Caring for Health and Wellbeing

Here you will find a selection of blogs around the theme of Caring for Health and Wellbeing.

Relieving the 'stress and strain' in social care

Brendan Martin, 12 August 2015

The Observer newspaper and Andrea Sutcliffe of the Care Quality Commission (CQC) did a good job on Sunday to highlight the 'stress and strain', as she put it, afflicting social care.

'Stress and strain' is putting it mildly, as has long been obvious to anyone who works in or uses the service. But if repeatedly highlighting the failings of a broken system was enough to fix it we would not be where we are.

Valuing the commitment and skills of good care workers is undoubtedly necessary, and the terms of Unison's Ethical Care Charter are a minimum expression of that.

But raising the status and employment standards of the workforce probably cannot be sustained, and certainly won't be enough, without radical redesign of the service.

The core flaw is commodification of care, and by that I do not mean the involvement of non-state providers. In fact, as the fantastic success of Buurtzorg Nederland has shown, they can pioneer the kind of change required.

By commodification I mean the fragmentation of what should be relationship-based care into a production line of standardised tasks with standardised times.

Person-centred service, by contrast, demands that care workers focus — as most wish to, and many do the best they can — on the unique and changing needs of the human being to whom they offer support.

Social care of the future will be a professional vocation in which care workers have the freedom and responsibility to provide appropriate supports to strengthen and complement the capacity of the client and her networks.

Buurtzorg has shown that such an approach not only produces better quality but can lead to savings by reducing the number of hours of care required.

Additional savings and quality improvements come from providing the Buurtzorg service through self-managed teams supported by an IT system, regional coaches and small back office that support rather than control the frontline.

The UK Homecare Association (UKHCA) has warned: "The additional costs of the new National Living Wage could lead to a catastrophic failure of home-based care services, unless there is urgent action from Government and local councils to address underfunding."

That is true, but why invest in a broken model when the returns from supporting transition to a better one would be so much greater? A co-ordinated effort by national and local government, health and social care providers and the workforce itself could make that happen.

Unfortunately, the government responded to the Observer article with denial, claiming that the "'fit and proper person' test for directors and a care certificate for frontline staff" would ensure compassionate care.

But the unsuitability of a few directors is not the fundamental problem — most want to do a good job and will sail through the test.

And while staff certainly need better training, the care certificate does not disrupt and could even reinforce a failed model that objectifies the client and undermines the carer's vocational ethos. We can wait for the next scandal or we can do our best to prevent it. That's why Public World is working with Buurtzorg to test how to make person-centred, relationship-based care through self-managed neighbourhood teams work in the UK.

If you would like to help us, or if we can help you, please get in touch.

Living wage is just the start in valuing home care workers

James Archer, 11 May 2015

Increasing numbers of Adult Social Care Commissioners acknowledge their role in driving down the cost of home care contracts, and that by doing so they became “part of the problem”.

The result is staff turnover often over 30% per annum and around 200,000 home care workers paid under the minimum wage, if unpaid travel time between visits is taken into account.

There are welcome signs that growing numbers of new home care contracts with local authorities require providers to pay the living wage.

However, raising pay is easy in comparison with a shift away from ‘time and task’ towards a holistic approach in which home care workers play a key role in the integration of health and social care systems.

Such an approach helps people receiving support to remain as independent as possible, able to achieve their maximum potential and to be treated with dignity, compassion and respect.
This vision transforms the role of home care workers into one in which they will be trusted, listened to, supported and treated with dignity, compassion and respect by their own managers and by health and social care professionals.

Some hope to achieve this through well-crafted specifications, but what is actually required is Systems Leadership, which has been described as a way of working that shares the leadership load to achieve large-scale change across communities.

Systems Leadership goes beyond organisational boundaries and traditional ways of working and extends across staff at all levels, professions and sectors. It involves people using services, and carers, in the design and delivery of those services.

Local authorities will need to develop genuine partnerships with home care providers, recognising that home care workers are often the person in most contact with the person needing support, and with the most knowledge of their changing needs.

Genuine partnerships can start to build the trust that is so sorely lacking between home care workers, their employers, commissioners, social workers, district nurses and GPs.

Research by Jill Maben, Director National Nursing Research Unit, et al has shown that compassion only grows where staff feel safe, and that lack of trust erodes nurses' professional values and desire to do good.

Maben cites the following prerequisites for compassionate care to be delivered:

- motivated and receptive colleagues;
- adequate staff and good skill mix;
- ideas welcomed and change encouraged;
- support for staff through mentorship; and
- a support period for new staff.

That all needs to be underpinned by a philosophy of care that supports compassionate care.

If it is hard for qualified nurses to feel trusted it is far worse for care workers! Too often, they have been ignored in the creation of new models of care for people living at home, but they need to be seen as central participants in any new service design.

The first step is to start building a shared understanding of the new role between the councils and the providers.

This new understanding must be used the create the conditions where compassion can flourish or else the onslaught of five more years austerity will overwhelm and undermine attempts to transform care at home.

- **James Archer** is a senior consultant with Public World and co-author of *Business Analysis and Leadership* (Kogan Page, 2014).

Keeping older people healthy and well at home—collaboration is key

Tamsin Fulton, 12 December 2014

Keeping people healthy and well at home for longer is a key driver for integrated health and social care and major initiatives are underway to shift activity and resources into the community.

That seems to put GPs at the heart of the health and social care economy, but the landscape is much more complex than that - particularly for older people and their carers.

As well as GPs, in the care mix we see home care workers, community nurses, allied health professionals, social workers, geriatricians, nutritionists, dentists, community mental health teams, dementia nurses, meals-on-wheels staff, befrienders, advocates, family & informal carers, other relatives, clubs, groups and day centre staff and volunteers.

In fact, that is possibly just a starter list and many combinations of groupings of these individuals will be contributing to an older person's care at any one time, particularly with so many older people with more than one acute condition.(Co-morbidities are at 50% amongst 65-year-olds, rising to 75% of 75-year-olds).

Arguably, however, the specialist at the heart of these complex relationships with her client is not the GP but the home care worker -- and according to a recent CQC survey, carers said choosing care is one of life's most stressful events.

Of all the staff and volunteers who see an older person, it's often the care worker who has by far the most potential for regular contact. I say "potential" because we know that care worker continuity is far from assured, which means that the ability to form relationships with clients is also compromised.

But if that could change then care workers are ideally placed to assist the prevention agenda, being able to affect, as they can through daily routines, a person's behaviours and habits, as well as to spot early needs before they escalate.

What does an effective model of home care look like and how it should work as an integrated part of the wider health and social care economy?

In terms of prevention and helping people keep healthy and well at home we can just start with the top reasons why older people get admitted to A&E -- namely falls and urinary tract infections -- to see which kinds of practical support care workers could provide.

Making sure the older person has access to fresh water during and between visits, does not need to climb on a chair to change a light bulb, or watching out for early signs of cellulitis are examples of the important roles care workers can play.

This would make a huge contribution to reducing A&E admissions -- but they can do that only if, in collaboration with GPs and nursing staff, they know what to look for, what to do and who to contact. The Malnutrition Taskforce 2013 estimates 1 in 10 people over 65 are malnourished or at risk and in over 75s the risk of malnutrition is projected to double in the next 30 years. This is a condition that rapidly contributes to acute illness or deterioration in ability to manage life at home.

Supporting older people to eat well -- whether that's cooking a meal with fresh ingredients, organising shopping or getting a person along to lunch clubs -- would all help in very practical ways to combat malnutrition.

And this is just the health bit of health and wellbeing. Preventing isolation amongst older people is also an urgent challenge.

We know isolcation of care workers is also an issue -- a Unison survey found most home care workers did not see a colleague on a daily basis. This undermines morale and impacts on the ability of the home care worker to learn and develop in the role.

So building strong collaborative networks between care workers and clients where capacities, budgets and services could be shared or pooled would offer opportunities for social interaction and new friendships.

Being active and engaged in the community is a well-known indicator of wellbeing. Bromley-by-Bow Centre has been championing the concept of Social Prescribing, where people can prescribe social activities, such as lunch clubs, befriending and strength & balance exercise classes.

Suffolk Council's recent survey with service users and family carers found 41% thought it very important (6/6) that their carer knows their local community. Care workers knowledgeable about the local area, knowledgeable about what to do and where to go, and who are deeply embedded in the local fabric -- such a service would make significant strides to realising wellbeing at home.

Simply commissioning home care as a stand-alone service will only add to the fragmentation of care and not bring about this radical shift to greater health and wellbeing at home. Care workers must be able to collaborate with individuals and teams from health and social care and the voluntary sector to design and deliver the best outcomes.

Collaboration across the organisational boundaries of primary care, community, acute and voluntary sector services is necessary to establish a successful relationship-based model of integrated home care.

We need collaboration over a period of time to explore new routes to health and wellbeing at home that draw on the creative capacities of people from across the system, and that seek to strengthen rather than fragment precious resources.

