Battles on the NHS Frontline

Stories from the Vanguard of Health and Social Care

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Witch-hunts, whistleblowing and precarious jobs – how NHS working culture rips us all off

The battle lines for the NHS were re-drawn on Sunday when Simon Stevens, the head of NHS England, declared war on private employment agencies. In an attempt to get more nurses the NHS has spent £1.8 billion on agency labour – double what was budgeted. Apparently the NHS is officially being ripped off. In these flexible neo-liberal times, its a rare thing to see an employer in favour of permanent contracts.

The title of this new column might sound a bit much. Although actual war has yet to be declared on the NHS, the battle for health is going on at a hospital near you. Over the coming months this column will look at what's going on from the perspective of the people on the frontline.

As health inequalities become an everyday reality it gets harder to kick stuff under the public interest carpet. With the former chief economist of the World Bank on a book tour about the systemic failure of our economic system, you don't have to be Marx to think that a concentration of capital into 1% of the world's population is bad news for our collective mental and physical health.

The psychosocial consequence of not being able to access joined-up health services is that people develop more complex and serious health problems, often ending up in A&E and police cells as a last resort.

This is not just a problem for patients but also the people delivering that care. If you go to the frontline, it's obvious that in addition to the emotional strain of dealing with the distress of patients, the pressure placed on people working in our health and social care

systems will go up as demand rises. The compulsive drive for a 24/7 health system, combined with declining real wages and increased job insecurity, also means that although you don't have to be mad to work for the NHS, it's extremely likely.

Precarious work

One of the things that's almost always overlooked in the NHS debate is the experience of the people delivering these services. There are three rather obvious reasons for this.

First, the reality of working life is very low down on the political food chain in a system that is dominated by politically set targets and appeals to managerial efficiency. Employment relations have not been considered important in the debate so far. For example, the NHS's own workforce database didn't collect information about its internal labour agency - Bank - until November 2014. They still don't collect information on the number of external contract and agency workers providing NHS services nor, more importantly, whether it makes a difference to patient care.

It means that the real financial cost of using externalised labour is actually not known.

The second reason is that the people delivering these services are just too scared to engage in the debate. When you work in a precarious job you are highly vulnerable to precarious states of mind, completely counterproductive for people employed to contain the anxieties of others. It is not just the migrant workers working as nurses for private employment agencies that feel insecure, it affects everyone working in this system. Precarity is inclusive, with even senior clinicians on permanent contracts unwilling to join the ranks of the self-employed by raising patient safety concerns with management.

The Francis reports offer us an insight into the crisis of care in the UK. Impossible health targets managed through command-and-control management and a stomach-churning rise in racism,

whistleblowing and victimisation. According to the people working in it, the NHS runs on a "pervasive culture of fear". This is a culture where nobody can afford to make mistakes and people manage workplace conflict by keeping their mouths shut.

It means that people working in health and care are often disorientated by a sense of "liquid fear" where a sense of fear permeates every aspect of our working and home lives. This is a state of mind where distinctions between serious and less serious workplace problems can't be made. The smallest mistake becomes the end of your career and you wake up bolt upright sweating at 3am wondering how you're going to handle the next "informal" chat with your line manager.

This fear goes right up the management chain, with NHS leadership reduced to talking about the very evident financial crisis only from the safety of retirement.

A third reason why so little is known about employment relations is because of the nature of the work. Caring for people is not like working in IT. Emotional work has never been highly valued in our society, reflected in the bad pay and the ease with which emotional workers are blamed for systemic failure. Billions of budget deficits get passed down through decentralising commissioning, politically set targets translated into work intensification, easier to blame a nurse than succumb to the anxiety of realising that our health and social care systems are failing.

When people are scared at work it results in witch-hunts, whistleblowing and tribal warfare. A working culture where staff meetings become an exercise in the yes/no game of talking around issues while walking one eggshells, means that targets cannot be met safely. And externalising the employer's duties to staff and accountability – with taxpayers footing the bill – means that we're all being ripped off at this point.

Setting the battle lines

Winning the war for healthcare means defending its borders and choosing our battle lines. Although Stevens' focus on the employment relationship is a massive opportunity to turn the debate into something meaningful, we don't yet have a clear picture of what is actually happening on the frontline.

This requires that we start where we actually are rather than where we'd like to be. It means being honest and realistic about what can be delivered which can only be determined if frontline workers and managers can talk about the realities of work without losing their jobs.

Ultimately this rests on creating a "just" culture where raising concerns is met with the respect it deserves and where people are not charged with fighting losing political battles.

NHS guardians won't help whistleblowers unless they're protected from bullying too

The third Francis report on how to build a safe NHS has been published, this time focusing on the problem of how staff can raise their concerns about patient care without fear of victimisation or whistleblowing – a last resort that happens only when there are no other adequate avenues to report failures.

The report, which took evidence from more than 600 people about their experiences in the NHS and another 19,000 from an online survey, says nothing new to those working in the NHS, where bullying is endemic and most people survive working in the NHS's "pervasive culture of fear" by keeping their mouths shut.

The new report tries to get to the bottom of this bullying crisis by going to the real experts, the people working in the NHS. Hardly a radical idea, but chronically missing in an institution dominated by top down targets and feverish policy-level action, all of which has totally and utterly ignored the working realities of the people that are supposed to deliver them.

As a result, there's important stuff in the report about the reality of health and social care in the UK. Not wishing to blind you with all the research that confirms it, there are some really bad jobs in the NHS. Take the billion-pound business of agency nursing. In an attempt to save costs, the way people work in the NHS has changed with a radical increase in temporary and agency work, outsourcing, zero hours contracts, work intensification and a decline in real wages.

These changes in the employment relationship have triggered changes in the duty of care towards patients, including projecting risks and duties away from the principal employer onto service providers and labour agencies. And the negative impact on patient safety of these trends is a growing theme in both clinical and employment relations research.

Along with the revival of discrimination and racism, and the emergence of command and control management, it is no wonder that most NHS staff are too vulnerable to speak up.

