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EDITOR'S COMMENT

COMING TOGETHER

By Matt Roberts
National Health Executive Lead

Coronavirus. It's a word we cannot escape at present given the ongoing viral outbreak across the world, with a health emergency being declared seemingly in new countries every day. Healthcare services across the UK are expected to be under significant strain in the coming months and as such we must strive to support our healthcare workers and continue to seek ways to maximise the quality and efficiency with which we can provide patients their necessary care.

The outbreak has not taken the place of other pre-existing healthcare challenges, which continue to need NHS services too. In this issue's cover story (page 30), we hear from Faye McGuinness, Head of Workplace Wellbeing Programmes at Mind, about how we best protect the mental health and wellbeing of our healthcare staff. With tough, demanding times likely ahead, protecting and shielding staff health, both physically and mentally, is of the highest priority.

We also hear from the NHS Business Service Authority (page 4), described by their Chief Executive Michael Brodie as the NHS' hidden gem and Matthew Jordan-Boyd, Director of Finance & Corporate Governance at the NHS Counter Fraud Agency (page 42) about how the NHS can cut out fraud from the national health service, potentially preventing the NHS from losing over £1bn.

Diversity among our health and social care industry's directors is also tackled on page 28 by Joan Saddler, Director of Partnership and Equality at NHS Confederation, while Jonathan Field, Spinal Extended Scope Practitioner and Member of the British Chiropractic Association (BCA) explains the need for a move to support a population health movement (page 34).

Finally, our Industry Voice section sees us hear from the Chief Executive of the Royal College of Midwives, Gill Walton. Ahead of us lies some tough months in health and social care, so turning towards collaboration and shared thinking will help us get the most out of this country's health expertise and best support patients throughout the ongoing situation.

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A HIDDEN GEM OF THE NHS

***Michael Brodie**, Chief Executive, NHS Business Service Authority*

The NHS Business Services Authority (NHSBSA) is "an extraordinary organisation, and NHS jewel". These aren't my words, but those of Duncan Selbie, Chief Executive of Public Health England, who knows a lot about what 'good' looks like. It's a great endorsement for an organisation that many, even within the health and care system, are not aware of. Perhaps that jewel has been too well hidden? I've been in post as Chief Executive of the NHSBSA for just over six months now and I am still astonished by the breadth and depth of the services we provide.

We of course all know that the NHS is our nation's greatest institution. It provides hope, it fixes us in our time of need and helps us to live longer and healthier lives, creating more memories with those that we care most about. But to be at its best, its most efficient and its most effective, the frontline NHS needs support; and the NHS Business Services Authority (NHSBSA) exists to provide that support. We are the expert delivery organisation relied upon by Government and the health and care system to provide a range of complex and essential high volume business services to support the day-to-day smooth running of the NHS. We provide a platform for at scale, national payments for primary care services to pharmacists and dentists. We support the NHS workforce providing employment, HR and payroll platforms, as well as providing financial support to NHS students and running the NHS Pension Scheme. And we provide a range of services direct to the public to help citizens in gaining access to the healthcare and support with health costs to which they are entitled. All in all, we manage about £35bn of health service transactions.

By transitioning these complex and complicated services, digitising, transforming and then delivering them once, nationally and at scale we can deliver better patient outcomes and great taxpayer value, generating significant savings for the NHS which can then be reinvested in frontline care. As we develop our role in the health and care system, the breadth and depth of services that we have been asked to undertake has grown significantly and we group them into three broad operational areas:

Platforms and services, we provide to the NHS to best support the workforce agenda and its people

Our support for the NHS workforce agenda starts right at the beginning of a prospective NHS employee's journey. From September we will be administering the new NHS Training Grant to support new colleagues through their training and we also help hundreds of thousands of people to find work each year or progress their careers with the NHS through our NHS Jobs service. Our national Electronic Staff Record system, with over one and a half million staff records, is the platform on which NHS organisations record essential workforce, skills and training information and make accurate and timely payments to our invaluable NHS workforce. And once our NHS colleagues have completed their careers, we support their retirement

through delivery of the NHS Pension Scheme – the largest pension scheme in Europe - which has over three million members and makes payments to NHS Pensioners of over £12bn annually. We also provide HR Shared Services delivering at scale, efficient and effective HR services to other organisations.