A collaborative approach will build the foundation for preventative care at home and provide a blueprint for commissioning home care services of the future.

This is a call for collaboration where the costs, risks and outcomes are shared across all parties so that:

- People who need care and support get the best outcomes for their health and wellbeing;
- Frontline staff and volunteers explore how new and existing teams can work better together;
- New models of training and support can be devised that will motivate and develop the workforce;
- New integrated funding models can be devised and commissioned.

Tamsin Fulton *is an Associate Consultant with Public World.*

Integrated community services demands co-design of relationship-based home care

Brendan Martin, 2 December 2014

Amid the gathering gloom of wintry nights and the hospitals crisis everyone in the National Health Service expects before the Christmas decorations come down, a little ray of light from an unexpected quarter.

You might have missed it, and given his government's drive to privatise NHS services it is hard to believe it, but Health Secretary Jeremy Hunt has declared we need more district nurses and that the market can never deliver the community services essential to the future of integrated health and social care.

If he means that, he will surely give a big welcome to the urgent call for change issued today by the Local Government Information Unit's Key to Care, the report of the Commission on the Future of the Home Care Workforce.

The Commission, chaired by former social care minister Paul Burstow MP and sponsored by the home care provider Mears, reports (page 16):

"Providers compete fiercely on individual cases and they compete on cost per contact hour, not on the creativity of solutions, outcomes or the quality of their staff.

"Worst of all, there is little incentive for improvement or change in the delivery of care once a client has been secured."

Far from improving quality, in fact, the report finds that this market structure tends to drive down standards (p.15):

"Methods such as reverse auctioning – getting providers to bid on care and choosing the lowest price to drive down the cost of care – are not an appropriate approach to lowering the cost of supporting people.

"These methods have a profound effect on the quality of care that is delivered and on the quality of people's working lives."

With austerity tightening the eligibility criteria for publicly funded home care, the Commission finds (p.13) that "30% of women and 22% of men over the age of 65 who need help carrying out daily activities do not get that support and 43% of those over age 85 need help but are not getting it". But the answer is not simply to expand eligibility and increase budgets, important though both are. As the Commission points out, radical service redesign is also essential because the 'time and task' model has had its day.

The growing recognition of this fact, combined with Hunt's acknowledgement that the market cannot deliver the integrated community services of quality without which pressure on hospital beds can only grow, presents an opportunity that must be grasped.

The Commission report points out that of the 685,000 home care workers, 60 per cent are on zero hours contracts and a third paid less than the national minimum wage. No wonder staff turnover, at 21 per cent, is double the labour market average, which further undermines quality.

"Home care will not become a career of esteem until we start treating both service users and care workers with esteem – and that really means letting them work together to decide what the best care is in each individual case."

Public World's is aiming to deliver just that with **LIFT** and I'm delighted that the Commission's report flags it up, albeit while also promoting the 'outcomes-based commissioning' favoured by its sponsor, about which we are less convinced.

Our approach is inspired by the experience of our Swedish partner Alamanco, which has worked with health and social care providers in that country to develop relationship-based home care through teams in which zero-hours contracts have been reduced from 60% to 10% per cent (probably an optimal level).

If you think that can only have been possible with increased budgets, think again. In Sweden, in work validated by the European Social Fund, the shift to more regular hours and secure employment cuts costs by improving continuity of care and reducing waste.

It's a similar story in the Netherlands, where the Buurtzorg model has grown from a single team of four district nurses seven years ago to some 8,000 today, capturing 60 per cent of the home care market there.

The LGIU report points out that in Britain, "generally speaking, home care is not meant to include health care, but there may be help with changing dressings or some care that can also be offered in a clinical care setting.

"Increasingly, though, home care workers are being expected to carry out some 'clinical' assistance and, as there is a continued push for further health and social care integration, this will become more common."

Indeed, and so it should, but that means a shift to nurse-led home care services here too, and to the kind of autonomous team work that has been key to the transformations in Sweden and Netherlands.

It works because instead of being rigidly tied up in 'time and task' care plans that no longer fit an older person's needs almost as soon as they are written, the local multi-disciplinary teams are able to adapt flexibly to changing need.

Team-based autonomy — within a transparently regulated framework that provides vulnerable people with the safeguards they need — is also much cheaper because the administration costs are far lower.

Jeremy Hunt is right: the market cannot deliver integrated health and social care to older people in their homes. But cooperation — between local authorities, providers and clinical commissioning groups, between care workers and their clients, and within multi-disciplinary teams — can do it. With cuts and commercialisation all around, it's easy — too easy, in fact — to be pessimistic. The growing recognition that home care must change, allied to our growing understanding that we can improve jobs and services while cutting costs, allows us to reshape the future with optimism -- if we grasp this opportunity.

- *Brendan Martin is founder and managing director of Public World, which is working with the the LGIU, the UK Home Care Association and My Home Life to improve quality and productivity in home care.*

The NHS Five Year Forward View: where are home care providers and their staff?

Brendan Martin, 23 October 2014

The Five Year Forward View (5YFV) published today by NHS England packs a lot into 36 pages and offers a promising change agenda with resource challenges that should be central to next year's General Election campaign.

It cannot cover everything, of course, and some omissions are covered by inference. However, the absence of any explicit reference to the home care service is a real concern because its potential role in the approach outlined in 5YFV demands a step change in the way we understand, fund and provide it.

Quite rightly, there is much in 5YFV about improving integration between health and social care through Clinical Commissioning Groups (CCGs), the need for better support for England's 1.4 million unpaid carers, and the important role of volunteers.

"The traditional divide between primary care, community services and hospitals -- largely unaltered since the birth of the NHS -- is increasingly a barrier to the personalised and coordinated health service patients need," says the report (page 16), adding:

"Increasingly we need to manage systems -- networks of care -- not just organisations."
That's right, but when will the crucial role of home care workers in such networks be brought out of the policy shadows? In reality, as statistics from the United Kingdom Home Care Association have shown, they are already the everyday frontline in care of older people.

In one of several examples of a "new care model" to be supported in future, 5YFV refers to 'Multispecialty Community Providers', which "would become the focal point for a far wider range of care needed by their registered patients". The report adds (page 19):

"As larger group practices they could in future begin employing consultants or take them on as partners, bring in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers, and other staff."

But what of England's home care workforce of around 300,000, whose status and rewards belie a hugely important role that demands a wide range of skills that are vastly underestimated? Most of them work for agencies, many of which would like to improve their terms and conditions but are prevented from raising the bar because the fees they receive from local authorities are simply too low.

5YFV does promise that the NHS will work with the care home sector "to develop new shared models of in-reach support". But if we want to support older people in staying at home safely surely an enhanced role for domiciliary care providers and their staff is just as important?

According to the 5YFV plans, GP surgeries will serve as hubs of neighbourhood services combining health and social care. Rethinking the role of home care, and raising the service's status and resources accordingly, could determine the sustainability of that approach.

Is it affordable? Leaving aside the fairness issue (not that we should), the real question is whether we can afford *not* to raise the status of home care and the service's staff in line with its already crucial and potentially even more important role.

More investment and better service design there will not only enable savings elsewhere in health and social care budgets. They will also contribute -- as international experience such as the Dutch Buurtzorg model has shown -- to sustainable increases in the productivity and quality of domiciliary care itself.

- *Brendan Martin is managing director of Public World.*

Productivity in social care services: innovating for better jobs, service and resource use

Brendan Martin, 8 April 2014

The School for Social Care Research was set an important and interesting challenge at its fifth annual conference today when the Westminster government's social care minister Norman Lamb asked it to focus on how to increase productivity in the sector.

"With the pressure the system is under, nothing else will do," said the minister, reminding his audience that social care costs are rising at 4% a year while the ratio between working and retired people reduces rapidly.

As the School is funded by the government, which has just renewed a £15m grant for the next five years, no doubt it will give serious consideration to Lamb's suggestion, along with the two other areas of focus he outlined today, to find "new and better ways to personalise care" and "ways to integrate and join up care systems".

Indeed, it would surely have done so anyway, since productivity improvements will feature highly in the future social care agenda whoever forms the next government. As ever in the public service context, however, much will depend on how productivity is defined and measured, and how improvements are achieved.

The outlooks and intentions of government ministers will clearly have a significant bearing on those questions, and social care workers and their unions can be forgiven for fearing the worst. But that should prompt them not to reject the challenge of productivity improvement but to contribute positively to framing the debate about how it can be done.

No-one disputes that more resources are needed for social care, although how much more and how it is raised are contested. But whatever the level of funding it will never be enough to meet every conceivable need well, and the political case for sufficient resources is strengthened by showing how budgets can be used more productively.

The good news is that there are big potential synergies between improving working lives and livelihoods for care workers, better and more flexible and personalised services for those they look after, and higher levels of labour productivity.