A foundation of bullying

It is a stomach-churning reality that the NHS rests on bullying the people who are supposed to protect patients and service users. This systemic and leadership failure has become very personal for NHS workers, leading to high levels of burnout, stress and a growing number of cases of suicide – all detailed in the report.

Francis rightly says that any staff involved in raising concerns and whistleblowing will need therapeutic support to survive the brutal process ahead. But the reality is that mental health services continue to experience higher cuts than any other part of the NHS. With mental health workers some of the most vulnerable workers in the UK, you don't have to be mad to work in the NHS but it's extremely likely.

One of the reasons this report might be different from its predecessors is that it actually asks health workers about their experience of work and as a result looks at some of the problems from a pragmatic rather than a political perspective. It means that the report is for the first time pretty specific about what needs to happen next to address bullying. From training to reprimanding managers who don't address bullying, the report also includes all NHS workplaces nominating a Freedom to Speak Up Guardian, people who will be tasked with encouraging people to talk and to support staff, which has been given the go-ahead by ministers.
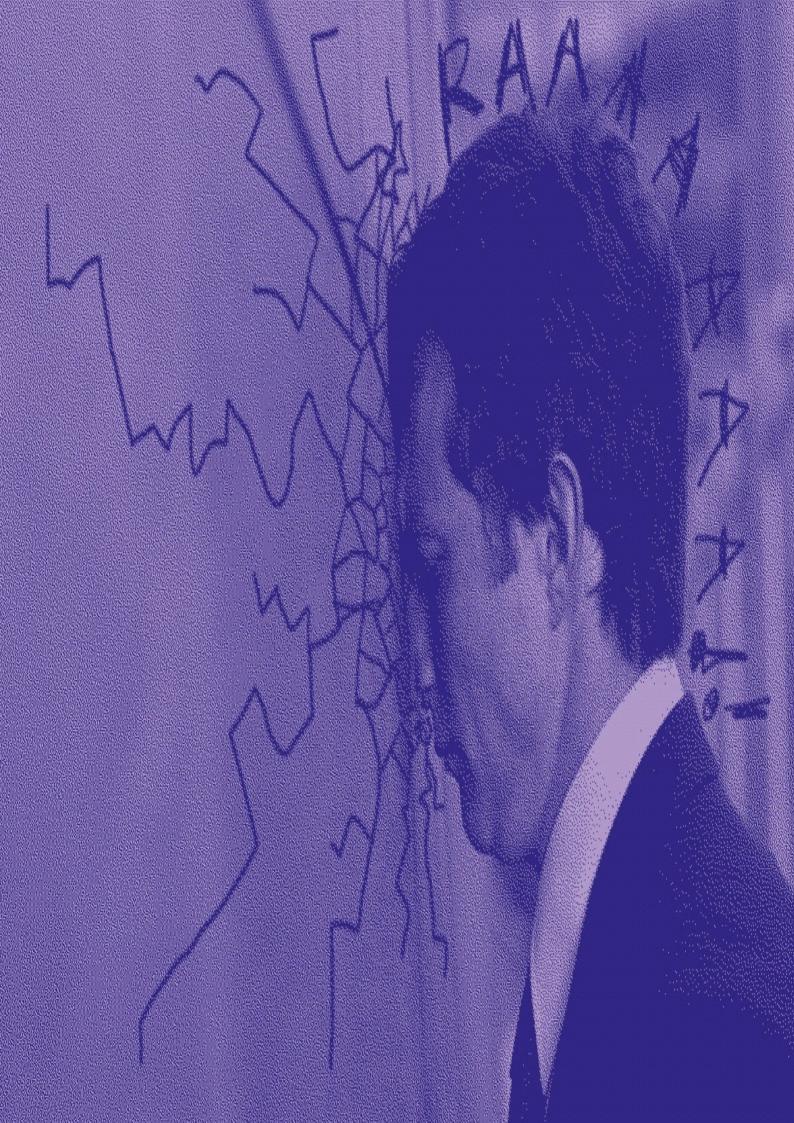
Guardian angels?

For those of us who have worked on diversity, this is neither a good nor a bad thing. It remains to be seen whether these guardians will be able to negotiate the structural and management changes that need to happen to create environments where this can work.

Probably the key job of work is going to be influencing managers – particularly line managers – whose attitudes are crucial in setting workplace cultures, and management responses when cases of victimisation are raised. Without leadership buy-in to this system, individual guardians will go the way of decades of diversity and equality reps: burnt out and bullied into silence themselves.

In workplaces where these conflicts exist there is likely to be a stigma attached to trying to change things, as a defence against anxiety. Easier to bully a guardian into silence through a ruthless wall of non-cooperation than address the systemic problem of why they are needed in the first place.

In management speak this is about building teams where people feel safe to come forward rather than locking themselves in the staff toilets every time there is a staff meeting. It also means creating inclusive teams – involving everyone delivering care from the contract and agency workers, the part timers, the people that raise concerns every single week and the people that you just don't really like. Everyone, across disciplines and employers needs to be involved.

What's new about this report is that frontline staff started talking. The trick now is to keep them talking about what's really going on, rather than continuing to focus on politically-set targets that won't survive past May 2015. The capacity of NHS leadership to deliver these conversations should be the primary measurement of whether they are delivering quality care.

The privatisation of mental health: how good services are turning in favour of the rich

The Care Quality Commission, the independent regulator of all health and social care services in England, recently produced a sobering report about the crisis in mental health services, with A&E staff attitudes bearing the brunt of criticism about failed care. However, the Guardian's recent ClockOff survey found that those working in health are the most stressed in public service – 61% say they are stressed all or most of the time.

Mental health has always been the poor cousin in public services and these reports are not about failures of individual compassion or positive thinking, but the impact of precarious work on all of our states of mind.

Take the psychotherapy profession. A 2015 report about a deterioration in public psychotherapy provision found there had been a 77% increase in complex cases, yet 63% of clients reported that NHS therapy was too short to do any good.

Insecure jobs and the growth of contract and agency labour, unwaged labour, and the retreat into private practice are linked to changes happening in the NHS that have left a fragmented and confused system of healthcare that even the leadership finds difficult to manage.

