's director of policy. "There are huge opportunities and it's a really exciting time for anyone thinking of coming into analytics in health and social care."

and "inspire and empower current and future data and analytics professionals in and into our workforce," Licorish adds.

The analytics profession is now pushing for greater recognition and a voice at the top table, and crucial to this a new competency framework being developed with AphA by NHS England, which could lead to more standardised career pathways. "That provides a structured framework for skills development for analysts in health and care," says Morgan. "That did not exist before."

Analysts often work in multidisciplinary healthcare teams with other professionals for whom continuous professional development (CPD) and keeping up with new technologies are requirements. Holland argues similar requirements should apply to analysts. "How can we keep pace with such a rapidly evolving sector if we don't invest in our own CPD?" she says.

Self-assessment using the new framework will allow practitioners to profile their own skills, see gaps in their and their team's competencies and also celebrate what they can do, says Morgan. And professional accreditation through groups such as AphA will also help, he adds.

Out of the shadows

Many analysts, including Morgan and Steve Black, welcome the emergence of chief analytical officer (CAO) posts in many NHS organisations, hoping they will become advocates for the profession at board level.

"It's really important that the CAO is in there, ideally at board level," says Morgan. "A CAO is the opportunity to influence decision making but also to think about the strategic and operational level. It helps to focus the requirement for both professional development and the need for analytical and data literacy at all levels in the organisation."

Licorish says that analysts are often lumped in with other IT and digital professionals, with a reporting structure leading upwards to the chief digital or information officer. He warns that this leaves analytics as a "shadow profession", where the unique value analysts can bring goes unrecognised.

With her job title as chief data and analytics officer, he sees NHS England's Ming Tang as effectively 'head of profession'. "We need a chief data analyst officer at a C-suite [senior executive] level, given weight and the opportunity to speak," Licorish says. "This could address the knowledge gap on boards about what analysts actually do."

The NHS often puts analysts "in a box", undervaluing them and making only limited use of their skills, says Steve Black. "Senior people are not engaging with analysts to get the best answer to a question," he warns, often asking analysts to produce particular sets of data rather than asking what data is needed to solve a problem. "Their position often doesn't allow them to feedback," he says, and sometimes their suggestions are ignored

Waste of talent

Richard Carthew, a recently-retired analyst for NHS Digital and former member of MiP's National Committee, agrees there is a "waste of talent" among NHS analysts. Their skills are "just not harnessed in a productive way. You can get more and more data but if you're not prepared to do anything with it, then don't do it," he says.

Organisations also need to learn more from each other, he says. Many mental health trusts use the Rio electronic patient record system, but there has been little sharing of knowledge between the different analytical teams extracting data from it—there's no need for each organisation to reinvent the wheel, he adds.

Failing to deploy data analysts effectively can also devalue other investments the NHS makes, Carthew warns. For example, many hospitals use bed management software but have failed to invest in the analytical capability needed to get full value from the system in terms of improving patient flow and, ultimately, A&E performance. "It's easy to destroy value in other things if you don't employ analysts," he says. //

Constructive dismissal: understanding the challenges & exploring your options

Competing priorities, lack of support and stress at work leave some managers feeling they have no option but to resign. But in what circumstances could resignation amount to constructive dismissal?

What is Constructive dismissal?

Constructive dismissal is when an employee considers they have no option but to resign because of a serious breach of contract by the employer. For a successful claim, an employee must prove that:

- there has been a breach of contract by the employer
- the breach is sufficiently important to justify resignation, or is the last in a series of acts which justify resignation
- the breach is the reason for leaving, not some other, unconnected reason
- there is no delay between the employers' breach and the resignation

What is a breach of contract?

A breach of contract could include a fundamental change to terms and conditions of employment, such as non-payment of wages, not providing a safe working environment (for example, by failing to stop bullying) or suspending an employee without pay where there was no contractual right to. But most cases are brought on the grounds that the employer has breached the implied term of trust and confidence.

What is a 'breach of trust and confidence'?

The law implies a term into all employment contracts that employers will not, without reasonable or proper cause, conduct themselves in a manner calculated or likely to destroy or seriously damage the relationship of trust and confidence between the parties. Examples from case law include:

- putting pressure on an employee suffering from depression to return from sick leave
- issuing an employee with an 'improvement notice' about their conduct, without first hearing their side of the story
- mentioning in a reference complaints about an employee which they were unaware of

Why is it so hard to win a constructive dismissal case?