I have recently returned from a visit to several projects involving Public World's partner social enterprise in Sweden, Alamanco, where in one municipality — validated by a European Social Fund study — big savings have been produced by reducing — yes, *reducing* —the use of zero-hours contracts.

Public World is now working to introduce to local government commissioners and service providers in Britain a model of home care inspired by Alamanco's 20 years of experience in Sweden. We call it Fairly Flexible, and the idea is to redesign services and training so that frontline workers operate in small semi-autonomous local teams able to adapt to changing need in real time and combine more effectively with supports provided by the families and local communities of the older people they care for.

This is incompatible with the 'command and control' methodology behind the prevalent 'time and task' model of home care services, and with the abuse of zero-hours contracts, because,

paradoxically, insecure employment reinforces rigid service delivery while more secure employment supports more flexibility in work organisation.

Similar approaches have been shown to work well in residential settings too, proving that productivity improvement in social care does not necessarily mean more precarious jobs with worse pay and conditions.

On the contrary, it *does* necessarily involve better and more secure jobs, and that can be achieved if the service opens up to innovation to enable the entirely possible synergies between better resource use, better services and better working lives.

We are actively seeking partners among local government commissioners and service providers for our Fairly Flexible home care project. If you would like to discuss it, please contact me.

This might hurt a bit: staff engagement and care standards in the NHS

Brendan Martin, 15 January 2014

Almost every NHS Foundation Trust says it has the systems in place to engage effectively with staff. Yet only a third of NHS staff report effective communication with management.

These facts highlight a "disconnect" between NHS leadership and staff that is harming patient care, says an important report from the Point of Care Foundation, published today.

As a member of its advisory group, obviously I am not surprised by the findings of *Staff Care: how to engage staff in the NHS and why is matters*.

Then again, no-one who has taken even the vaguest interest in the NHS for the last year, from the Francis Report into the Mid Staffs scandal onwards, will be surprised by them either.

Only yesterday came further evidence of the vital relationship between staff engagement and service standards, in the Care Quality Commission's report on the Bart's NHS Trust, which found: "Staff feel disconnected from the trust's Executive and feel undervalued and not supported. The culture was not sufficiently open and some staff felt inhibited in raising concerns.

"Morale was low across all staffing levels and some staff felt bullied. This must be addressed if the trust's Executive Team's vision is to be successful."

It's not all gloom. *Staff Care* reports success stories from Oxleas, Walsall, Derbyshire and elsewhere. They underline the correlation between staff engagement and care quality as positively as the Barts report does negatively.

But understanding the importance of staff engagement and wellbeing is one thing; fixing the disconnect and achieving the desired cultural change is another.

The *Staff Care* report provides a useful resource list that includes Public World's report of our Best Workplace approach, which has been tried, tested and developed over 20 years in Sweden and is now available in Britain.

Unlike some approaches to staff engagement, we do not start from the pretence of entirely shared interests and priorities among NHS leaders, managers, staff and patients.

On the contrary, our approach is based on acceptance that common purpose can be undermined by differences and conflicts that need to be acknowledged even if they cannot easily be eradicated.
A problem with some employee engagement methodologies is that they emphasise top-down rather than bottom-up communication. Leadership has a vital role, of course, but too many managers fool themselves into believing that when staff reflect back their own narrative it is because they "own" it. In fact, when staff display an understanding of the message their bosses want to hear it can conceal a toxic culture in which they have little confidence that their voices are really being heard.

The evidence in *Staff Care* suggests, indeed, that a key disconnect comes from many staff feeling that nothing changes even when they do speak up.

That is why a defining characteristic of our Best Workplace approach is to enable staff not only to be heard but to act, collectively, on their own decisions.

Of course that brings risks, both to leaders who fear a disconnect between responsibility and control, and to patients who have good reasons not to assume staff always put them first.

So it is vitally important that staff involvement is designed to strengthen team work in transparently accountable ways that enable responsibility to be shared but not fudged.

That kind of culture takes time and learning to develop, and the process can be uncomfortable at times.

But if there is one public service that should understand that making things better can sometimes hurt a bit it is surely the NHS!

- *Brendan Martin is managing director of Public World. For more information about how we can help you, please contact him at bmartin@publicworld.org.*

Safe staffing and skill mix: a hot topic for the NHS in 2014

Brendan Martin and Roger Kline, 12 December 2013

Today's evidence of cuts in mental health services in England make us wonder what, if anything, the government has really learnt from report after report in 2013 highlighting the need for sufficient NHS staffing.

According to Robert Francis QC, who has conducted two public inquiries into the scandalous care failings in Mid Staffs, "the overwhelmingly prevalent factors were a lack of staff, both in terms of absolute numbers and appropriate skills, and a lack of good leadership". (First Francis Inquiry Report, 2010, no longer available online.)

Recommendation 23 of his 2013 report was that the National Institute for Health and Clinical Excellence (NICE) should produce evidence-based tools for establishing the right staff numbers, skill mix and staff/patient ratios for different services. This should be done, Francis said, in consultation with "professional organisations and patient and public representatives".

The Keogh and Berwick reviews this year also highlighted staff shortages and their impact on care standards, and yet it wasn't until November that the government finally got around to a full response to Francis and to instructing NICE to act on Francis's Recommendation 23.

As a result, NICE has announced a "comprehensive review" of the evidence and promised to produce "definitive guidance on safe and efficient staffing levels in a range of NHS settings" by next summer.

The focus will be on adult wards in acute in-patient settings to begin with, but by August 2014 guidance on safer staffing levels are promised for accident and emergency units; maternity units; acute in-patient paediatric and neonatal wards; mental health in-patient settings and community units; learning disability in-patient settings and community services; and community nursing care teams.

"The guidance will focus on nursing and midwifery staffing levels, including nursing support staff, to ensure an appropriate balance of skills across the whole team on the wards and in other settings," NICE stated, but "will not cover recommendations on setting minimum staffing levels."

As the government accepted Recommendation 23 in full, should we assume that NICE will implement it in full? One concern is that the NICE announcement made no reference to a key clause of the Francis recommendation, that the guidance should be "created after appropriate input from specialties, professional organisations, and patient and public representatives".

Rather, NICE says it "will develop the guidance by reviewing the evidence behind existing products, together with any new or additional relevant evidence", and that "there is already a lot of information available to help us develop the guidance".

There is indeed plenty of evidence. According to a *Nursing Times* report of a study by the National Nursing Research Unit at King's College, London, for example, more than 80 per cent of hospital nurses had to leave care undone on their last shift because of staffing shortages.

This prevalence of "missed care" is an "early warning" for potential patient safety concerns, said the report, revealing that this happened when the number of patients per registered nurse was more than seven.

In May this year the Safe Staffing Alliance, which includes the Royal College of Nursing, Unison and the Florence Nightingale Foundation, said one nurse should look after an absolute maximum of eight patients.

Yet the government's healthcare regulator, Monitor, says that nursing numbers fell in the last financial year and forecasts further falls in future years after a brief spike in recruitment following the Francis and Keogh reports this year.

This is in line with research by the Nuffield Trust, which has shown that the funding gap will grow considerably as a result of the government's austerity programme.

The government has rejected mandatory staffing ratios, even though within six months of his inquiry -- persuaded, apparently, by subsequent evidence, such as the Berwick Report -- Francis himself changed his mind and said he supported the idea.

Without additional staff and appropriate skill mix, patient care and safety will suffer. In 2014 this will be a hot topic in the NHS, and our three questions are:

1. Will the NICE guidelines be genuinely evidence-based?
2. Will professional and patient organisations be consulted?
3. Will the government provide the necessary funding?

Many of us will be watching closely.

Home care of older people: the revolution has started!

Brendan Martin, 25 November 2013

What a difference a week makes! The future of social care in Britain looks very different today than it did just last Monday, because of three big steps in the right direction.

1. Allied Healthcare, one of the biggest social care employers, announced it would do away with zero-hours contracts and give 15,000 staff the right to contracted hours from next April.
2. Then the London borough of Southwark became the first local authority to sign up to the Unison Ethical Care Charter, which commits it to "improving working terms and conditions for hundreds of local care workers".
3. Now, the Guardian reports, Her Majesty's Revenue and Customs has investigated 183 home care providers and found half of them are paying less than the minimum wage.

Does all this add up to the beginning of the end of one of our country's biggest scandals – that of forcing some of the most valuable workers in Britain to be also among the most badly treated? Let's hope so, but just because social norms are changing in that respect doesn't mean that local authorities, service providers and personal commissioners of social care suddenly have more money. Undoubtedly social care must have more resources, but demographic and other trends mean that it is not just government austerity policies that are piling on pressure to do more and better social care without a proportionate increase in resources.

So a second stage of a revolution in social care will be needed to ensure the first stage is completed, because without big increases in productivity we risk replacing low paid home care with less home care, through more rationing.

It means we need not only to change how home care workers are employed but also to innovate in how they work.