Rise of the agency

The advent of agencies is nothing new in healthcare but with the massive rise in demand for mental health services, NHS cuts and the waiting lists of between six and 18 months for talking therapies, we are now seeing the creation and expansion of private contractors and employment agencies for therapists. Because of the intense insecurity of agency work and the fear of blacklisting of in-

dividual therapists, professionals don't want to talk about this growth of third parties in mental health and, as a result, not much is known about them.

The growth of contract and agency labour is part of a national campaign to downgrade mental health services. Under the NHS's Increased Access to Psychological Therapies (IAPT) the main bulk of services are low intensity "well-being" programmes, based on a diluted model of Cognitive Behavioural Therapy. This service is delivered by "psychological well-being practitioners" (PWPs), a formalised and standardised role with intense targets of eight to ten satisfied clients a day. Under this system, if a patient does not pick up the phone for an initial assessment within the allotted 15-minute time period they are referred back to their GP, presumably to wait for a further six months.

This model of well-being, to be clear, can under no description be considered as therapy. Although most of the people working as well-being practitioners are highly qualified, their job is not to provide a space where patients can actually say what is on their mind. The work is scripted and always leads to one compulsory outcome which is that everyone feels well. Those who offer more support, mainly through giving more time and going off-script, are forced to keep this secret from employers because it breaks their contract of employment, leaving them to carry the full ethical and clinical consequences of their interventions.

To add insult to injury, tucked away in the 2015 budget is the proposal that increased access to psychological therapies should be introduced to 350 job centres in the UK. It's a psychologisation of poverty, where unemployed people are forced by precarious PWPs to internalise a global economic and social crisis. In this scenario its hard to imagine who needs the most help, the client or the clinician.

A growing percentage of such services are provided by contractors and labour agencies who are literally buying up the growing NHS waiting lists. As with all externalised employment relations, it is

not just the contract of employment that gets passed over to third parties, it is also the responsibilities of employers.

Internships and honorary psychotherapists

The most important part of your training as a psychotherapist, along with your own personal therapy, is to carry out clinical work. In order to train as an adult psychotherapist and become an accredited member of a professional body you have to work part-time, usually one to three days a week for between four to eight years.

The problem is that trainees are not paid. There is currently no comprehensive data on how many psychotherapists work unwaged as "honoraries", but with an estimated 6,000 psychotherapists training every year, a conservative estimate is that 2,000 full-time jobs in mental health are covered by unwaged workers. This includes a substantial percentage of the psychotherapists working for the NHS, the big third sector providers such as Mind and many local mental health charities providing clinical and well-being services in the UK.

Professional bodies are complicit in this system of unwaged work leading to the curious situation that the bodies charged with building a sustainable profession are currently not able to do that. If there is a political cause worth fighting for it is to make the demand for our professional bodies to organise a platform to negotiate wages.

There are some who work full time and do the training on top, but like other areas such as the media and arts, it means this profession is open primarily to people from families affluent enough to support them. This is not to say that rich people make worse therapists, but it does raise important questions about class and power.

Turning to private practice

Then there are the therapists employed directly by the NHS. In most cases the days of "permanent" contracts are over, cuts in

funding and increasingly short funding cycles mean many jobs are fixed and short term.

Most NHS services are understaffed, particularly in child and adolescent mental health services leading to an emerging gold rush for private contractors and agencies. The insecurity of NHS workers has profound implications for workplace fear, creating cultures where clinicians are reluctant to raise concerns about patient care. Despite the important debate going on now about raising concerns, in the NHS the reality is that precarious workers are unlikely to speak up for fear of victimisation and job loss.

Many experienced psychotherapists have retreated to private practice, unable and unwilling to navigate a broken system. Many make enough money to live, but only having spent most of their working lives in the NHS with their pensions intact. This generation will retire within the next five to ten years leaving behind a whole generation of self-employed practitioners, who will never earn enough to cover the basics of pensions or sick pay. Private practice does offer massively needed services and a careful assessment and referral can make the difference between life and death, but it increasingly means that services are accessed only by those that can afford it.

The current economic argument for mental health services is based on the unacceptable working conditions of thousands of mental health workers. From psychological well-being practitioners, to psychologists in job centres, to the clinicians employed by Maximus and Atos to carry out welfare assessments, working in mental health poses significant risks to both clients and clinicians. As long as psychotherapists are working quietly and diligently under precarious conditions, the NHS as an employer will never respect the people who work for it. In a context of deteriorating mental health services, the fact that psychotherapists are an unorganised and silenced group of public servants is a matter for both professional and personal ethical concern.

Many 'benefits scroungers' are hard working people you rely on for your care

Navigating the welfare system is part of the daily work of most health and social care workers – from the therapists advising patients on how to survive a "fitness to work" assessment to the 30% of NHS workers earning less than a living wage.

You didn't have to go on the End Austerity Now march to notice that welfare in the UK is on its knees. The government's flagship reform combining six welfare programmes into one under the Universal Credit system has totally failed. Unrealistic and random cuts conflated by the failure of Atos, the large private contractor, to deliver the Department for Work and Pension's (DWP) review of incapacity benefit, leaving millions of people without money to live.

Disability benefits have been transformed into personal independence payments where "clients" can "choose" their care from a range of "service" providers. But incapacity benefit reform is driven by budget cuts, with decentralisation of budgets masking the reality of 20% cuts under the banner of customer choice. The launch of the DWP's new National Health and Work Service, delivered by US contractor Maximus which will assess anyone likely to be off work longer than four weeks, is playing a perverse game of assessing the presence of "fitness" while avoiding actual "sickness" by not providing any solutions to the problem.

In the UK the number one cause of long-term absence is mental illness, predominantly depression and anxiety. If you manage to convince a Maximus worker that you are not fit the question remains: how do you then get back to work? As it already stands, 75% of people get no treatment for mental health problems after visiting their GP.

In order to cut welfare and the costs to the UK economy of people getting sick, disability got banned and replaced by a ruthless regime of positivity. We are no longer asking what's wrong, just what's right. Fitness became compulsory and the social contract between the state and the people has been transformed into a commercial contract signed with heroically named private companies.

