

Changing the National Health Service

By

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1. INTRODUCTION

The National Health Service (NHS) is world-renowned for the high quality service it provides. Despite increasing demands in the face of continuing budget restrictions, it is a world leader in health care. A major employer in the UK, the NHS has circa one million staff across hundreds of Trusts, many of which have several thousand employees. Indeed the recruitment and retention of suitably qualified staff is one of the biggest challenges facing the service at the start of the twenty-first century.

However these problems are not new. In her report for the month ending November 26th 1937, one matron wrote:

"As the winter pressure is now being felt, I have found it impossible to staff the wards adequately.... During the past year we have spent £132.8.10 on advertising, by far the greater part of this amount has been spent on advertisements for nursing staff.... Not a single application has been received over that whole period for a staff nurse vacancy." (Swift, 2003).

The National Health Service been swept by continuous tides of change throughout its history. Led by politicians and bureaucrats at national level, the current health service modernisation agenda is dependent on a system of performance targets that reflect little understanding of the role of the frontline worker in improving the quality of patient care.

The Government White Paper "The New NHS: Modern, Dependable" (HMSO, 1997) describes a vision for change in health care. This has been followed by numerous documents, providing guidance on how this is to be achieved, performance standards to be met, and the controls and financial restraints within which the Government requires Trusts to regulate their activities. It has become a performance driven service with huge pressures on Trust management to achieve up to 400 targets a year. When implementing these new initiatives, management effort is dislocated from the real pressures faced by their workforces.

This paper is based on the author's experiences as a front line worker in the NHS over twenty four years, including five years as a local trade union steward. It provides a view of the NHS from the bottom up and challenges traditional hierarchical management practices experienced by frontline staff. The paper examines the impact that middle management can have on the implementation of Trust policies affecting the work force. It then offers a critical examination of the government's Improving Working Lives Initiative (IWL), designed to spread good practice through staff involvement and more effective partnership between employees and management.

The Wave of Change in the NHS

The change agenda facing National Health Service Trusts can be compared to a huge tidal wave. It starts in the high pressure turbulence of national politics and leadership, where change is initiated in a rich, deep and vast ocean of central management and policy. The wave gains momentum, becoming more powerful and widespread, and on reaching the Trust it engulfs higher management. Steered by the Chief Executive and the Board, the wave drives new strategies and priorities through the complex organisational structures of the hospital. This tidal wave surges forward through the higher management structure and as it reaches its peak, crashes onto the barrier reef of middle management. This is the demarcation line, separating the office-bound, nine-to-five weekday managers from the flexible, twenty four hour, seven-days-a-week clinical and support workforce.

To cope with this onslaught it is essential for such managers to have experience in change methods, to communicate effectively with staff, to involve them in planning and piloting changes so that they are acceptable, achievable and equitable. Yet many managers are unsuccessful at surfing the wave of change and become engulfed in the pressures and volume of responsibility; so the wave dissipates. Spread over a vast area of the organisation, having lost its momentum, the high ideals and expectations driving the wave flounder.

Much NHS middle management remains steeped in an authoritarian tradition. Having worked up through the roles of student nurse to manager, without appropriate training or understanding of their role in a modern organisation, they are often unwilling to relinquish their powers of control. Driven by short-term performance targets many implement changes with little or no staff involvement. As the Involvement & Participation Association argues, such emphasis on performance management systems can be self-defeating:

"The research evidence suggests that the way managers are managed has a critical bearing on people management more generally. Time and time again it emerges that innovations such as quality circles, TQM and teamwork largely fail, because organisations continue to appraise and reward their managers purely and simply on the basis of 'hard' operational or financial targets, rather than the softer development and inter-personal skills so essential to the success of these initiatives" (IPA, 2003).

'Shared governance' in contrast is an example of a decentralised approach which encourages staff involvement in decisions that affect their clinical practice, work environment and personal development. However many middle managers remain ineffective in involving, communicating with and learning from their staff. Moreover they are hindered by poor communication systems because the NHS is gravely under- resourced in terms of the technology and training required to provide staff with twenty four hour access to information in their work areas. Inadequate communication with staff about corporate issues creates a barrier, leaving many staff feeling under- valued and disconnected from the organisation.