The problem is that the current model has a rigid structure of time-limited slots of care, as though the needs of an older person in her home don't change from day to day.

So the carer is told to spend 15 minutes here or half an hour there, and to get that one out of bed and showered and the other one fed and watered.

Wouldn't it be better if home care workers were organized in local teams able to adapt to changing needs day to day, or even hour to hour, through intelligent and self-managed co-ordination? And wouldn't that also mean that their clients could shape the services they receive more directly, and get to know more than one of the team, so that the frequent complaint of unknown replacement carers turning up could be reduced?

As part of the Public Service Launchpad initiative, Public World is working to develop such an approach in Britain. We call it Fairly Flexible. We are starting by looking at international experience, such as the Buurtzorg model in the Netherlands and the work of our Swedish partner, Alamanco, in Jönköping. Next year we aim to pilot our new approach in Britain.

The aim is to improve jobs and services in a way that will be affordable because of higher productivity. The current model, as well as encouraging low quality services and jobs, is also highly inefficient.

If you are interested in working with us on this, do please get in touch by writing to me at admin@publicworld.org. I look forward to hearing from you.

Inspection doesn't work! NHS needs TQM not CQC, writes Roy Lilley

Roy Lilley, 26 October 2013

Here's a little factoid that might just get you over the line in a pub quiz. Or it might be one of those dinner party jaw-droppers. Over the Clawson Stilton and Taylor Fladgate port you might want to casually mention: "Did you know, there are 30,000 components in a modern car?" Not many people know that…

Interestin' innit?

It's probably more interesting than you've ever thought. Why? Ask yourself this: how is it that people on the other side of the world, often with a poor education, can assemble 30,000 bits and pieces into a shiny new automobile; ship it to Europe; and drive it straight off the boat… and warranty it for five years… and expect it to work flawlessly for 200,000 miles?

The answer is total quality management. TQM had its genesis in post-war Japan, a country, at that time, famous for shoddy manufacture. Japan's strategy switched to the new 'total quality' approach. Rather than relying purely on product inspection, Japanese manufacturers focused on improving all organisational processes through the people who used them.

As a result, Japan was able to produce higher-quality exports at lower prices, reaching into the US market and causing American managers to reach for the aspirin.

American managers were taken by surprise. They thought any competition from the Japanese would come in the form of price, not quality. Japan increased its share in American markets, causing widespread economic effects in the United States. Manufacturers began losing market share, organisations began shipping jobs overseas, and the economy suffered a way-out-of-whack trade balance.

How did it happen? In the mid-1940s, the physicist, later turned pioneering management guru, William Edwards Deming, was sent by the US government to Japan. Their food production was wrecked and parts of Japan were starving. Deming's 'statistical quality control' techniques proved a winner and he was rewarded and later lauded by the Emperor Hirohito.

Deming went on to develop his '14 Points for Management', the third of which says: "Cease dependence on inspection to achieve quality. Eliminate the need for inspection on a mass basis by building quality into the product in the first place."

The NHS has been ‘inspecting’ for quality in the NHS since 1999 when the predecessor of the present Care Quality Commission was born. Since then we have had 'learning from inspection',' light touch inspection', 'regulatory inspection' and the latest Chief Inspector of Inspection.

Still the complaints about care quality roll in. Still patients are marooned in their own faeces, starved, dehydrated, forgotten in pain, ignored, overlooked and messed about. The latest news is that 25% of our hospital Trusts have been pronounced potentially unsafe and dangerous -- the news brought to us by the organisation that has been conducting inspections for 14 years.

When do you think they might wake up and realise what industry knows, service organisations take for granted and every MBA student learns in the first year of their studies: ‘Inspection doesn’t work!’?

The car industry doesn’t inspect the finished car; it makes sure every step of the way is done properly by well-trained and resourced people who know what they are doing, are happy to be doing it and are proud to be part of it.

There is an institutional arrogance at the heart of the NHS that it knows better about everything and in all circumstances. Inspecting hospitals sounds good in the headline world of newspapers and sound-bite public opinion. Politicians play to the gallery; the staff at the CQC are the luckless cast who know in their hearts they are in pursuit of a foolish enterprise.

When Deming wasn’t guru-ing he composed music for the organ. He rewrote the national anthem to make it easier for people to hit the high notes. He used it as a metaphor for management: don't blame the singers (workers) if the song is written poorly (the system is the problem); instead, rewrite the music (fix the system).

So next time you are at a dinner party and in the pub you can ask: what has a hungry Japanese bloke got to do with safe hospitals? You can dazzle everyone with the answer.

- *Roy Lilley is a health writer and commentator. @RoyLilley*

The ambulance service: what about the workers?

Roger Kline, 12 September 2013

2013 has not been a good year for England's ambulance services. We've had the 111 crisis, queues of ambulances waiting outside A and E departments, regional industrial disputes and now a stand-off over sick pay.

As if all that wasn't bad enough, it comes on top of evidence in the NHS staff survey that ambulance staff are more likely than other NHS employees to feel negative about their working lives.

According to the report of the NHS staff survey, "it is important to note that ambulance staff work in a distinct and different environment to others in the NHS and they report poorer experiences on many of the issues picked up by the staff survey." The numbers below justify that observation all too well:

- Only 40% of all NHS staff were satisfied with the extent to which they felt that their Trust values their work, and this figure is lowest for ambulance staff (23%)
- Only 35% of all NHS staff said that communication between senior managers and staff is effective, and this figure is the lowest for ambulance staff (20%).
- Under a third of all NHS staff (30%) feel that there are enough staff to enable them to do their jobs properly; this score is lowest amongst ambulance staff (21%).
- Just over half (55%) of all NHS staff, but only 40% in ambulance trusts, would recommend their organisation as a place to work.
- While 63% of all NHS staff said that if a friend or relative needed treatment they would be happy with the standard of care provided by their organisation, for ambulance staff the figure was 57%.
- 68% of NHS staff overall felt able to contribute to improvements at work but that fell to 44% for ambulance staff.
- The percentage of all NHS staff reporting well structured appraisals in last 12 months was 38% but it fell to 20% amongst ambulance staff.
- Fewer ambulance staff (75%) than all NHS staff (81%) said they received job-relevant training, learning or development in last 12 months.
- More ambulance staff (84%) said they worked extra hours, but the figure for all NHS staff was 70%.
- 38% of all NHS staff reported they have felt unwell as a result of work-related stress in the preceding 12 months. This figure is 44% for ambulance staff.
- Twice the proportion of ambulance staff compared to all NHS staff (32% and 15% respectively) reported experiencing physical violence from patients, their relatives or other members of the public in the previous 12 months.
- While 30% of all NHS staff reported that they experienced bullying, harassment and abuse from patients, their relatives or other members of the public in the previous 12 months, that figure rose to 48% amongst ambulance staff.
- Whereas 27% of all NHS staff reported feeling pressure to attend work when feeling unwell, that rose to 38% for ambulance staff.
- The percentage of all NHS staff witnessing potentially harmful errors, near misses or incidents in last month was 31% for NHS staff overall but rose to 38% for ambulance staff.
- However, the percentage of all NHS staff reporting errors, near misses or incidents witnessed in the last month was 90% but this fell to 81% amongst ambulance staffs.
- 72% of all staff said they would feel safe raising concerns at work but that figure fell to 62% among ambulance staff.

- If they did raise concerns, only 55% of NHS staff felt confident that their organisation would address concerns but for ambulance staff the figure fell to just 42%.

These statistics are yielded by data collected from 9,000 ambulance staff, and they paint a grim picture of the the service's workplace culture.

The excellent research published this week from Mary Dixon-Woods and colleagues reiterates that “good staff support and management" in the NHS is "highly variable", despite being "fundamental to culture" and "directly related to patient experience, safety and quality of care”.

You cannot read the ambulance staff survey results without wondering what on earth is being done, as a matter of urgency, to better support and value such an important workforce.

So here are three questions:

- Does anyone know what ambulance Trust employers are doing to tackle the problems revealed in the survey?
- What is NHS England doing about it?
- Is there any chance Jeremy Hunt could take time out to ensure ambulance Trusts take on board the research evidence and recognise that a skilled workforce with high morale, well-treated and feeling able to raise concerns is a precondition for the ambulance service we all deserve?

Why NHS staff involvement is essential to improving care

Brendan Martin, 9 September 2013

One in three nurses surveyed by the Chartered Institute of Personnel and Development (CIPD) say they have come under excessive pressure to behave in ways that undermine patient care.

It is a shocking finding -- but the danger is that we will cease to be shocked by such evidence because it is no longer surprising.

This is literally the 15th blog piece Public World has published in the last six months that has referred to a report or a study showing that inadequate staff voice is putting patients at risk.