Unlike an unfair dismissal claim, where the burden is on the employer to establish a fair reason for dismissal, with constructive dismissal the burden of proof is on the employee.

To win a claim, you need to prove that your employer committed a serious breach of your contract. This could be an express, written term (non-payment of wages, for example) or an implied term, such as the duty to provide a safe working environment. The challenge lies in showing that the breach was sufficiently serious to justify resignation—unreasonable behaviour by the employer, for example, will rarely be considered serious enough.

Proving that your resignation was a direct result of the breach is another obstacle. In one case, an employee who resigned because they didn't agree with how the business was run was held not to have been constructively dismissed. Neither was an employee who resigned over a dispute about pay. In both cases, the court held there was no breach of contract. Employers often counter constructive dismissal claims by arguing that the employee resigned for reasons unrelated to a contract breach, or that they were unaware of the employee's concerns.

The time limit for bringing a employment tribunal claim is three months less one day from the end of employment, and employees must also notify ACAS within three months that they have started the early conciliation process. Tribunals can only award financial compensation and most have a backlog of cases which could lead to significant delays.

Alternative actions

If you are considering resigning and claiming constructive dismissal, your MiP rep may be able to help you find a resolution with a better outcome. These include:

- **Lodging a grievance** gives you the opportunity to resolve the issue and stay in your job with agreed changes, such as a reduction in workload or more support.
- **Mediation and negotiation** can also help de-escalate conflict, especially if the root of the problem is miscommunication or a breakdown in relationships. Agreed action may include a change of line manager, more training or different responsibilities.
- **A settlement agreement** negotiated with your employer would enable you to leave under mutually agreed terms, including compensation.

If you're facing an intolerable situation at work, it's essential to seek advice from your MiP rep and explore all possible avenues before resigning. MiP is there to support you every step of the way. //

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

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

How to do a personal quarterly review

HOANGPTS/ISTOCKPHOTO

Executive coach *Jane Galloway* explains how taking time to reflect on your last quarter can set you up for a brilliant next three months.

Performance reviews are a fact of life for most NHS managers and can often feel like a tick-box exercise. But research shows reviews are great for goal setting, self-reflection and awareness, building resilience and boosting your motivation and confidence. They can also give you the chance to 'reset' and provide you with fresh clarity and direction.

So why not make a meaningful quarterly personal review a regular feature of your self-development?

Grab a notebook and make a repeat date with yourself to work through the questions below. You can use them to set your course for the next few months, and to celebrate what's gone before. Keeping notes will give you a record of your progress. These questions are effective in both a work and more general 'life' context, and you can use them as talking points with your teams too.

For each prompt, write down your answers, as well as any patterns you notice, what you want to let go of, and which elements you want to maintain or develop over your next quarter.

1. Brilliant you

Let's start on a high! What have you done brilliantly this quarter?

Sometimes it's difficult to remember all the things we've aced; it's so much easier to remember the stuff you didn't nail. But dig deep. There's amazing stuff there; I know it! Don't shy away from this. It's not showing off, it's celebrating. Stuck? If your friends were answering, what would they say?

2. Barriers and blockers

What's stopping you from being your brilliant self every day? What, if anything, gets in the way of you working on and achieving your hopes, goals and dreams?

Are these blockers and barriers external or internal? External could look like money, time, geography, circumstances, lack of knowledge or not having the right tools or equipment. Internal would be things like mindset, confidence, self-judgment, fear, worry about what others think or procrastination. How can you begin to move past them?

3. Connection and support

It's a cliché to say that we're better together, but we can achieve goals more quickly when we ask for help. Although we often enjoy being asked for and giving help, we're usually not so great at asking for it. Help from others could be just what you need to move through those barriers you've just listed. Ask yourself:

- Where do you get your support and help?
- In this last quarter, when did you ask for help and when didn't you when it might have benefited you?
- Who might benefit from *your* help going forward?

4. Focus

What really matters for you at the moment? Take a moment to list all the areas where you are currently putting your energy (good or bad). Now make a list of where you'd *like* to be putting your energy (you may have done this before using the 'wheel of life'—find out more from quietthehive.myflodesk.com/springclean).

Once you're clear on where you want and don't want to spend your precious, limited energy and focus, make a plan for how you can focus your energy on those areas over the next quarter.

5. Boundaries

Boundaries can be essential in helping us maintain our values, achieve our priorities and meet our needs. Only we can embed and maintain those boundaries. Think about where you've set good boundaries, and where you need to review them.