Weakened, the wave of change flows over the barrier reef of middle management, and over the layers of line management on its upward struggle to the pebbles on the beach - the frontline of healthcare delivery. On reaching these pebbles the wave has become a mere ripple, trickling around them with little impact. These pebbles are the staff trying to deliver and maintain high standards of care and service with little recognition, poor remuneration and frequent feelings of exhaustion. Yet in some areas the wave of change retains its power and without warning hits the service so hard that sudden change erodes the beach, undermining parts of the workforce and drowning team spirit. Some staff may react by becoming defiant like rock stacks, standing firm and resisting change.

When there is weak partnership between workforce and management, staff and union representatives are often excluded from discussions about service change and role redesign. Imposed changes will lack the support of staff, who may not be willing to embrace the new ways of working. Case study evidence from the recent redesign of a specialist service initiated and led by middle management within an acute NHS Trust demonstrates the effects on staff where they were excluded from the planning stage (Exton, 2003). Changed roles and job descriptions, and the down-grading of specialist nurses, led to low morale, poor retention of specialist staff and difficulties in recruitment. This in turn reduced staffing levels, increased sickness rates and altered the skill mix, with the risk of cumulative consequences for patient care.

If harnessed efficiently wave power can produce great energy and change. Management should recognise the resource available in their workforce: the wealth of experience and knowledge individuals have about their profession and the service they provide. Too often frontline staff are considered as no more than pebbles on a beach, uniform in appearance and without aspirations. Yet in many cases it is their choice to stay at the sharp end, delivering care and services. Opportunities for involvement in change would provide management with a channel of communication from the workforce, stimulating innovative ideas and promoting the sharing of good practice, so harnessing a valuable energy.

The Culture of Change

Building workplace partnership between management, trade unions and the workforce is an essential precondition for sustainable change in the NHS. Within such a culture of partnership, teamworking is a key building block for effective involvement, workplace innovation and service improvement. This is often understood at the strategic level, but has yet to filter through to middle managers.

Traditional forms of work organisation and middle management culture in the NHS prevent effective team working. Teamworking is a term often used when a line manager leads a group of workers - even when he or she is deeply reluctant to relinquish traditional authority and thereby inhibits autonomy, innovative practice and the ability of staff to promote change.

The nature and benefits of real teamworking need to be better understood throughout the NHS.

Within the Government's NHS modernisation programme (DoH, 1997) there has been increased emphasis on leadership development for middle management with the aim of improving patient care through teambuilding, networking and enhanced political awareness. Likewise the nursing, midwifery and health visiting national strategy 'Making a Difference' (DoH, 1999b) set out action plans to improve recruitment and retention, reform education, improve working lives, modernise career paths and pay, enhance quality of care and work in new and more effective ways. The implementation of the NHS Plan (DoH, 2000) promises well-publicised changes in investment and reforms. These include ambitious plans for changing the Health Service around the needs of the patient, as well as providing a better place in which to work.

Despite this mounting crescendo of change, many ground floor staff are oblivious to the existence of such initiatives, not being consulted or involved in the plans for their department or Trust. It is middle management who are leading and initiating the changes at local level - and with only minimal involvement, if any, of frontline staff.

Evidence based on interviews with staff during 2002 demonstrates that many initiatives for change have yet to make an impact on them (Exton, 2003). Many continue to experience problems affecting their working lives including stress, frustrations with work/life balance, shift patterns, unfairness, ineffective communication and inadequate support:

"Travelling long distances to work is very expensive. If I could do fewer, longer shifts I would reduce my petrol costs. My ward manager will not allow 12 hour shifts on her duty rota."

"On site affordable childcare, that would accommodate my irregular, part time shifts, would reduce my stress levels."

"My manager doesn't seem to understand our staffing problems and workload. Some support, feedback and acknowledgement would be appreciated."

"There is inequity in the provision and accessibility for training courses in my Trust."

"Some departments are so understaffed there is no one to provide cover for training sessions, yet other departments seem to manage."

"I don't know what is happening in my unit and the Trust. I work mostly nights, and find it difficult to attend unit or team meetings. I have little chance to access the bulletin board on our computer system as there are too few terminals in our busy work area."