Sickness and low pay

Since 2008, sickness absence has gone down. This is not just because everyone has officially become fit – the public sector still has one of the highest levels of absence (9.6 days on average) compared to other sectors (7.7 days) – but because with public sector cuts come a climate of fear, where more people keep working until something goes very wrong, the very opposite of good health policy that emphasises early intervention.

What about those who depend on welfare because of low pay? Since 2009 the number of people earning less than a living wage has increased from 3.4m to 5m in 2014. The government's proposal to cut £5bn tax credits has exposed the reality that 7m working people don't earn enough to live. Despite no official government data, it is estimated that 1.5m working people need housing benefit to pay their rent, a number that is going up by an estimated 10,000 people every month.

On top of this came the "bedroom tax", which asked people to pay a levy for council and housing association tenants for any unused bedrooms in their home – a tax the UN reprimanded the UK government for as a human rights abuse.

In-work benefits

The people receiving in-work benefits are mainly women and single parents, many of them working in health and social care. With pay freezes and reduction in collective bargaining the real value of NHS wages has gone down over the past five years. Of the 1.4m people

working in social care, 160,000 are earning less than the living wage, particularly domiciliary carers who are paid only for their 15 minutes of contact time and not their travel between clients.

Not earning enough to live puts us in a precarious position, and when we are precarious at work we are vulnerable to burnout, bullying and failures in our duty of care.

One of the reasons for low wages in health and social care is the decline of professional bodies that have historically fought for wages and conditions. The Social Care Association closed in 2012 and the College of Social Work set up after the case of Baby P also recently closed. Both of these bodies provided the professional framework for their sectors, and both were closed due to pitifully small deficits in funding. If we had wanted to maintain them we could have, easily.

In Julian Lousada and Andrew Cooper's important book Borderline Welfare they argue that when we lose the institutions of welfare we lose the general conditions that are necessary for care to take place. What we are left with is lots of activity that is done by increasingly vulnerable individuals trying to bridge a massive governance deficit. By not maintaining the institutions of welfare, the state fails in its duty of care to create the conditions under which health and social care work can responsibly be done.

Crisis brings us face-to-face with one of the unavoidable facts of life: that we are all dependent on each other. As the containment of public services breaks down social anxiety goes up and the temptation is to manage this by projecting our vulnerability into others. The demand for cuts is a defence against this anxiety precisely because it denies our inherent need for care.

Despite the rhetoric, austerity is not principally an economic issue because by cutting welfare and wages we do not save money, we merely pass the buck to the people needing and providing care. Even by drawing borders between people - between the sick and the

fit, "scroungers" and "hard working people" - we can never success-
fully cut ourselves off from the reality that as human beings we are
inherently vulnerable.

If charities are to deliver more health and social services they'll need to become better organisations

In a week of Greek tragedies it has also been hard to distinguish the gods from the monsters in civil society. Three recent important stories about charities question the accountability and management of the third sector.

Despite Kids Company being the most successful organisation working with poor children in the country, the charity's founder, Camila Batmanghelidjh, took a sustained beating from the Cabinet Office which ended up in a demand for her resignation in return for £3m of a £5m funding shortfall – something she says she won't be bullied into doing before her plan to leave next year.

A former government minister was quoted as saying that governments of all colours recognised that the charity's work is extremely valuable and reached parts of the statutory social care system that others didn't, there as an "unsatisfactory process where Camila would effectively come in and say 'I'm about to fold if you don't give me £5m'. That happened on a regular basis and more often than not the hole was plugged ... the charity keeps growing and there's been no retrenchment. She [Camila] cannot say no."

Putting aside the irony that welfare cuts are in response to a sudden and massive private banking crisis, it appears that Kidsco is a victim of its own remarkable success.

Then there was the very different case of Turning Point and Ibukun Adebayo, the IT director who won her case against the mental health charity for unfair dismissal. This was a sorry tale of old-fashioned discrimination and lack of accountability in which Adebayo discovered, among other things, that she was described by the David Hoare, the charity's deputy chief executive as

"Looney Tunes" in an email to the chief executive. Unlike Adebayo, Hoare continues to work at Turning Point.

And then there was the Daily Mail's exposure of the "boiler room" tactics of the big charities including Oxfam, Cancer Research and Save the Children, who were accused of cold calling people who had signed up to a "no call" list on the UK telephone preference services, pressuring people to donate and asking for donations from vulnerable people who had dementia.

With government policy to expand public funding to the third sector and the decentralisation of commissioning in health there is likely to be a growth in sub-contracting services to this sector. As a result we must be able to map which third sector organisations are working in health and social care and make distinctions about organisations on the basis of their capacity to provide quality care.

The third sector

Around 800,000 people work in the third or "voluntary" sector in the UK, and with more than 164,000 registered charities and a combined annual income estimated at £64 billion, their role in providing social goods is not marginal.

The state funded the third sector to the tune of £13.9 billion in 2010, nearly half of which came from local authorities. An estimated 437,000 third sector workers are employed in health and social care with 115,000 in residential care.

Much of the work with the most disadvantaged is carried out by religious groups, for example churches have historically provided services for prisoners and the homeless, social care and education, with a growing role in managing food banks used by half a million people in the UK. We are also seeing the growth of religious organisations sub-contracted to provide public services, such as welfare services in Scotland and in Kent.

Despite a long history of providing care, many religious groups are fundamentally sectarian in nature raising questions about universality of access when it comes to sub-contracting services.

Social exclusion and the 'dis-established'

Third sector organisations have a competitive advantage when it comes to providing services: they have access to the people that need the help the most. The poor and vulnerable people who are hardest to reach.

Many people living in the UK are "dis-established" either by choice or necessity, living outside of the social systems set up to protect them. Some, like people with addictions or long term mental health problems, have exhausted state support or are unable to follow the treatment available. From illegal immigration to those working in the grey economy, outside of labour regulation and national insurance systems, many people are excluded from health and social care, unable to give a name and address to even register at a GP practice. We don't know how many families live by necessity outside of the social contract but as "cashless" welfare reforms take place and poverty goes above 13m people we can anticipate the number is growing.