Services we provide to support essential primary care functions

We support primary care in the NHS by helping commissioners to manage their contractual arrangements with NHS providers and we support those essential providers of services to the NHS, in particular our pharmacy and dentistry colleagues. We do this by processing over one billion prescription items each year and nearly 50 million dental claims, making over £12bn of accurate and timely payments for the essential services they provide to patients and the public. So, in many ways we help to keep services in primary care flowing. We also provide a high-tech scanning service which saves NHS organisations money and, as importantly, vital office and operational space in their buildings.

Services direct to the public to support access to healthcare and help with health costs

Finally, we support members of the public in gaining access to healthcare services and the help with health costs to which they are entitled. Whether that be through the range of exemption schemes that we operate (such as maternity, low income, medical exemption schemes) providing free or reduced cost prescriptions or dentistry, or through our work supporting UK residents living or working overseas and the broader reciprocal healthcare arrangements with other countries. Each year we support around ten million citizens in this way. We have also recently taken over responsibility from the DHSC for a range of Healthy Foods schemes, all of which are key preventative and population health interventions.

Of course, it isn't just what we do that matters, what is equally important is how we do it. In many ways it defines who we are and our sense of purpose. We take pride in designing our services around the needs and experience of our users, of having a digital first mentality, whilst still ensuring a range of channels are available for the public to access our services. Our multi-award-winning contact centre is testament to our belief in inclusivity and accessibility of our services by all.

Because of the national and at scale nature of our services we produce and collate vast amounts of data. Our first duty is to ensure the safety, security and accuracy of this data and we understand and prioritise the importance of this data governance and stewardship role. We then apply our analytical skills to produce actionable insight and we collaborate and innovate with partners to use these insights to drive improvements in patient outcomes, patient safety and taxpayer value.

As the NHS and the government work to implement the NHS Long Term Plan (and supporting People Plan) and to deliver the Secretary of State's priorities for the NHS workforce, its Technology Vision for the NHS and its focus on prevention, working alongside NHSX, NHSE/I, PHE and NHS Digital we believe our portfolio of services and our capabilities are right at the sweet spot of this agenda. Our talented and dedicated colleagues across the organisation care deeply and passionately about supporting the NHS and despite delivering what many would class as back office or support services, we are all proud to say we are the NHS delivering for the NHS.

SHARING EXPERTISE

AN NHS PERSPECTIVE ON INTERNATIONAL PARTNERSHIPS

***Professor Chris Harrison**, Director, Lead International Programme, The Christie NHS Foundation Trust*

Since The Christie was founded over 100 years ago we have sought to share our expertise across the globe and work in partnerships to advance the treatment of cancer for all patients. Indeed the 'Manchester Method' of radium treatment, pioneered at The Christie in 1932, has been adopted around the world.

In an ever-shrinking world, the development of the first high energy NHS proton beam therapy service and the raised profile of the Manchester Cancer Research Centre have resulted in many more organisations seeking to affiliate with The Christie.

Academic and philanthropic opportunities have always flourished, through our diverse and highly motivated teams wanting to collaborate, but when it became clear commercial opportunities required more time and effort to reach maturity we established a dedicated clinically-led team to take on the challenge under the banner, The Christie International.

The team seeks to grow our reputation as a world-leading centre of excellence and to generate revenue through commercial partnerships with the proceeds being invested into cancer services for NHS patients in Manchester. Since its formation we have been able to engage with potential partners in a more systematic way to better understand the requirements for the oncology service they wished to develop, and the time burden on a wider group of clinicians in hosting introductory international visits.

Our starting point with new approaches has evolved from endeavouring to understanding a potential partner's needs and developing a bespoke offering, to a more proactive position of offering specific product packages, such as the International Affiliate Programme and International Fellowships.

As an NHS organisation with constraints on marketing expertise and travel budgets, we have targeted certain key markets and aligned ourselves with other UK exporters, trade bodies and industry partners, which has not only helped to discern credible client approaches, but has specifically facilitated our engagement with a number of international partners, providing in-country expertise and leading to commercial contracts.