Many of these comments are echoed by recent research on why midwives leave their profession. Ball, Curtis & Kirkham (2002) concluded that:

"... while the need for greater flexibility in working patterns within Trusts was frequently articulated, the need for profound cultural and organisational change has also to be recognised."

Quality of working life depends on the extent to which people feel empowered to influence their work environment and to use their professional knowledge and experience to the full. Indeed Ball et al demonstrate that lack of ability to influence work is a major reason for midwives leaving the profession:

"Many midwives felt that they had insufficient control over their working lives. Frequent dislocations at work made it difficult to build and maintain confidence and expertise, and difficult to develop and sustain relationships with colleagues and clients. Fuelling these concerns was a frequently articulated need for more effective support within the work environment... Moreover, not only were midwifery managers not seen by many clinical midwives as a source of support, they were often perceived to be an integral part of the problems that midwives face in the modern health service."

2. REMOVING OBSTACLES TO STAFF INVOLVEMENT: THE CASE OF FLEXIBLE WORKING

The tide is turning, trade unions are becoming more widely involved in Trust matters. Experience shows that staff side representatives and stewards of the trade unions and professional bodies can become a vital link in two way communication between management and staff. Trade union representatives are also a largely untapped source of expertise with detailed knowledge of their professional and service areas and a clear understanding of the likely impact of change. They are in a unique position, combining their experience as members of the workforce and their active involvement with senior management in deliberating the implementation of Trust policies.

These stewards and representatives make a major contribution to supporting and counselling staff, since many managers are not readily accessible to the workforce and are often not involved in the day-to-day provision of clinical services. Issues affecting clinical risk and quality of patient care are often raised initially with the union steward or representative, whereas in an effective teamwork environment they would be discussed and dealt with in a team forum. However this requires managers to work as part of the team, encouraging dialogue, supporting staff and representing their views at Trust level.

In practice the staff side steward or representative's role often extends to that of facilitator for staff issues, especially in ensuring the equitable implementation of Trust policies. For example, one NHS Trust has clear

policies for staff involvement, flexible employment and work-life balance, yet different models of leadership in two adjacent departments demonstrate different consequences for their implementation. In one department, the staff have established a system of shared governance and have designed their own approach to self-rostering. Just next door, staff suffer a management-dominated system, with line managers reluctant to allow empowerment or attempts to enhance work-life balance by introducing new working practices. Staff side representatives held discussions with management highlighting discrepancies in working practices throughout the Trust. Despite acknowledgements at Trust level that the introduction of the EU Working Time Directive would necessitate changes to shift patterns, the manager of this particular department was reluctant to address the recommendations for self-rostering of the duty rotas.

Many staff contacted the union steward requesting a system of self-rostering for their shifts. There is evidence that this can work effectively in nursing and midwifery, aid recruitment and retention and improve the working lives of staff. Despite the steward's request for the implementation of self-rostering, supported by evidence of improved work/life balance and the application of a Flexible Working Practices policy in other areas of the Trust, two of the four team managers refused to accept the benefits to staff and continued to manage the rostering themselves. Interviews with staff subsequently identified a number of negative reactions:

"We are made to feel that we have let the team down when we put requests in. We can't say they are for childcare because the manager then suggests that childcare dominates the rota and other people have needs."

"My line manager's answer to my requests for flexible shifts to accommodate my child care problems, was to say I had to reduce my hours worked. Thinking I had no option I now don't earn enough to cover my childcare. I have since heard of other staff in my Trust who can self roster their own flexible shifts."

"My line manager refuses to let me do 12 hour shifts which would help with my childcare - she says the ward can't be run around childcare, but other wards in the Trust have these shift patterns"

In the same unit some staff requested shorter shifts to suit childcare arrangements, while some wanted to improve their work-life balance by working fewer but longer 12-hour shifts. Line management were reluctant to consider these different shift patterns that would accommodate this even though this would have provided a means of ensuring compliance with the European Working Time Directive.

Together the staff and their trade union steward arranged a series of meetings. A group of enthusiastic staff prepared a pilot rota, based on the results of a questionnaire completed by the majority of unit staff. A team

leader was approached and reluctantly agreed to trial it. The first pilot rota incorporated the self-rostered duties and the 12-hour shifts, providing adequate staff cover at all times. Feedback from the staff unit meeting was positive, and the member of staff who managed the rota was told by her colleagues that the team leader had thought it a success and that she was requested to manage the next rota.