It is not that we keep referring to the same evidence. The fact is that the CIPD findings are as shocking as they are not because they are new but because they confirm so much other research. Of the hundreds of pages of the Francis Report into Mid Staffs, for us its key lesson was expressed concisely in paragraph 1.118, which stated (emphasis added):

"The patient must be first in everything that is done: there must be no tolerance of substandard care; **frontline staff must be empowered with responsibility and freedom to act in this way** under strong and stable leadership in stable organisations."
Since Francis we have had the Keogh and Berwick reports co
nfirming much the same message, as well as the NHS Staff Survey revealing much the same findings as the CIPD research.

So what is to be done? The CIPD itself stresses the importance of data: "Better collection, reporting and analysis of data on, for example, training and development, appraisals, employee engagement, stress and absence can provide trust boards with key intelligence on how NHS Trusts are really functioning and highlight early warning signs which might indicate patient care is being compromised."

Important though that is, however, surely the familiarity of the CIPD findings suggests that the core problem is not too little information but too little commitment to using it, or too little clarity about how to do so.

As Kevin Croft, president of the Health People Management Association (HPMA), for which CIPD conducted the research, commented:

"These survey results are disappointing but similar to messages from the national staff survey. The findings reinforce the need for a much greater focus on the staff experience, good people management and staff engagement, at both a system and local level, to improve the patient experience."

We agree, which is why Public World has invested this year in the development of two new resources we believe can help NHS Trusts and their staff make the changes required:

- With the support of NHS Employers, we are offering an innovative approach to staff involvement. Our approach is based on the Best Workplace methodology, which is the product of 20 years experience of our Swedish partners Alamanco. It has a tried and tested record of simultaneously improving health and social care quality, resource use and job satisfaction.
- We also offer training support linked to our Duty of Care handbook and website, in which nurses and other health care staff can find practical guidance about how to raise

concerns and combat bullying. With the support of Unite the Union, we are currently producing a special edition of this resource for their health professional members, and we can do the same for others.

The CIPD and HPMA are to be congratulated for research that should be on the agenda of every NHS trust this week, but surely not one of those trusts will be surprised by the findings.

The challenge now it to ensure that if a similar survey is conducted 12 months from now the findings show the right direction of travel.

Our own contribution may be modest, but we could not be more committed to making it, and we welcome conversations with any NHS trust or staff side organisation about how we can help you.

- Brendan Martin is managing director of Public World.

Employ enough trained staff and engage with them better: key lessons of the Keogh Review

Roger Kline, 17 July 2013

The key lessons of the Keogh Review into 14 NHS Trusts were drowned out yesterday when Government and Opposition politicians responded to its publication by acting out a blame game. In fact, this is an excellent report, criticising poor care but full of praise for NHS staff. It identifies concerns about staffing levels, skill mix, support for staff and a fear of raising concerns - all of which impact on patient care and safety.

The Medical Director for NHS England reported:

1. Trusts were not being truthful about their staffing levels
"Contrary to the pre-visit data, when the review teams visited the hospitals, they found frequent examples of inadequate numbers of nursing staff in some ward areas. The reported data did not provide a true picture of the numbers of staff actually working on the wards."

2. There were often not enough staff on duty and the skill mix was flawed:
"The review teams found inadequate numbers of nursing staff in a number of ward areas, particularly out of hours - at night and at the weekend."

"This was compounded by an over-reliance on unregistered support staff and temporary staff."

3. There was a link between staffing ratios and patient care
"Statistical analysis performed showed a positive correlation between the in-patient to staff ratio and a high HSMR (hospital standardised mortality rate) score."

4. Staff engagement is not good enough and that hurts patients
"From talking to people in the 70 focus groups we conducted as part of the review, it was clear that staff did not feel as engaged as they wanted or needed to be: yet academic research shows that the disposition of the staff has a direct influence on mortality rates."

5. A climate of staff fear continues in too many trusts.
"During several of the reviews, staff came forward to tell the review teams about their concerns in confidence. These staff felt unable to share their anxieties about staffing levels and other issues with their senior managers, which suggested that staff engagement at some of the trusts was not good."
NHS staff do not go to work to cause harm. As the report concludes:

"We also found numerous examples, in every hospital we visited, of staff working extremely hard to deliver great care for their patients. Many patients and former patients told us about staff who had 'gone the extra mile' to be kind and generous or to save their lives or those of their families.

Too many NHS leaders see staff as a cost but not an asset. Yet the evidence is overwhelming: treat staff better and they care better for patients; engage with staff and don't tolerate bullying and it becomes much easier to create a health environment where staff admit and report mistakes and learn from them.

Keogh is by no means the first to draw those lessons. For example, in his first report into failings at the Mid Staffs NHS Trust, Robert Francis found "the overwhelmingly prevalent factors were a lack of staff, both in terms of absolute numbers and appropriate skills, and a lack of good leadership". (Francis Report, 2010. P.186 Vol 1.)

But just because the NHS has failings does **not** mean it is failing. As Keogh made clear:

"The NHS embodies the social conscience of our country. Every week, our NHS positively transforms the lives of millions of people and we should be deeply proud of this fact. Sadly, there are times when the NHS falls well short of what patients and the public rightly deserve. The harrowing accounts set out by Robert Francis in his two reports into the failures at Mid Staffordshire NHS Foundation Trust highlight the lasting physical and emotional damage we can cause to patients and their families when we get things wrong and fail to make quality our primary concern.

"Our NHS is the only healthcare system in the world with a definition of quality enshrined in legislation. It is simple. An organisation delivering high quality care will be offering care that is clinically effective, safe and delivering as positive an experience as possible for patients. These are not unreasonable expectations. The NHS should be good in all three. Being good in one or two is simply not good enough."

Those problems must be solved, which means acknowledging them and examine their causes rather than engaging in the political ping pong we saw yesterday.

If we are serious about improving the care and safety of patients we have to treat NHS staff – all NHS staff - better. The 2012 NHS staff survey showed how far we have to go in many Trusts.

If you really care about NHS patients, then NOW is the time to prioritise that work, Mr Hunt.

The NHS tops the league table for workplace stress. Staff and patients deserve better.

Roger Kline, 2 May 2013

The recent tragic death of Helen Mann, a Worcestershire primary school head teacher who committed suicide after a period of work-related stress, should be a reminder to us all that teaching, health and social work are the three sectors with the highest levels of stress in the UK.

Work-related stress is defined as a harmful reaction that people have to undue pressures and demands placed on them at work. The latest figures for 2011/12 are shocking.

They show that 1.1 million working people suffered from a work-related illness, with 10.4 million working days lost. What is worse, the number of NHS staff reporting stress through the NHS survey has risen, a fact hardly mentioned.

The Labour Force Survey (LFS) conducted by the Office for National Statistics reports that the prevalence (total) and incidence (new) of cases of work-related stress have remained broadly flat over the past decade.

Moreover, the total number of cases of stress constituted 40% of all work-related illnesses across all sectors:

- Occupations reporting the highest rates of total cases of work-related stress (three-year average) were health professionals (in particular nurses), teaching and educational professionals, and caring personal services (in particular welfare and housing associate professionals);
- The main work activities attributed by respondents as causing their work-related stress, or making it worse, were work pressure (tight deadlines, too much work, pressure or responsibility), lack of managerial support, and work-related violence and bullying;
- On average, each person suffering from this condition took 24 days off work. This is one of the highest average days lost per case figure amongst the recognised health complaints covered in the LFS.
-

The NHS figures are equally shocking and have implications for the quality and safety of patient care. The number of NHS staff reporting they had suffered from work-related stress rose sharply in 2012 to 38% from 29% in 2010 and 30% in 2011. It was highest among staff in ambulance (46%) and mental health trusts (42%).

And only today the British Medical Association (BMA) reported that its Cohort Doctor Study, which tracks the career progress of 430 doctors who qualified in 2006, found 34% of newly qualified GPs stated they had 'high' or 'very high' work-related stress.

The NHS 2012 Staff Survey results showed correlation between problems experienced by staff and the causes of stress as reported in the LFS:

- under a third of staff (30%) feel that there are enough staff to enable them to do their jobs properly;
- one third are not satisfied with the support they get from their immediate manager;
- a quarter reported they had experienced bullying, harassment or abuse from either their line manager or other colleagues;
- only one third felt that communication between managers and staff is effective.

Some trusts are getting it right. Too many are not. If we are to move to an open, transparent, learning culture then we have to start by acknowledging and discussing what is going on here, since the work of Michael West and others demonstrates that a workforce that is valued and looked after provides better safer care.

So what can be done? A good start would be for every trust to "drill down" into its own stress, workload, management, and bullying data to identify specific causes and dangerous departments, and to do so jointly with staff. The HSE Management Standards helpfully define the characteristics, or culture, of an organisation where the risks from work related stress are being effectively managed and controlled.