But one of the inherent conflicts for third sector organisations is how public funding influences the principles on which they were established. This is acutely the case for charities, who legally cannot take a political position on the economic and social policies that are increasing the demand for their work. It means that an organisation like Kidsco has to walk a very thin line between continuing to access government funding and taking a position on the link between austerity and child poverty.

The lack of core funding for charities means that their accounts, although not technically corrupt, are often squeezed to fit the reporting requirements of donors. It means that core salaries are hidden

under "project coordination" and numerically defined outputs ex-aggerated to satisfy demands for value for money. All the while the unsustainability of many services in a climate of economic crisis and austerity is denied. It means that charities are often silenced when under attack.

Getting the house in order

Much of civil society is led by charismatic people who have a deep and sometimes obsessive belief in their cause. One of the problems with this commitment is that it can generate bullying by default. Where leaders are forced to sustain themselves for decades working unchallenged, their organisations can easily undermine the principles on which they are based. Many are run on guilt and the pressure for people within the system to sacrifice their health for the greater good. A demand for total devotion and self sacrifice that walks the thin line between being right and becoming righteous.

The growth of third sector organisations in providing health and social care raises questions about organisational cultures and accountability. It also raises questions of equality and employment practices for the people working within them, when issues of conscience and belief are a requirement for the job.

Challenging leadership is always hard, particularly when they operate on the moral high ground but that's precisely what we have to do if we are to defend quality care. To do this we have to see civil society as it is. It is this realism that allows us to make the necessary distinctions between corruption and saying something that society doesn't want to hear. If civil society is to protect the most vulnerable it has to be just that, civil, with the rights and responsibilities this entails.

What the Netherlands can teach the NHS about cutting cost but not quality

The social care sector recently underwent a serious reality check. A chronically underfunded system is "turning good people into bad carers", claimed Andrea Sutcliffe, the Care Quality Commission's social care chief, following news that 150 complaints about elderly care are raised every day. In the same week the government announced it would delay the introduction of "limited liability" - the cap on the costs an individual must pay for their care for a further four years, kicking the crisis in social care funding into the safety of the next election.

But as financial cuts bite, the private Dutch company, Buurtzorg, claims to have the answer for doing more with less in social care. It offers a radical model for high-quality social care at 65% of the going rate by cutting the number of administrators and letting carers organise their own work.

Set up six years ago, Buurtzorg now employs over 7,000 frontline staff, representing 60% of Dutch community nurses – with just 30 managers on its books. Staff costs per hour are higher but patients need 30% to 40% less contact time every month, the company claims, because care is directly responsive, changing on a day-to-day basis depending on what the patient needs.

Nurses work in teams of ten, each serving a particular community and working closely with local GPs and services. They see themselves as having a key social function of identifying and building relationships within the community. Buurtzorg says that not only are patients happier but so are staff – it has 60% lower staff absenteeism and 33% lower turnover than the sector average.

Buurtzorg's Dutch model of care is in stark contrast to the UK where 160,000 social carers earn less than the minimum wage and social care job vacancies are higher than any other sector.

Most of the people who currently work as carers, whether public or private, are female ex-public sector workers over the age of 45. Half of private care providers come from the not-for-profit sector and tend to have a memory of public service. Within the next decade most of these carers will retire and with them goes our heritage of how to manage social care the old-school way.

Essential differences

The UK and the Netherlands, despite both being European capitalist systems, are profoundly different in their approach to providing social care. Two institutional factors really stand out.

The first is that Dutch institutions are framed within a political culture of social democracy and based on strong egalitarian principles. The Dutch and Nordic countries have a shared emphasis on equality, reflected in the lack of pay differentials and a dominant workplace culture of flat leadership which is non-hierarchical and emphasises democratic practices. To maintain equality, the Netherlands has one of the strongest welfare systems in the world.

The second institutional factor relates to employment relations. Although wages by UK standards are moderate, Dutch workers are compensated by a generous "social wage" including high unemployment benefits, labour protections and social security benefits.

These differences are seen most clearly if we look at flexible work in health and social care sectors. Unlike the UK's often brutal neoliberal model of high flexibility and insecurity, the Dutch model specifically tries to balance the demand for flexible working with the security needed by workers, something the EU calls "flexicurity".

The Dutch system protects carers from falling into in-work poverty and de-skilling by having higher protections and investment in skills development. This security includes a higher percentage of flexible workers that are represented by Dutch trade unions, including new unions designed specifically for self-employed workers.

Can we go Dutch?

With a £22 billion efficiency challenge and "restructuring fatigue" within health and social care, its tempting to go for a technical solution to a political problem. Cut the 48% of non-clinical staff in the NHS and we're in Amsterdam.

There's nothing wrong with importing new management ideas - we did it in the 1980s with Japanese production methods – but to do this successfully we have to understand the institutional systems within which they can work.

Cutting bureaucracy is only one part of the socio-political equation, because the Buurtzorg model is one of workplace autonomy and democratic leadership where decision making and setting targets is decentralised to clinical teams. The UK and Netherlands' profoundly different institutional settings mean that to do this successfully would require an enormous shift in both the UK's employment relations and workplace cultures.

How showing your emotions at work can make you a better leader

A staggering 20% of senior management positions remain empty in the NHS – a figure that goes up to 37% in mental health. As demand for health and social care services go up in a context of recession and an ageing population, it appears that nobody wants to take the lead when it comes to jobs in health and social care.

One cause is the brutality of the bullying culture that goes right to the top – reflected in highly publicised cases of senior management turned NHS whistleblowers. Leadership vacancies are in part due to the fear of "double jeopardy" when clinicians take up senior management positions and find themselves with often conflicting organisational and clinical duties of care.

Set productivity targets combined with austerity cuts have increasingly put clinical best practice in direct conflict with financial targets and encouraged gaming the system – parking patients on trolleys in hospital corridors to avoid falling foul of waiting time targets and early discharge of patients followed by quick and unreported re-admission.