However the team leader altered the next rota, without consultation with any of the staff and failed to provide adequate cover for all shifts. The other team leaders then complained that the pilot rota was not workable, and many staff were asked to work extra shifts. The steward and staff involved met to discuss the problems with middle management, since two first-line managers were reluctant to consider further trials of the 12 hour shift pattern despite many requests from staff.

The steward later received a copy of a letter sent from the manager to the team leaders and staff members involved in the pilot, requesting them to attend a meeting to discuss these problems. The steward's copy clearly stated it was for information only - she was excluded from the meeting and received no management feedback from it. The two staff members who had led the trial rotas attended the meeting, but were so disillusioned by lack of management support for flexible working patterns and self-rostering that they declined to be involved further.

The twelve hour shift trial was continued over six months but there was resistance from management to extend it to include all the staff in the unit who wanted to work these shifts. Despite the efforts of the steward, some first line managers refused to change traditional shift patterns and relinquish control of the duty rota. The inequity for staff in this department led to low morale and discontent, with some staff leaving for more flexible arrangements elsewhere.

The steward discussed her concerns with senior managers, who were unaware that the Trust's flexible working policies were not being implemented equitably within this part of the hospital. Meanwhile, an external NHS assessment team evaluating the Trust's employment practices had arranged an open meeting with staff in this directorate. The steward informed the manager that they would be interested in the trial for flexible working patterns in the unit. A week later a letter was sent from the manager to the steward informing her that flexible working patterns, including twelve hour shifts, would be available to all staff within the unit.

This case study of middle management resistance to agreed policy measures demonstrates the difficulties faced by trade union representatives and senior management alike in making change happen, even where a clear and agreed policy framework is in existence.

3. IMPROVING THE WORKING LIVES OF NHS STAFF

At a time when the health service struggles to rise to the challenge of staff recruitment and retention, the NHS Plan (DoH, 2000) announced the government's commitment to improve the working lives of staff. All NHS Trusts are being assessed against new performance measures as part of the 'Improving Working Lives' (IWL) initiative (see figure 1).

FIGURE 1

Key Strands of the Improving Working Lives initiative

- Flexible Working Patterns
- Staff Benefits and Child Care
- Communication and Staff Involvement
- Healthy Working Practices
- Equality and Diversity
- Training and Development
- Human Resources Strategy and Management
- Staff Attitude Survey

While IWL is to be welcomed, senior NHS management recognise that the difficult task is not to design the appropriate policy framework but to make sure it is implemented equitably across the service. Trusts are already required to have policies for flexible working, equal opportunities, healthy workplace practices and personal development. Although the IWL initiative addresses these same issues, amongst others, Trusts will now have to demonstrate that policies are being implemented effectively and that they have begun to make a real difference to the working lives of staff. IWL performance measurement only allocates a maximum of 25% weighting to the written portfolio of evidence which includes Trust policies. Much more emphasis is placed on evidence collated from interviews with a cross section of staff from the Trust, which accounts for the remaining 75% of the assessment.

IWL is important as a new initiative, but improving the quality of working lives of staff needs to be embedded into all areas of hospital management and practice. It should not become yet another initiative geared to the achievement of narrowly defined performance targets. There is evidence that many middle managers interpret and apply their Trust's policies in arbitrary ways (see for example Exton, 2003). This new standard will highlight areas of poor communication, the uneven application of human resource policies and insufficient staff involvement. More positively it will demonstrate areas of good practice and service innovation.

As a key part of the NHS Plan, the IWL initiative will only be successful if it effectively engages and involves frontline staff, providing the opportunity for them to develop their professional, service and working conditions. The eight key areas to be assessed within the IWL standard (listed in figure 1) address some of the most important reasons given by employees leaving the Health Service. Involving staff at all levels of the IWL initiative would empower them to make a difference within their Trust, shaping future health services and lead to improved retention and recruitment.

These improvements will ultimately influence their work environment, increase their quality of working life, enable work-life balance and lead to improved standards of patient care.