The Management Standards cover six key areas of work design that, if not properly managed, are associated with poor health and well-being, lower productivity and increased sickness absence, the primary sources of stress at work. These are:

- **Demands** – including issues such as workload, work patterns and the work environment.
- **Control** – how much say the person has in the way they do their work.
- **Support** – including the encouragement, sponsorship and resources provided by the organisation, line management and colleagues.
- **Relationships** – including promotion of positive working to avoid conflict and dealing with unacceptable behaviour.
- **Role** – whether people understand their role within the organisation and avoidance of conflicting roles.
- **Change** – how organisational change (large or small) is managed and communicated in the organisation.

If the HSE stress survey or a local adaptation is undertaken, and then discussed and acted upon in an open way, that might well start to identify some causes and some immediate areas of change that are needed. The Francis Report makes such inquiry and action a precondition for better and safer care.

Too many NHS staff are damaged by unnecessary stress. Helen Mann's untimely death should be a wake-up call to all in the public sector professions.

How a social carer was “God’s gift” to Margaret Thatcher

Brendan Martin, 11 April 2013

No doubt I am getting soft with the advancing years, but I was touched by the photograph of Margaret Thatcher sitting on a park bench with her carer -- identified only as a New Zealander called Kate --in today's Guardian newspaper.

Perhaps this was because it reminded me of sitting with my mum on a park bench near her home during her final years, and of the care workers who nursed her so well in her final months.

In the article accompanying the Guardian picture, one of Thatcher's closest friends, Lady Powell, is quoted as saying that carer Kate would read to Thatcher and keep her mind going. "She was God's gift to Margaret Thatcher", Lady Powell was reported as commenting.

God doesn't send care workers, in fact. It might seem that way, because the work they do is so important, and enhances many a life, as Lady Powell acknowledges.

But they have to look after themselves too, which means they have to be paid. And the irony is that the service is largely privatised and staffed by workers whose terms and conditions amount to one of Margaret Thatcher's most lasting legacies.

A survey conducted by the public service union Unison last year found that four out of five respondents "reported that their work schedule is arranged in such a way that they have either have to rush their work or leave a client early to get to their next visit on time".

Most "did not receive set wages, making it hard to plan and budget", and were not paid for travelling time between clients, "potentially a breach of the minimum wage law".

More than half also reported deterioration in their terms and conditons in the preceding year, and nearly half were "not given specialist training to deal with their clients' specific medical needs, such as dementia and stroke-related conditions".

I'm guessing that Thatcher's carer Kate had received such training, which no doubt contributed to the quality of the care she provided right to the end.

You can take equality too far, and I don't argue that we should all be entitled to see out our last months at the Ritz hotel (even in the unlikely event that we would want to).

But here's my proposal to Lady Powell: will you join with us in working to bring about the transformation in social care required to ensure every older person can enjoy the compassionate and professional care enjoyed by Margaret Thatcher?

Or are you content that "God's gift" should be reserved for the rich and privileged, while those without Thatcher's means struggle on with low pay and inadequate services?

Never again? Roger Kline argues that Jeremy Hunt's response to the Francis Report is inadequate.

Roger Kline, 8 April 2013

Robert Francis's report on the biggest single scandal in NHS history stressed failings in regulation and inspection alongside failings of resources (not enough staff, wrong skill mix), failings of leadership (bullying culture to achieve financial and other targets at expense of patient care and safety), failings of trust (with patients and relatives, and among staff) and a complete absence of staff engagement (staff treated as cost not asset).

Jeremy Hunt's response emphasises some aspects of regulation (new Chief inspector of hospitals, beefed up role for the Care Quality Commission (CQC), Ofsted-style ratings, a welcome duty of candour), although many hospital chief executives believe some of this framework will be ineffective. The response also commends some excellent existing examples of good practice, such as Schwartz rounds.

But its failure to address other key issues in the Francis Report has left many NHS patients, staff and managers sceptical about how the government will help ensure such scandals never happen again, especially given that there has been no change in the NHS leadership which presided over the toxic management culture revealed in evidence to the public inquiry.

The central challenge is to create a working environment in which staff feel valued and safe about sharing robust data and raising concerns, so that a learning safety culture is created. There is plenty of evidence that this is both crucial and works -- but also that we have some way to go.

The 2012 NHS staff survey revealed the shocking statistics that 24% of NHS staff say they were bullied in that year by managers and colleagues and 28% feared the consequences of raising concerns. Perhaps that is why the number of incident alerts fell by 100,000 at a time when, post Mid Staffs, one would expect them to rise.

Yet he government's response to Francis fails to address those issues. Although the response spends pages on whistleblowing, it fails even to mention bullying or to propose any measures to ensure that those who raise concerns are better protected when they do so.

Moreover, the 'reforms' that have just taken effect could make things worse. It turns out, for example, that some GP practices are actually forbidden from exercising their duty of candour by new Clinical Commissioning Group (CCG) constitutions.

Similarly, while Hunt promised that the patient would be "the first and foremost consideration of the system and everyone who works in it", he signed off on a revised NHS constitution -- now withdrawn -- that stated the NHS would "aspire" to put patients first, not actually do so.
While rejecting mandated minimum staffing levels and Francis's call for regulation of healthcare assistants, Hunt calls for all trainee nurses to spend a "cost-neutral" year as healthcare assistants. That proposal is widely regarded either as unworkable or, worse, as suggesting that nurses were the major culprits in Mid Staffs. There are no equivalent year long plans for aspirant general managers, although some managers certainly had a compassion bypass in Mid Staffs.

Nor does Hunt explore how the £20 billion cuts and the chaos that the Health and Social Care Act has triggered will contribute to the required "culture change". The fragmentation and privatisation of services appear more likely to disrupt institutional memory and weaken incentives to put the patient first.

Six months ago I hazarded a guess at what Francis would recommend and the government's response. I was downbeat. The Francis Report and the immense efforts of Julie Bailey and local Stafford relatives has forced a recalibration of the balance between finance and care, but the government's response fails to meet the challenge.

After the Bristol Inquiry a decade ago we were assured 'never again'. This time, the best employers and many staff will undoubtedly do their best to improve safety and quality, and Don Berwick's future safety recommendations may assist them. But it is taking optimism too far to conclude from the government's response to Francis that we will never again be told 'never again'.

What David Cameron's new patient safety tsar said five years ago. You might be surprised.

Roger Kline, 27 March 2013

Don Berwick is a world authority on patient safety. For two decades he led the US Institute for Health Improvement and he led the US president's "Obamacare" reforms. In 2011 was forced to resign that post, partly for referring to the NHS as an example for the US to follow.
In 2008 he was quietly commissioned to report on the culture of the NHS by the then Chief Medical Officer Liam Donaldson. He reported a climate of "fear" but this did not become public until the Francis Inquiry into the Mid Staffordshire scandal.

Last month David Cameron announced Don Berwick had been asked to become NHS Patient Safety Tsar to lead a panel "to make zero harm a reality in our NHS". Don't be surprised if their recommendations run counter to the government's 'reform' agenda.

In July 2008 Don Berwick wrote a 60th birthday message to the NHS in the British Medical Journal. In it he made ten suggestions for improving the NHS. His advice was so good, and so prefigures the Francis Report, that I thought I'd share it.

"First, put the patient at the center – at the absolute center of your system of care". Berwick argues for "the active presence of patients, families, and communities in the design, management, assessment, and improvement of care, itself" rather than any reliance on focus groups or surveys.
"Second, stop restructuring." In an echo of Francis he warns that it is destructive of time and confidence and leads to risk averse healthcare. Stability, he says, helps change "become easier and faster, as the good, smart, committed people of the NHS – the one million wonderful people who can carry you into the future – find the confidence to try improvements without fearing the next earthquake."

"Third, strengthen the local health care systems – community care systems – as a whole." Health economies, not the fragmentation into individual elements like hospitals, clinics, surgeries, should become the "core of design".

"Fourth, to help do that, reinvest in general practice and primary care". Berwick describes general practice, not the hospital, as "the jewel in the crown of the NHS".

"**Fifth, please don't put your faith in market forces**." I'm not sure David Cameron read this bit before appointing him. Berwick scathingly says: "It's a popular idea: that Adam Smith's invisible hand would do a better job of designing care than leaders with plans can. I do not agree. I find little evidence anywhere that market forces, bluntly used, that is, consumer choice among an array of products with competitors' fighting it out, leads to the health care system you want and need. In the US, competition has become toxic; it is a major reason for our duplicative, supply-driven, fragmented care system. "

"**Sixth, avoid supply-driven care like the plague**." He warns, rightly, that the pursuit of institutional self-interest has helped make healthcare unaffordable in the USA

"Seventh, develop an integrated approach to the assessment, assurance, and improvement of quality." He warned we needed a coherent system of "aim-setting, oversight, and assistance." As Francis also discovered.

"Eighth, heal the divide among the professions, the managers, and the government." This was another theme of the Mid Staffs report, made much worse by the rise of "general management" after the Griffiths Report of 1983. Berwick warned, again echoed by Francis, that "the NHS and the people it serves can ill afford another decade of misunderstanding and suspicion between the professions, on the one hand, and the managers and public servants, on the other hand."