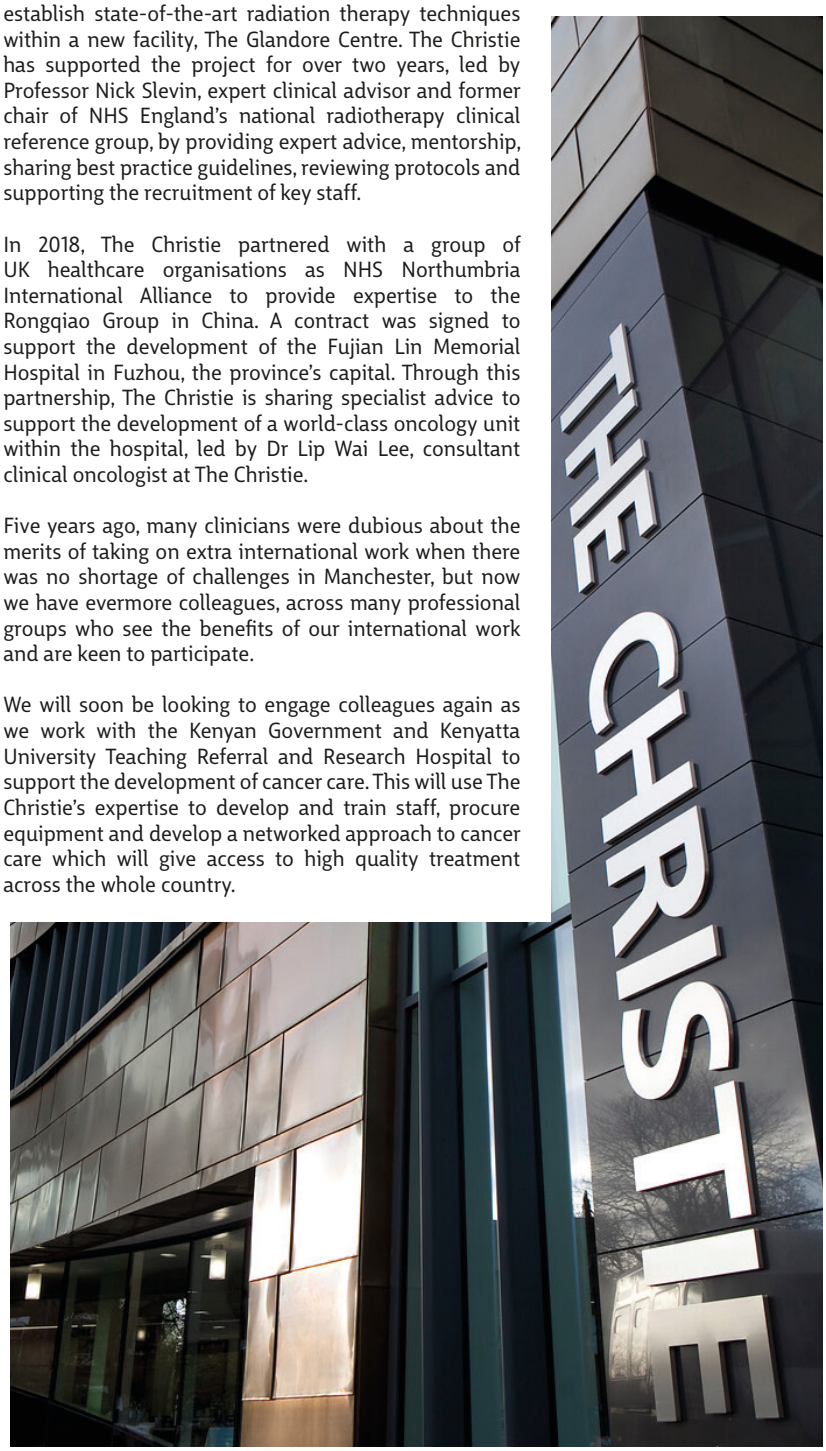
In 2017, a partnership was established between Cork University Hospital (CUH) and The Christie.

Through the identification of key service priorities within the National Cancer Strategy for Ireland and its consequent funding, CUH was given a unique opportunity to fundamentally change how radiation therapy services could be delivered at the hospital and establish state-of-the-art radiation therapy techniques within a new facility, The Glandore Centre. The Christie has supported the project for over two years, led by Professor Nick Slevin, expert clinical advisor and former chair of NHS England's national radiotherapy clinical reference group, by providing expert advice, mentorship, sharing best practice guidelines, reviewing protocols and supporting the recruitment of key staff.