Shifting the balance of power

For the IWL Standards to be implemented effectively, the dominant management culture in the NHS needs to be challenged. *Shifting the Balance of Power: Securing Delivery* (DoH, 20001a, p24) argues that:

"A real shift in the balance of power will not occur unless staff are empowered to make the necessary change... Staff need to be involved in decisions which effect (sic) service delivery. Empowerment comes when staff own the policies and are able to bring about real change."

This represents a massive change from the way most staff work at present and these changes won't happen without a struggle. By achieving IWL accreditation, Trusts will not automatically create real changes in working life - there have been plenty of examples in the NHS where performance measurement has led to quality assurance without quality enhancement. Even when Trust Boards are fully committed to improving the quality of working life, there is no guarantee that this will be realised at workforce level.

Many staff side union representatives experience the present system of implementing Trust policies as inadequate, ineffective and inequitable. Despite the existence of Trust-wide policies, directorate managers or even lower line managers have considerable discretion in interpreting how (or sometimes whether) they will be implemented, based on their assessment of 'the needs of the service'. Employees are therefore often unable to benefit from Trust policies on issues such as family friendly flexible working patterns. As the previous case study demonstrates, many staff-side representatives and their colleagues strive to bring about changes at ground floor level. Unfortunately this can cause a considerable increase in stress for those individuals. Management often gives little more than token verbal support for involvement in issues traditionally seen as part of their own remit. For these ground floor staff, involvement in improvement programmes and other initiatives is often undertaken in their own time because there is rarely cover to release them from their clinical or service commitments. Will the IWL initiative crash onto the same barrier reef of middle management described above?

The costs of non-involvement are great. Even if IWL standards are seen to be met and the performance measures met, staff will leave the Health Service in even greater numbers if policies continue to be inequitably implemented and staff are not consulted.

Staff involvement must ensure that real life issues are heard and addressed. Staff experiences of both good practice and the need to address bad practice can be identified to support improvement. Consultation with and feedback from the work force will identify the real

issues of working in that Trust. Managers need to be accountable to their teams and accept the challenge of engaging with staff to steer the NHS through much-needed cultural change.

FIGURE 2

Staff Involvement in Improving Working Lives – a case study from Nottingham City Hospital NHS Trust

In January 2002 members of Staff Side, clinicians, non-clinical staff and human resource managers participated in an Improving Working Lives (IWL) time-out meeting. The brief was both to audit and enhance current policies and practice across the Trust, and to assemble evidence towards the achievement of the Improving Working Lives (IWL) Practice standard.

The participants placed staff involvement at the heart of the IWL process. In particular it was agreed:

- to ensure the widest feasible participation of staff at all levels in steering and implementing IWL procedures
- to establish mechanisms through which staff at all levels throughout the Trust can identify problems relating to working life and contribute ideas for improvement;
- to ensure that principles of staff involvement become deeply embedded in the culture and practice of the Trust and are not just adopted as a means of ensuring IWL accreditation.

IWL Steering Group

A Steering Group was established, chaired jointly by the Director of Human Resources and a Non-Executive Director. Staff Side representatives were invited to join the Steering Group, together with a cross-section of managers from clinical directorates and service departments.

The Steering Group sets the direction for achieving the IWL Practice Standard and is responsible for encouraging change within the organisation. It ensures that IWL initiatives are co-ordinated and communicated across the Trust. The Group is responsible for agreeing the work programmes of the Workstreams (see below) and managing their performance.

IWL Workstreams

Four Workstreams were established to address areas of organisational policy and practice central to the improvement of working lives:

- Human Resource Strategy
- Staff Involvement
- Working Practices
- Equality & Diversity

Workstreams each comprise members of the Steering Group, Staff Side representatives and a cross-section of other employees, supported by an

HR manager. Particular efforts were made to recruit members of staff of all grades from across the Trust. Each Workstream will produce an action plan based on an assessment of the Trust against the IWL Practice Standards. Workstreams will also involve staff all stages of the process, enabling ideas and suggestions from a wide section of the workforce to be incorporated and acted upon.

IWL Staff Involvement Roadshows

To secure maximum staff involvement, an innovative programme of 'Roadshows' was proposed by the Staff Side Secretary and developed by a subgroup of the Staff Involvement Workstream. Staff Side representatives played the lead role in designing and implementing these forums for consultation and participation open to all Trust employees. It is intended that Roadshows should be run on a regular basis, perhaps three times a year.