"Ninth, train your health care workforce for the future, not the past." The new skills we need are those in "patient safety, continual improvement, teamwork, measurement, and patient-centered care".

"Tenth, and finally, aim for health." He warns that "great health care, technically delimited, cannot alone produce great health", and goes on: "Developed nations that forget that suffer the embarrassment of growing investments in health care with declining indices of health. The charismatic epidemics of SARS, mad cow, and influenza cannot hold a candle to the damage of the durable ones of obesity, violence, depression, substance abuse, and physical inactivity."

Don Berwick concluded the article by writing: "The only sentiment that exceeds my admiration for the NHS is my hope for the NHS. I hope that you will never, never give up on what you have begun. I hope that you realize and reaffirm how badly you need, how badly the world needs, an example at scale of a health system that is universal, accessible, excellent, and free at the point of care – a health system that is, at its core, like the world we wish we had: generous, hopeful, confident, joyous, and just. Happy birthday!"

Don Berwick's own publications are a joy to read. You can also hear him in these two short videos. The first, ironically, was posted by an American free market think tank aiming to discredit him as being too left wing: it is indeed a brilliant two-minute defence of the NHS. The second summarises some key themes for good healthcare.

In defence of constructive criticism of the National Health Service

Roger Kline, 11 March 2013

Frank Dobson was always a decent and serious Health Secretary. It was no surprise to me that he failed to join Alan Milburn, Patricia Hewitt, Alan Johnson and Andy Burnham is their recent defence of David Nicholson, the beleaguered head of the NHS.

Dobson campaigned against the early attempts at privatisation more than two decades ago, long before he became Tony Blair's first Health Secretary, from 1997-99.

Now he has said what no other senior Labour figure has said, that the 'mad rush' by his successors to bring in more competition and targets was reckless.

"I told Blair that reckless changes could undermine patient care, but he didn't want to listen," Dobson told the Mail on Sunday (10 March 2013), going on to criticise his successors Alan Milburn and Patricia Hewitt.

"They became obsessed with wanting to break up the NHS into individual units. I made my views known to them but was ignored. They preferred to take the advice of management consultants to medical consultants. Huge sums were diverted away from nurses, doctors and patients to lawyers, accountants and PR men."

I have argued previously that without criticism and analysis of what caused Mid Staffordshire we risk a repetition and we risk discrediting the NHS. That's why the failure of Andy Burnham so far to address issues of culture and bullying is a serious mistake.

So is his failure to understand that retaining David Nicholson as NHS chief executive will ensure that the culture that created Mid Staffs and which treats staff as a cost not an asset, and which seeks comfort in denial and secrecy, remains disastrous for health care.

If we do not have open discussion, transparency and real change in how the NHS is managed we will not be able to learn the lessons and improve the NHS. And if we don't do that the NHS will indeed become vulnerable to those who wish to utterly undermine it.

Frank Dobson understands that. Critics of the current culture like Julie Bailey, Kim Holt and Brian Jarman understand that. They care about the NHS but understand that the management mumbo jumbo, culture and policies of the last decade have to change.

Just as I was writing this I read this very poignant response to an article in Health Service Journal speculating on who might replace David Nicholson. Dr Peter Brambleby, a doctor, has himself suffered for speaking out on public interest issues on the NHS. Between Frank Dobson and Dr Brambleby we can discern what sort of leadership the NHS really needs. As Peter Brambleby puts it:

"A plea to any involved with recruitment and appointment of deputy leader and/or leader:-

- Can we have leadership that understands "Health" and "Service" (as in National Health Service)?
- Can we have someone who understands that at the heart of medicine and nursing is a gift relationship not a financial motive?
- Can we have someone who trusts and respects the workforce, letting them set their targets and priorities rather than imposing them from above, and in return ask them to demonstrate local involvement, evidence of progress and financial probity?

- Can we have someone who understands narrative as well as numbers - who listens to what patients and staff have to say, and doesn't just scan the spread sheets on activity and finance?
- Can we have someone who measures efficiency in outcomes, not outputs?
- Can we have someone who will clarify the "mission" in "commissioning" so we return to a sense of common purpose?
- Can we have someone who welcomes comment, concern and constructive criticism?
- Can we have a coordinator of a network rather than an autocrat of a hierarchy?
- Can we have someone who values collaboration higher than competition?
- Can we have a conductor of an orchestra, not a principal violin?
- Can we have a horse-whisperer rather than a lion tamer?
- Can we have a leader, not a driver?"
- Thank you."

Hear hear!. Thank you, Peter, and thank you, Frank.

Go West to save and improve the NHS

Roger Kline, 1 March 2013

Macho management of healthcare has had its day. Command and control is outdated. Money must be the servant not the master.

Those were some of the key messages I took from an inspiring lecture at the King's Fund in London this week by Professor Michael West. You can see it online here.

Professor West's research over two decades has shown, to put it crudely, that if you take good care of NHS staff they will take good care of the patients.

It is an inspring message, strongly rooted in the occupational psychology work of Professor West and his colleagues at Aston and Lancaster universities.

Coming three weeks after the Francis Report, and in the same week that the national NHS staff survey confirmed widespread lack of trust in management, the lecture showed what the new culture must look like and why it is essential.

It drew on work funded by the Department of Health showing that the more staff work in (effective) teams the fewer deaths will follow emergency surgery, to give just one example of the hard evidence Professor West presented.

The data he cited – and you can find the detailed research online here and here – show that:

- how staff are managed is the decisive influence on quality and safety
- the level and nature of staff engagement is the best predictor of patient outcomes
- organisations in which staff are consulted on important issues and able to influence them, and have postiive attitudes to their leaders, have greater patient satisfaction and are more likely to be 'learning organisations'.

But for this evidence to be embedded in operational practice, leaders must challenge behaviours that undermine and corrode such a culture, such as the bullying and punitive approach that Francis and other evidence show to be so widespread in the NHS.

The culture needed, and which the Mid Staffs tragedy tells us is a precondition of better, safer care, is one which whose core values Michael West summarised as having

• a commitment to learning
• the courage to stand up for what we believe in
• humanity and kindness
• justice and transparency in which people are treated fairly
• self regulation to permeate change for the better
• wonder and spirituality recognising that humour and "giving" are important

In such a healthcare organisation staff and their teams need time to reflect – and allowing that time doesn't undermine productivity but improves it.

I found this inspiring. I think the rest of the audience did to. It is so close to the principles Public World was founded on. It is what most whistleblowers and the best managers aspire to.

But this week also brought not only NHS Staff Survey results showing how far from the required culture we actually are but also the latest steps towards NHS privatisation by a government determined to learn all the wrong lessons from Francis.

We are at a crossroads. Professor West, after Francis, has pointed the way. They have shown what is needed to secure the NHS as a public service that puts safety and standards first. The challenge for the rest of us is to make it happen.

Defensive denial won't save the NHS—Roger Kline's blog

Roger Kline, 19 February 2013

Last week a paramedic was suspended for posting a threatening message to Julie Bailey, the best known of member of Cure the NHS, the campaigning group of relatives of victims of the Mid Staffordshire scandal. Julie and colleagues have previously had death threats and regular abuse. In response to their tireless campaigning, which led to the public inquiry chaired by Robert Francis, QC, which reported earlier this month, a group of NHS staff have set up a Facebook group called 'We support the front line staff at Stafford Hospital'. I looked at another Facebook group who published a picture of Julie's café with the caption "I believe that it is this one" in the middle of abusive comments. Friends have commented that, more generally, significant numbers of NHS staff appear to have become defensive about the criticism from whistleblowers and patients organisations.
I have spent many years criticising poor care in some parts of the NHS as well as resolutely defending the NHS against those who would break it up and privatise it. As a trade union official in the health care sector, I have probably represented several hundred individual NHS staff, as well as supporting numerous collective grievances and campaigns on behalf of NHS staff trying to do their very best in difficult circumstances.

In particular I have represent whistleblowers in social care and health who have made a courageous decision – often at great personal cost – to raise concerns about the care patients and service users receive. In my book, trade unionists (whose families are patients anyway) should, when appropriate, criticise poor care and its causes as well as standing up for good care and the conditions that encourage it.

I recognise that there are those who find criticism of some aspects of the NHS uncomfortable. Some NHS leaders simply circle the wagons and repeatedly victimise those who do raise concerns. I have worked with brilliant whistleblowers whose sole motive was to protect patients and "do the right thing".

In almost every single case the timeline is the same: Raise a concern. Be surprised when instead of being welcomed, the response is denial, isolation and harassment, often very subtle. Then watch as the employer finds fault with some real or imaginary aspect of the whistleblower's work. Then shout with dismay as their employer suspends them and disciplines them.

The files of Patients First and Public Concern at Work are full of such histories which generally end with a compromise agreement as an alternative to being sacked but with the condition of a gagging clause.