One of the problems is that targets are politically motivated, passed down from ministerial to management level without due consideration of local needs and resources. It was therefore surprising that health secretary Jeremy Hunt recently called for more transparency and fewer targets in the NHS. Although the principle is welcome, unless the dominant culture is addressed then this just becomes another ministerial dictate with more than the usual hint of irony.

Inclusive leadership

Research indicates that managers under pressure to deliver targets typically default to a command-and-control management style which is unresponsive to both patients and staff – "do this now" rather than "what is the best we can do?" This, in turn, is linked to workplace cultures where staff are reluctant to raise concerns, and become disengaged and dysfunctional, a long way from best practice and patient safety.

What we know from the research is that inclusive teams – which promote diversity, working across disciplines and democratic practices – are significantly better at capturing knowledge and promoting organisational learning. Where teams are inclusive they have a tendency to widen the pool of experience and knowledge they have and to encourage dialogue and the exchange of ideas.

This allows for organisational learning which can be linked to increased public sector productivity and patient safety.

Democratic and emotional leadership

At policy level this inclusive model is a no-brainer and gaining widespread support but the difficulty remains in actually doing it. This is in part because for people to participate at work they have to be allowed to speak their minds, make decisions about their work and challenge their own leadership without penalty.

Within this tradition of democratic leadership, teams are the primary unit of management and hold the collective responsibility for performance. This model was developed in the manufacturing sector in the 1980s, using a Japanese model of team building – a "support and stretch" as opposed to a "control and constrain" culture which emphasises interdisciplinary and experiential learning and importantly is linked to high clinical results.

All well and good, but how do managers create democratic cultures in an NHS where most people manage work by keeping their mouths shut and doing what they're told?

Emotional intelligence

One characteristic of inclusive leadership, whether at senior or frontline level, is to show some emotion. This is not a call for tears in the boardroom or team hugs, rather it's the argument that delivering democracy at work requires managers to address the deep and often destructive emotions that we all carry in our jobs. From getting to the bottom of bullying to addressing racism in the NHS, working life requires both emotional intelligence as well as bravery.

Emotional intelligence can be defined as the capacity for self-reflection and self-regulation, empathetic qualities which allow us to understand the situation of the people around us, and social skills which allow people to hear and observe reality as it is. In the case of health and social care this inevitably involves experiences of trauma, pain, distress and - not wishing to burst any Human Resources Management bubbles - death.

Inclusive leadership prioritises practices of listening, observing, auditing, self-awareness, social awareness, and emotional management. It is through this emotional capacity that leaders become effective at building teams that are both realistic and resilient rather than grandiose and unresponsive to patient needs.

It also requires a demanding regime of this from executives to frontline managers. This involves a radical departure from the current "pervasive culture of fear" that operates in the NHS and creating workplaces that are structurally, politically and emotionally open to the people that work within them. A workplace where I can say what's on my mind and you can bear to listen to me.

Hidden crisis: 80% of hospital doctors are considering early retirement due to stress

Research into the health of health workers is a source of great contention and, often, more than a degree of irony. A new survey of senior hospital doctors suggests that 80% are considering early retirement just as the announcement landed that doctors' union, the British Medical Association, has reluctantly agreed to negotiate compulsory weekend work for consultants – something that is now the subject of an important debate by the government's petitions committee after a petition opposing a 24/7 health service more than doubled the required 100,000 signatories.

So will a 24/7 health service risk turning doctors into patients? NHS England chief executive Simon Stevens recently announced a £5m scheme to improve the health of 1.3m NHS workers. From healthy eating to fast-tracking mental health services this is an attempt to address a real problem.

Something that many of us missed was that this includes a specific health initiative for GPs. We do know that GPs are increasingly vulnerable to burnout and depression – with particular groups such as trainee doctors and women GPs most vulnerable to suicide. But the data around the health of GPs is contested – not least because of the immense difficulties and shame attached to GPs admitting that they can't make it all better for themselves.

There are systemic problems for GPs: the push for seven-day-a-week surgeries and the creation of the Clinical Commissioning Groups that hold the financial responsibilities of a broken system mean that frontline managers, often untrained to manage clinicians and GPs, are left having to juggle financial and clinical demands which cannot both be met.

As a society we have allowed the job of a GP to become impossible by playing games with health targets – the seven-day openings is just one of these. This provokes an often deeply cynical response

from clinicians when there are attempts to build their collective "resilience" through training designed to bolster their toughness, including the ability to 'bounce back' from adversity.

As 74% of GPs say their workload is unmanageable the current suggestion that they might want to drop a few pounds and go to Zumba might be met with hostility.

Flexible roles

GPs hold a difficult position in society. We want them to be authoritative and have all the answers – where they are able to diagnose the tumour, remove it and cure us. But we also want them to do a more delicate job of healing our minds and bodies which are both always involved in the process of getting better. This is a delicate procedure requiring sensitivity, diplomacy and a big dose of humanity.

There is something about GPs that makes them vulnerable. The nature of the training means the career attracts people who make massive demands on themselves – an internal script of "do this now" rather than "what can I realistically do?". For many, medical training is an entry into the cult of perfection where massively bright people become highly vulnerable to fantasies of omnipotence.

It's also the case that GPs need to adopt a position where they have to do things patients don't want them to do. From prescribing medication with unpleasant side effects to encouraging people to give up smoking, the good doctor sometimes has to know best.

At the same time, a doctor cannot always be "emotionally defended", where they adopt psychological strategies to defend themselves from the pain and anxiety they're exposed to. Exposure to psychological risk is inevitably part of the job, but their coping strategies could result in doctors losing their curiosity and compassion towards their patients. By being cut off from patients, real problems can be missed. This is particularly the case with mental

health where the psychosomatic complaints we innocently take to our GPs are sometimes code for distress.

The optimum situation would be one where GPs are able to defend themselves psychologically, enough to treat the patient, but not allow those defences to become so psychologically brittle that they become cut off from their emotions and cease to care.

How doctors treat other doctors

I had the huge pleasure recently of talking to Clare Gerada – a GP and former chair of the Royal College of General Practitioners who now works with the NHS Practitioner Health Programme – and Chris Manning from Action for NHS Wellbeing. These people are of the brave and humane variety, willing to talk about their own states of mind and at the same time having the brass to shout loud at NHS leadership.