In 2018, The Christie partnered with a group of UK healthcare organisations as NHS Northumbria International Alliance to provide expertise to the Rongqiao Group in China. A contract was signed to support the development of the Fujian Lin Memorial Hospital in Fuzhou, the province's capital. Through this partnership, The Christie is sharing specialist advice to support the development of a world-class oncology unit within the hospital, led by Dr Lip Wai Lee, consultant clinical oncologist at The Christie.

Five years ago, many clinicians were dubious about the merits of taking on extra international work when there was no shortage of challenges in Manchester, but now we have evermore colleagues, across many professional groups who see the benefits of our international work and are keen to participate.

We will soon be looking to engage colleagues again as we work with the Kenyan Government and Kenyatta University Teaching Referral and Research Hospital to support the development of cancer care. This will use The Christie's expertise to develop and train staff, procure equipment and develop a networked approach to cancer care which will give access to high quality treatment across the whole country.



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THE PANIC OF NHS PRIVATISATION

***Kristian Niemeitz**, Head of Political Economy, Institute of Economic Affairs (IEA)*

The TV series "The Simpsons" uses a narrative device called a "floating timeline". This means that even though the series is always set in the present (it has always contained plenty of references to contemporary politics, contemporary pop culture, etc.), the characters of the show never age. Bart Simpson is always ten years old, Lisa Simpson is always eight years old, and Maggie Simpson is always a toddler.

There is a peculiarly British type of popular fiction which uses a very similar narrative device: *The Great NHS Privatisation Conspiracy*.

The story goes like this: The NHS is being privatised. Now. Right under our nose. Before our very eyes. If we don't act immediately, then in a few years' time, there will be no NHS left.

The trouble is, if you look up healthcare-related news stories from ten, twenty, thirty or forty years ago, you will find that people have always been saying this. Sure, the details will be a bit different. The names of the

IT IS WRONG TO EQUATE "PRIVATISATION" WITH "AMERICANISATION"

people accused of doing the privatising, and the precise mechanism through which this is supposedly being done, will have changed. But the basic storyline has always been the same.

Most recently, we have been panicking about a post-Brexit UK-US trade deal, which will supposedly mean selling off the NHS to Donald Trump. In the early 2010s, it was the (now largely forgotten) Health and Social Care Act, overseen by the (now also largely forgotten) then-Health Secretary Andrew Lansley, which was supposed to spell the end of the NHS.

In 2011, Kailash Chand, the Honorary Vice President of the British Medical Association (BMA), wrote in the Guardian: "The British Medical Association [...] thought it necessary to call a crisis meeting of its members [...] to consider its position in relation to Andrew Lansley's plan to [...] prepare the NHS for privatisation.

"The BMA must [...] unmask Lansley's reform agenda for what it is – the final step in the privatisation of the service."

Nearly a decade on, the NHS is still around, but this has not stopped the same articles appearing again and again, with the specifics subtly updated.

Further back, in the mid-2000s, some saw the Blair government's reforms as privatisation through the backdoor. In 2004, Professor Allyson Pollock of Newcastle University published her book 'NHS Plc: The Privatisation of Our Health Care', which received rave reviews in papers like the Guardian: "Our government [...] has been progressively and furtively dismantling our life-support systems and auctioning them off to the highest bidder.

"There has clearly been a long-term plan at work.

"Pollock shows the only choice people in the UK will enjoy when the process is complete is whether or not to take out insurance and accept the prospect of escalating co-payments, or go without any healthcare provision at all"

Events didn't quite pan out as such, and twelve years later Professor Pollock published a sequel entitled 'The End of the NHS' with many of the same fears for the healthcare service's privatisation.
In the 1990s, the purchaser-provider split triggered a wave of privatisation panic, and in the early 1980s, the Times lamented: "It is no exaggeration to say that the Health Service is now under serious threat. [...] There is no doubt in my mind that the NHS is in danger and over the next five years we could find ourselves drifting towards American-type [healthcare]"

NHS privatisation panic is a lot like a Millenarian cult, which just keeps pushing the date of the apocalypse (or whatever it is they are predicting) further and further into the future. Except, it is worse, because Millenarian cults at least have to come up with some excuse why it did not happen last time, whereas NHS privatisation fantasists can just use their Simpsons-style floating timeline.