Start with your values. What's important to you? What matters? In an ideal world, what would you not compromise on? You need to communicate your boundaries so people know what they are. Who do you need to tell?

How can you keep these boundaries? If they're new, or boundaries you currently struggle with, how can you protect them? This might include blocking out diary time, removing or time-limiting apps on your phone, or setting reminders. Finally, think about how you will know if you've successfully kept your boundaries.

6. What's next?

This is the really important bit. Based on your insights, start to formulate a plan or some ideas and principles that you want to take into the next quarter. Then set a date for your next review. This will help you focus for your next review, and move you closer to achieving your personal and professional aims. //

To download a free workbook to help you answer these questions and make it a regular habit, visit mip.social/qpr

Jane Galloway is an award-winning coach and founder of Quiet the Hive. For further info, visit: quietthehive.com

meetyour**reps**:**Catherine McCarthy**

If I hadn't joined the union, I would just have left

Programmer, teacher, business analyst and project manager: Catherine McCarthy beings a wealth of different experiences to her new role as MiP rep at the Health Research Authority. Interview by *Craig Ryan*.

MiP's workplace reps bring the same breadth of experience to representing members that they bring to their day jobs as managers. None more so than Catherine McCarthy, MiP's new rep at the Health Research Authority (HRA) who is now well into her third career.

A geography graduate, Catherine joined Sainsbury's as a junior programmer "almost by accident" from university. Recruiting arts and social science graduates was an "experiment" for the supermarket giant, she explains. "They wanted to grow the business analysts and project managers of the future and none of the maths and computer science people wanted to take that route. So that worked out well for me."

For a non-IT specialist, the learning curve was steep, she says. "I did programming. I did some testing. I did design work, business analysis and worked my way up to become a project manager and then a programme manager."

Catherine then went in a very different direction: retraining to teach computer studies at north London's Queen Elizabeth's Girls' school for 11 years. "I really enjoyed teaching but then changes came in which meant a lot of excessive paperwork and the workload went through the roof," she recalls.

By 2016 she was looking for another change of direction, and an analyst vacancy in the HRA's project management office caught her eye. "The bit of my career I'd enjoyed most was the project and programme management," she says. "I got a real sense that this would be the right job for me."

The HRA oversees and regulates health and social care research in England. All health research proposals—from the NHS, universities, charities or pharmaceutical companies—must be submitted to the HRA for approval.

As head of the corporate portfolio office, Catherine and her team review the business cases for internal projects, monitor progress and make recommendations on where the organisation should focus its efforts and resources. Currently, those projects include the HRA's 'research systems programme', which involves the replacing the core system for submitting research proposals, and a bringing its procedures for clinical trials into line with new legislation.

> *// I particularly enjoy developing people. We've just gone through the government accreditation process for project delivery—that was a massive achievement. //*

"I particularly enjoy developing people," Catherine says. "Six of us have just gone through the government accreditation process for project delivery—that was a massive achievement. I also enjoy improving our capability in delivering our projects and programmes, and knowing that we're helping the organisation to use its money wisely."

But there are frustrations too. Getting accurate financial information can be "tricky", she says, while not having a dedicated project management tool—"we've been waiting eight years and we've got nowhere"—means relying on spreadsheets and PowerPoint files. Previous cuts to project manager posts have also had a negative impact on the team. "What we do is not always understood or valued," she says.

Like many managers, it was a brush with organisational change that got Catherine involved with MiP. Unhappy with proposed changes to management structures and her workload, she contacted the union, receiving "absolutely fantastic" support from national officers Steve Smith and Chris Nelson. "I didn't feel on my own," she recalls. "Steve told me to just stick to my job description. Knowing I could say 'no' felt like a weight being lifted from my shoulders." MiP supported Catherine with a formal grievance, resulting in an improved outcome for her and the team.

Catherine completed MiP's training course. for reps earlier this year. "I thought, the union has been really good to me," she says. "If I hadn't joined, I would just have left. But with MiP's support, I've been able to continue in my role."

She sees changes in the pipeline having a big impact on MiP-level staff at the NRA. "There's going to be more digital roles and I think a lot of operational roles will disappear. So that penny is starting to drop with people," she explains. She hopes to expand MiP's small membership at the authority and is looking for another rep to join her. While being a senior manager and union rep can be "a weird position", Catherine says, "I feel quite empowered by it really. I can do a good job in helping the organisation avoid problems... It's an almost unique position to do good." //

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

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