Both organisations offer support to doctors but importantly they offer an invitation to GPs to form relationships with each other, where the reality of their situations can be known without shame.

The existence of GP networks, whether its at the level of new GP Federations or support groups like these is not just of therapeutic importance, but also of political importance. Because until GPs can openly and collectively challenge the current system of impossible targets, they cannot re-establish a profession worthy of them.

This means moving beyond the individual GP towards developing relationships with the people they work with that are sufficiently strong to challenge the demands being placed on them.

Stevens' new occupational health scheme is a possible opportunity for GPs but as the crisis deepens, how doctors treat other doctors will matter more.

Here's how to deal with bullying in the NHS

It is a stomach-churning reality that the NHS rests on bullying the people who work in it. This "endemic culture of bullying" has facilitated a growing crisis of structural discrimination and racism, staff burnout and stress, and with it a risk to patient safety.

Getting a perspective on bulling is difficult because it requires facing up to some hard facts of life. Bullying in the NHS is likely to get worse as the financial crisis deepens and, whatever our job, we are all involved in any bullying that takes place at work.

Psychoanalytic ideas can help us understand how bullying becomes established, defining it as a psychological and social defence against our own feelings of vulnerability, anxiety and aggression. Under this model, bullying is an attempt to project our own vulnerability and fear into other people, something that under the right (or wrong) circumstances we are all capable of doing.

This is not to suggest that everyone is actually a bully, but rather that bullying at work is painful in part because we are all involved. Whatever our role – for example the patients that stand by, the staff that turn a blind eye, the politicians that cut budgets and the bullies themselves – we all have a part to play in bullying becoming established at work.

How bullying works

Despite everything we know about the necessity of teamwork in health and social care, where bullying exists we generally don't challenge it. Common survival strategies include withdrawing from colleagues or striking up alliances with people who offer us protection. This can include establishing gang-like ways of working, such as blaming and excluding people with different views or ways of working.

Gangs, unlike functioning teams, offer a mafia-like organisation where accepting the rules protects you from attack but demands utter compliance. It is a dangerous culture in healthcare, where our duty of care demands we raise concerns about patient care.

Another important dimension to bullying is what happens in the mind of the victim when the bully launches their attack. One of the reasons why bullies get under our skin is because they enlist our internal bullies: the voices inside our heads that actually agree with the external bullies. In the case of health and social care workers, this internal voice can efficiently disorient us and undermine our self-confidence.

Understanding the dynamic nature of bullying in this way – that it has systemic and individual aspects – can feel like an attack on the victim. But it's a risk worth taking because by understanding the nature of bullying we can start to tackle it.

Sweat the small stuff

Having had the dubious honour of working on bullying at work for some time, I'm going to do something that I don't normally do and give you a checklist. It is based on one simple principle: that tackling bullying requires sweating the small stuff and taking some small practical steps.

Step 1: find some higher ground

Being bullied feels like drowning so you first need to get to safer ground. This involves getting out of bullying hot spots. This can be anything from avoiding the smoking breaks or those after-work drinks that seem to end up with someone calling you fat and ugly. Or it can be going somewhere every day where you feel safe, from your best friend's sofa to the nearby allotment.

Stage 2: bullying book

Methodically write down the times, places and what happened every time you were bullied. Not everything is subjective, there are facts about bullying behaviours so write them down. Keep the book at home and only ever open it when you're in a robust frame of mind and definitely not when you are drunk.

Stage 3: get a witness

It is essential that you tell someone what is going on. They can be someone that has witnessed the bullying or not, someone you like or not, but someone who you trust to keep their eye on you. Telling someone does a number of things but firstly it forces you out of your bunker and makes you admit what is happening.

Stage 4: phone a friend

Whether you are a victim of bullying or trying to help someone who is, there's a huge temptation to withdraw from other people. But tackling bullying requires doing something totally counterintuitive: making contact with other people and asking for their help. In a bullying workplace, joining a group can give us a profound sense of place and support to make changes. Trade unions are often good at dealing with bullies and reps can be dogged in their devotion to shouting back on our behalf when we can't summon up the strength to do it ourselves.

If you can regain your humanity by taking some small steps you will then be in a better position to make the bigger decisions about how to tackle bullying at work.

Acknowledging that bullying is an ordinary part of working life is not the end of the world nor does it inevitably mean you have to walk away from your job. Ironically the strength needed to face up to bullying involves accepting both our power and vulnerability. As any clinician will know, the work of helping other people involves helping ourselves. This turns out to be the hardest part because it requires us to put aside our shame and ask another human being for their help.

Why black working lives matter in the NHS

A few weeks ago I did something I have been avoiding for about 20 years: I talked about racism at work. As part of a frontline managers programme developed with the Tavistock Clinic, I and a group of health and social care practitioners have been meeting and having conversations about the juicy topics of whistleblowing, bullying, fear and loathing in the NHS.

Despite the blinding evidence, very few of us talk openly about the reality that the NHS is institutionally racist. In particular, recent research by my colleague Roger Kline into the racial makeup of the health service and the experience of black and minority ethnic (BME) staff has let the cat out of the bag. He described NHS leadership as "the snowy white peaks" among a workforce that that has seen its proportion of BME staff grow considerably in the last decade.

The research found the problem particularly bad in London, where 41% of NHS workers are from a BME background, compared to around 45% for the whole city. Despite much work to improve equality within the capital's health service, just 8% of London NHS trust board members are from a BME background. Similarly, white staff in London are three times more likely to become senior managers than BME staff and 25% of BME staff in the city consistently report they are discriminated against at work.

The NHS's workforce surveys also show that BME staff across England are more likely to be bullied at work and subject to disciplinary processes. The moment has come when we have to ask whether black working lives matter in the NHS.

Data is vital

If you're a patient, the answer is very much so. Research shows that the unfair treatment of BME staff is reflected in poor patient care. This is linked to our experience that a lack of diversity in

teams reduces innovation and learning, and that when staff don't represent their local communities they struggle to provide genuinely patient-centred care.