The truth is that the NHS only spends about one tenth of its budget on purchasing services from non-NHS providers, and this includes local authorities as well as charities and private companies. If we take the broadest possible definition of "private", including GPs, dentists, pharmacists and optometrists, the proportion rises to just over one fifth, but of course, people in most of these professions have always been technically self-employed. And whichever way you define 'private spending', the proportion shows no signs of increasing.
For the record – I would not have the slightest problem with privatising substantial proportions of the health service. It is wrong to equate "privatisation" with "Americanisation". The closest thing to a fully privatised healthcare system is not the (admittedly dysfunctional) US system, but the universal private health insurance system of the Netherlands. In the Netherlands, everybody has private health insurance (subsidised if necessary), and virtually all healthcare providers are private (although regulated). Healthcare spending is a bit higher than here, but clinical outcomes tend to be a lot better, and the system is just as equitable as the NHS.

But that is an altogether different topic. Privatisation is not happening, was never going to happen, and will not happen anytime soon.

However, will we ever stop panicking about it? Let's just say, it is more likely that the Simpsons children will grow up one day.

IMPROVING OUTCOMES FOR PEOPLE WITH ARTHRITIS

***Professor David Warwick**, President, British Society for Surgery of the Hand and Consultant Hand Surgeon, University Hospital Southampton*

Osteoarthritis and rheumatoid arthritis – the two most common types of arthritis – affect millions of people in the UK, negatively impacting their quality of life by causing painful and stiff joints. The most common sites in the body for osteoarthritis are the spine, knees, hips, hands and wrists.

Around 8.75 million people in the UK aged over 45 have sought treatment for osteoarthritis. By 2030, one in five people in the UK will be aged 65 or over and so with a growing and ageing population, this demand will only likely to increase.

Indeed, over the next 10 years, it is anticipated that there will be an increase of almost 40% in hand surgery for common conditions such as osteoarthritis and other degenerative hand problems. Reduced hand function has a significant impact on people's independence, their ability to carry out normal day to day activities, and their general quality of life.

There is a lot that can be done to help people with osteoarthritis in the hand or wrist. Non-surgical treatments such as painkillers, splints and steroid injections can help. If these are not adequate then surgery is considered.

Traditionally, an arthritic joint in the hand was fused. This took away the pain, but at the expense of all-important functional movement. However, joint replacements are now available for the wrist, thumb and fingers. Although less commonly performed than hip or knee replacement, joint replacement in the hand or wrist can successfully relieve pain while preserving the range of motion that people need for daily life.

But whereas joint replacements for arthritic hips and knees are nowadays extremely reliable and durable, current designs in the hand and wrist are still in a developmental phase. When they work well, patients' lives can be transformed but the outcomes are unpredictable and sometimes rather disappointing.

With further investment to enable both development by engineers and good quality clinical studies, we can develop the best possible implants which provide a long-lasting solution for symptomatic hand and wrist arthritis.

Of course, the NHS is stretched, with multiple pressures for resources. Yet we should not neglect investment into joint replacement of the hand and wrist, since advances in this area would have significant benefits for so many patients with arthritis, enabling them to enjoy the full use of their hands, helping them to stay active and independent.

John Welch
Deputy Director
Construction

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BRITAIN'S DEPENDENCE ON PAINKILLERS: WHAT ARE THE ALTERNATIVES?

Marc Sanders, *Chiropractor and Member of the British Chiropractic Association (BCA)*

For centuries, painkillers have been used to treat a wide range of conditions, and it's no different today; from 2017 to 2018, 5.6 million adults in England (13% of the population) were prescribed with opioid pain medications. The accessibility of painkillers, their low-cost margin, and effectiveness make them an easy solution for managing musculoskeletal pain.

Yet, studies are increasingly demonstrating that patients experiencing chronic back pain may be more responsive to other types of treatment. Our current most-widely used treatments such as opioids, spinal injections, and surgery are failing to address the burden of back pain disability; musculoskeletal conditions are the number one cause of disability in the UK, and this will likely continue to rise globally, as the years lived with disability caused by low back pain increased by 54% between 1990 and 2015.

What's more, Public Health England (PHE) found that over half a million people have been taking opioid painkillers to treat chronic conditions such as lower back pain for more than three years. Experts have warned that these opioid drugs are highly addictive, with over-the-counter medications such as paracetamol or ibuprofen being just as effective for chronic pain conditions. Whilst painkillers are a viable option for managing high levels of pain short term, there are often safer and more effective options available for patients who are treating ongoing conditions; yet non-pharmacological treatment is still not being widely utilised.