I accept that there are those who may jump on the criticism of the NHS that many of the whistleblowers' stories provoke as reasons to privatise it. My response is that unless we are open about our shortcomings we will never be able to conquer them. In particular, unless we change the bullying culture and resource the service properly, unless we create a culture where staff are valued as an asset not simply harassed as a cost, we are in deep trouble. Unless we create an open culture where staff and patient concerns and complaints are welcomed, we will not improve the shortcomings Francis uncovered in Stafford.

It is all the more astonishing therefore when, rather than welcoming the courageous stand made by Julie Bailey and her group of relatives of former patients of Stafford Hospital, some people have turned against her in a very nasty way. The message that prompted the suspension of the paramedic read "Julie Bailey, I hope you suffer a life threatening illness at night where you have to travel furthur [sic] than you should do because your local hospital is closed (your fault)".

So let's get is straight. Mindless criticism of the NHS from those who would privatise it is one thing. We should have no truck with it. Serious criticism from whistleblowers and others, allied to determined attempts to improve matters, is quite another. If some health service staff find that difficult, not least because many of them are struggling with heavy workloads in a bullying environment, then we should engage in constructive discussion. But personal attacks are out of bounds.

If we don't all take this opportunity to serious scrutinise the culture, leadership, management and resourcing of the NHS now, we risk losing the opportunity for a generation. If that happens. the enemies of the NHS will have won.

Francis: good in parts, but be careful what you wish for

Roger Kline and Brendan Martin, 6 February 2013

The Francis Report into up to 1,200 unnecessary deaths in the Mid Staffs NHS trust was published today. It has been widely welcomed, and in respect of many of its recommendations, rightly so. But there are others that could have unforeseen consequences that could undermine health care in Britain, and some omissions that represent missed opportunities and are hard to reconcile with the report's intentions.

First the good news. There is plenty, and here are three key items.

A **"duty of candour"** will oblige every healthcare organisation and their staff (and contractors) to be honest and open with patients and the public. This will involve amending the NHS constitution to embed a duty of openness, transparency and candour, and require all organisations to review their contracts of employment, policies and guidance to ensure they expressly include these principles. This must be good news, not least because it will provide professionals and staff with the right to assert their duty of care over any management instruction to the contrary.

Gagging clauses should be banned "insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care". This must be right in a public service, and, again, it means that professionals and other staff will have responsibilities that are matched with rights to exercise them.

Only registered people should care for patients -- so healthcare support workers must be regulated. Excellent. This will raise the status of health care assistants, and potentially of social care workers too. Why should the vet who checks your cat be regulated more rigorously than the person who looks after your mum in hospital?

But what about the potential for unintended consequences? We'll highlight three areas of concern there too.

Firstly, it should be a **criminal offence to cause death or harm to a patient**. The report recommends more powers to suspend or prosecute boards in the case of a system failure, and individual professionals when they are responsible.

Protecting patients from cruelty is, of course, essential, but as drafted this must run the risk of holding the infantry to account for the systemic failings of the generals

And there is another more fundamental problem. Throughout the inquiry, Francis stressed -- and rightly so -- that the NHS has a cultural problem. The danger is that this recommendation will encourage individuals to cover their own backs and blame others, at the expense of sharing information and concerns. This could impede the building of collective knowledge that is essential if there is to be a culture of mutual support and challenge.

Moreover, the recommended obligation to report incidents of concern, while appropriate from the point of view of the duty of candour, could combine with the threat of prosecution to encourage staff to go from failing to reports concerns to producing a tidal wave of incident forms. At present staff can be fearful of reporting incidents for fear of being blamed, dubbed a trouble maker or bullied for it. This is a deep-seated problem, and undoubtedly contributed to the Mid Staffs scandal. But without deep changes in leadership culture empowering staff and enabling them to tackle problems (not just report them) the Francis recommendation could lead to defensive practice and

failure to address the issues concerned. And it is unclear from the 290 recommendations where the step change in culture will come from.

Secondly, **a service incapable of meeting fundamental standards should not be permitted to continue.** This runs the risk of being used to justifying closing or privatising a service since the roots of failure (as is often the case) may be primarily lack of funding. Certainly the NHS cannot do everything we might want it to do, but we could lose a lot to gain a little if under-resourced, fragmented and in some cases privately run providers are able to use a regulatory requirement such as this to justify closing services.

Thirdly, the Care Quality Commission should develop a **specialist cadre of inspectors thoroughly trained in the principles of hospital care**. That sounds good, but it is worth pausing to consider why this is recommendation Prime Minister David Cameron latched on to in particular, announcing he would legislate for it even before Francis had reported. He argues that the Ofsted regime has raised standards in schools, but that is a moot point. What we do know about Ofsted inspections is that schools have learnt how to game them, and that they have tended to 'teach to the test' and tick the regulatory boxes rather than encourage more responsibility among education professionals. Top-down performance management was one of the problems that caused the Mid Staffs scandal and it is hard to see how more of it will contribute to preventing a repetition. Moreover, the jury is still out on whether the CQC is fit for purpose on its existing powers never mind new ones.

These areas of concern are heightened by the omissions in the report, and again let's mention three. Firstly, **where are the recommendations on bullying**? The inquiry showed that a central problem in Mid Staffs was that the top down management culture was enforced by deeming whistleblowers to be trouble makers and bullying people who raised genuine concerns. Yes, it is also possible for staff who are challenged over poor care to claim they are being bullied, and this too has sometimes been a problem. But let's not throw out the baby with the bathwater. There is a major bullying problem in the NHS and it needs to be addressed.

Secondly, in his first inquiry report Francis warned that **structural reforms will not tackle the problems** seen in Mid Staffs and could even make them worse. Surely the Health and Social Care Act could do precisely that, by fragmenting the service, encouraging competition instead of cooperation and placing obstacles in the way of information sharing and collective learning? While it is understandable that Francis might not want to stir political controversy in ways that might blunt his key messages it does need saying that the coalition's reforms are a serious step in the wrong direction.

And last, but by no means least, how is the NHS supposed to make the cultural transformation that is required, to put safety and care above all, to promote staff wellbeing and raise the status of health care assistants, and all the rest -- and still absorb **cuts of £20 billion over the next five years**? Productivity improvements are all very well, but austerity is another matter. We can have a good NHS or a cheap NHS, but we cannot have both.

The care worker philanthropists who each give us £100,000

Brendan Martin, 9 November 2012

If a full-time social care worker was paid the living wage over a lifetime she would be more than £100,000 better off than if she received the national minimum wage (NMW), at today's rates. The living wage was raised to £7.45 outside London, and £8.55 in the capital, this Living Wage Week, which Labour leader Ed Miliband and Unison leader Dave Prentis kicked off by declaring that no worker should have to manage on less.

It says a lot about where we are that the Labour Party is considered radical for insisting every worker should be paid enough for the basics of everyday life, even if it has no plans to make the living wage compulsory.

Yet if the proposal is taken as seriously as it should be the implications for policy are indeed radical, and nothing reveals that more clearly than considering what it would mean for Britain's 1.5 million social care workers.

Bear in mind that, according to government-commissioned research by Kings College last year, at least 150,000 care workers don't even get the NMW, which is currently £6.19 for over-21s, £4.98 for 18-20-year-olds, and £3.68 for under-18s.

Let's say the present government did something as surprising as actually enforcing the NMW. The gap between what a care worker outside London earned and what the living wage would give her would then be £1.36 per hour, or £2.46 in London.

That would mean that a social care worker doing a 35 hour week outside the capital would earn £47.60 a week less than she would on the living wage. If we assume she works 48 weeks of the year, this would mean she is down £2,285 over 12 months.

What would that mean over a working life of 45 years (yet another conservative assumption, given that the state pension age for a person entering the labour force today is 68)? It would mean a loss of more than £100,000 over her working life.

Andrew Dilnot's Commission on the Funding of Care and Support last year recommended that no individual should have to pay more than £35,000 from their own resources over their lifetime before the state started paying for their care.

Yet a care worker would contribute three times that amount to the care of others -- on top of the taxes they pay like the rest of us -- just by receiving the NMW rather than the meagre living wage, even on the basis of our conservative assumptions.

Given that Dilnot's numbers were based on actual current costs, and that the government is refusing to close even that funding gap, it is clear that the implications of paying the living wage would indeed have radical effects.

So the question is: will a Labour government put our money where its mouth is, and if so, how are we going to transform the political discourse about collective security and individual responsibility to enable that to happen?

This cannot be a question only of increasing the tax take to close the gap, although obviously that is a big part of it, and will require a robust approach to how the burden is shared and to ending illegal tax evasion and unethical tax avoidance.

But that won't be enough, financially or politically. We will also need tough choices about how public money is spent, and innovative approaches to improving service quality while containing costs in ways that are fair to workers and service users.

Ed Miliband and Dave Prentis are no fools. We should assume they mean what they say and know what it means. The transformative implications of this one modest proposal for every other area of public policy are indeed radical.