The NHS has until now relied heavily on not collecting data on its BME staff, not publishing it and therefore not having to acknowledge the problem in the first place. But earlier this year the Workforce Race Equality Standard was created to provide a way to measure staff equality in the NHS and encourage employers to ensure equal access to career opportunities.

Standards and measurements are extraordinarily important given the reality that nobody wants to talk about racism. Data also drives inquiry. In every other aspect of NHS life –- disease, patient safety, improving care – we use data to identify problems and make changes. If workforce race discrimination adversely impacts patient care, surely data on racism should be treated the same way. This is what the standard is starting to do.

But even with the data we still have the enormous difficulty of tackling staff racism in the NHS. The data doesn't express the deep and difficult emotions that are part of the experience of discrimination.

Institutional racism can occur when an organisation fails to tackle both the conscious and unconscious bias people can exhibit against others of another ethnicity. So understanding the psychology and emotions around individuals' racism are really important in tackling it at a wider level.

Psychoanalytic ideas give us a way of understanding racism as a powerful psychology where we project unacceptable or "bad" qualities into a group on the basis of their ethnic background. One much discussed idea is that of the "internal racist" – that we all have an internal drive to hate difference in others, a feeling that is provoked under stress and situations of scarce resources.

When we encounter differences in others, particularly if we don't like them or are working in a workplace in conflict, the psychological process can go as follows:

- One of our beliefs, values or practices are challeged;
- We become offended;
- We get angry;
- We become hateful towards the people around us;
- We then experience a paranoid guilt that the other person is going to retaliate;
- We get defensive and possibly slightly hostile.

In most cases, our egos can't handle this decline into primitive feelings and we deal with feelings of hatred by withdrawing from other people. This dilutes the strength of our ugly feelings but it also allows us to keep our views unchallenged and our superiority intact.

The world's not black and white

Psychoanalysis offers a model of development which encourages us to view the world as not black and white. Growth involves moving away from a perspective where people like me are good and people who aren't like me are bad, towards a more depressive position that we are all a mixture of good and bad aspects.

This more balanced perspective about the world allows us to reduce the very human default position to project our angry and negative emotions into other people. The argument is that, by accepting we are all able to experience hate and love for the people around us, we can better deal with the emotions we all face in adult life.

If you work in health and social care, dealing with a diverse group people is the nature of the job. Whether they're patients or colleagues, you don't get to walk away from them just because you don't like them.

Working with people who are not exactly like us and who are in pain and distress means that being offended by others is an occupational hazard. The issue is not whether we will be offended, rather what we do with the offence. If we nurture it and leave it unchallenged, it can turn to a hatred and a righteousness, producing a workplace where some people are seen as inherently better than others.

Equality data and standards are crucially important in maintaining the battle lines between offence and hatred. But we can only really do this if we are prepared to understand our own internal battle with difference, and keep the internal racist in its primitive place.

NHS staff need to speak up and start taking better care of each other

High-profile NHS failures over the last few years point to a real problem in getting healthcare staff to speak up at work. All NHS employees have a personal "duty of care", articulated in the newly amended NHS Constitution. A responsibility to provide good clinical care also includes a "duty of candour" to raise concerns about poor practice. But the new regulatory system brought in to encourage staff to fulfil their duty of candour doesn't address the real reasons why people don't raise their concerns.

The new regulations, although well meant, focus on establishing the crime and the punishment, rather than the pressing problem of how to tackle the culture in which NHS staff are afraid to raise issues. If our response is simply to regulate and punish, we are just setting up a system where silence is institutionalised.

Candour in the context of austerity

The NHS's current circumstances, including the junior doctors' current ballot to take strike action, make this problem particularly acute. Budget cuts imposed by the government via management mean that staff can find it difficult to know whether they should raise concerns over a lack of resources.

Professional codes, including regulations for doctors, advise that if you know that there is a serious problem with a lack of resources and prioritising them then you are obliged to raise this. In this situation, clinicians are personally accountable for following their professional code and are obliged to refuse instructions. This puts staff in, at best, a political position and at worst an impossible one.

The result is that staff don't speak up because they are worried about being victimised by their colleagues and employers. This problem is often seen as the need for a more just culture in the NHS that distinguishes between risky or reckless behaviour and human error when working out what has gone wrong. We need to look systemically at care rather than blaming collective problems on individuals.

Instead, we have a "pervasive culture of fear" where people are unwilling to raise their concerns about patient safety. This indicates a failure in the duty of care staff have towards each other.

As the Freedom to Speak Up initiative carried out by the government in response to the findings of the Mid-Staffs inquiries shows, our relationships with each other are not sufficiently strong to risk speaking up at work. Many cope with working in the NHS by shutting up and actually not caring very much about the people they work with.

Similarly, the NHS also has a duty of care to the people that work for it and yet 30% of staff are paid less than the cost of living. Junior doctors are threatening to strike because the government wants to make shifts on weekday evenings and Saturdays count as regular hours not as (better paid) overtime.

Meanwhile, the announcement of a £5m occupational health fund for NHS staff in response to burnout and long-term sickness shows that many of us are failing in a duty of care each other. All this means NHS staff, and their relationships, are not receiving the care they need to do their jobs.

A relational model of care

The service the NHS can offer is always limited by financial controls and targets and so the duty of care is compromised every day. This means staff relationships have to be strong enough to be able to raise concerns about patient care and safe enough to do so without risking jobs.

Capacity to deliver care rests entirely on having relationships at work that allow mistakes to be made, thought about and addressed without anyone being burned at the stake. If we are to respect a duty of care to patients we also have to respect our duty of care to colleagues.

The task of achieving this is a concrete political one. We need to defend a principle of care that is fair both to patients and staff. And staff need to build sufficiently intimate relationships that allow them to work responsively to patient needs rather than defensively against victimisation and job loss.

Ultimately, surviving work in the NHS depends on how staff treat each other. It matters if you ask people how they are and listen to the answer, support someone with a concern about patient safety at the next supervision or join a union. It's time to dig deep.

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