A pilot series of seven IWL Roadshow events was held during the first half of November 2002 in two key locations on the hospital campus, taking the IWL initiative out to the workforce at times and venues accessible to all. Publicity for the event included material on an IWL noticeboard in a key location, the distribution of handouts to line managers, articles in the Trust newspaper and electronic messaging.

Roadshow participants were encouraged to share examples of good practice, identify shortcomings and discuss ideas for improvement. Each Roadshow event included:

- quality of working life questionnaires;
- graffiti charts;
- anonymous comment boxes;
- facilitated small group discussions;
- visual displays on the Trust and its policies;
- a display and opportunity to comment on designs for the new uniform;
- an information leaflet on the IWL initiative and staff involvement activities, including an evaluation and comments section;

Food and drink were available throughout the events.

Issues and suggestions identified during the Roadshows were collated for further analysis and discussion by the Staff Involvement Forum (see below). Findings and recommendations from the Roadshows were reported to the Trust Board by the Staff Side Chair and Secretary in February 2003.

The Forum

The Forum was initiated on 6th December 2002 and meetings will be repeated at the end of each Roadshow cycle. The Forum provides an opportunity to explore selected issues arising from the Roadshow in greater depth. In particular it enables proposals arising from staff involvement activities to be 'peer reviewed' and developed in greater

detail. Specific proposals are subsequently referred to the appropriate IWL Workstream to develop appropriate actions in liaison with the relevant executive officers within a specified timeframe.

Participation in the Forum is open to all employees, and managers from each department are encouraged to ensure that at least one member of their staff takes part. Forum participants would also be encouraged to return during the next cycle to provide a measure of continuity. They would also be updated regularly on progress with the implementation of proposals agreed by the Forum.

4. CONCLUSION

The Improving Working Lives initiative encompasses all the areas that influence our working lives. Staff should be represented and involved at every level of discussion about IWL within the Trusts because without staff involvement the standards will not be met. Discussion within workforce teams about the IWL initiative can identify good practice, need for improvement, team performance and communication and promote ideas for change. Line managers should be accountable to their team for providing feedback on the communications within the Trusts about IWL and to support the aims of the initiative within their department.

The valuable resource represented by the skills and knowledge of the employees of the National Health Service needs to be recognised. There must be a positive culture for change and innovation, enabling employees to be motivated to initiate and embrace change and challenge the traditional processes of the NHS management. Breaking down the barrier reef of middle management and building a workplace partnership of management, trade unions and professional representatives with the workforce is necessary to affect the culture of change in the NHS. To achieve a high standard of patient care Trusts need to identify issues that will improve the quality of working lives for their staff and not aim simply to achieve their performance targets.

Building workplaces that improve the quality of working life of employees so that they are involved, feel valued, and are less stressed will be the cornerstone for the future National Health Service.

REFERENCES

Ball, Curtis and Kirkham (2001) *Why Do Midwives Leave?* RCM Report for the DTI Partnership Fund. London: Royal College of Midwives.

DoH (1997) *The New NHS: Modern, Dependable* London: HMSO.

DoH (1999a) *Agenda for Change: Modernising the NHS Pay System*. London: Department of Health.

DoH (1999b) *Making a Difference: Strengthening the nursing and midwifery and health visiting contribution to health and healthcare*. London: Department of Health.

DoH (2000) *The NHS Plan*. London: Department of Health.

DoH (2001) *Shifting the Balance of Power: Securing Delivery*. London: Department of Health.

DoH (2002) *Improving Working Lives National Audit Instrument*. London: Department of Health.

Exton, R. (2002) *Midwives take the lead, not leave*. *Midwives Journal* (Dec 2002).

Exton, R (2003) Case study of service redesign in an acute hospital Trust. Forthcoming.

Involvement & Participation Association (2002) *IPA Response to the DTI Consultation Paper on High Performance Working*. London: IPA.

Swift, P. (2003) *Nottingham City Hospital during the 1930s &1940s*. Nottingham: Paper by the Nottingham City Hospital Honorary Archivist.