Where does the harm lie?

Firstly, it's important to make the distinction between prescribed opioids and widely available painkillers, like ibuprofen. Prescribed opioids, by their nature, are more effective in targeting and managing pain in the short term such as after trauma or post-surgery, or for palliative care. However, the current NICE guidelines state that opioids should not be routinely offered for acute low back pain as benefits are minimal, and they should not be offered for managing chronic low back pain for the vast majority of sufferers.

PHE found that people are increasingly taking prescription drugs for longer periods of time without a tapering plan, increasing their risk of addiction and withdrawal. There's also little research into the long-term effectiveness and safety of taking these medications for chronic back pain. Short term use has possible negative side effects, including constipation and sedation, and an increased risk of falls. Over-the-counter medications such as ibuprofen don't carry the same heavyweight side effects for healthy individuals taking lower doses short term, but in themselves can present risks from prolonged exposure and at higher doses.

The NICE guideline on low back pain and sciatica recommends that weak opioids (with or without paracetamol) are reserved for managing acute low back pain only when a non-steroidal anti-inflammatory drug (NSAID) is contraindicated, not tolerated or has been ineffective.

Experts also know there is a risk of building a tolerance to these painkillers, and in some cases develop a phenomenon known as opioid-induced hyperalgesia, where there is a paradoxical increase in pain by taking an opioid medication. There is an alteration in the normal functioning of cellular and molecular pain mechanisms as a result of prolonged exposure to opioids, which leads to an increase in perceived pain levels beyond what the patient originally had.

Understandably, patients then take a higher or more frequent dose of the medication to manage their pain, resulting in an ineffective pain management cycle. It's clear that in most cases, these painkillers often aren't an effective pain management solution long term, or in isolation.

What are the alternatives?

Health care professionals across the industry should first consider self-management advice and information tailored to an individual's specific needs and capabilities. They should offer a wide range of treatments as a package of care rather than reliance on a single intervention, before prescribing opioid medication for lower back or chronic pain. The American College of Physicians recommends that nonpharmacologic treatment should be prescribed in the first case for chronic back pain conditions.

These treatments include a range of non-medication-based care; heat packs, massage, spinal manipulation, psychological therapies including cognitive behavioural therapy and a range of lifestyle changes such as mindfulness-based stress reduction, diet and most importantly exercise, have all proven to be successful treatment options for chronic back and neck pain. It's worth noting that these conservative treatments would not be suitable for a patient suffering with non-mechanical pain such as fractures, infection, inflammatory joint conditions and tumours, hence the importance of early triage of these patients by primary care practitioners with the appropriate skill set.

However, the recent Lancet Low Back Pain series has found that these guidelines largely aren't being followed. Opioid painkillers are still being prescribed as a first point of call, as demonstrated in recent studies. This isn't necessarily a result of the patients' or professionals' decision, but rather a lack of awareness of the range of treatments available, and how effective these can be in managing chronic back and neck pain.

Numerous studies show that chiropractic care is effective in treating these conditions. The profession focuses on non-medication-based treatment plans for patients, assessing their particular case and working with them over a longer period of time to find the best self-management solution for their condition to promote physical activity and function. I have treated patients who have been living with chronic pain for decades, and who have tried several different options ranging from medication to surgery. Even in these cases, chiropractic care, a package of evidence-based interventions, improved the management of their pain.

Recent studies have shown that those who use chiropractic care or physiotherapy are less likely to use opioids in the short and long-term. Those who use chiropractic care are less likely to be prescribed opioids by their doctors, and are prescribed opioid prescriptions less frequently after seeing a chiropractor. Incentivising use of conservative therapists such as chiropractors, physiotherapists, or osteopaths may be a potential strategy to reduce the risks of early and long-term opioid utilisation.

For chronic pain sufferers, we provide them the time and space to disclose their personal pain story including beliefs, concerns, emotions, social and lifestyle factors, perceived barriers to improvement and their personal goals. Non-medication-based care has proven time and time again to be an effective solution for chronic pain conditions – this is a gap we need to bridge.

Looking to the future

The treatment options now available present a great opportunity for closer collaboration between medical professionals, to ensure the most effective treatment plans are created for patients suffering with chronic back pain. Alongside collaboration, the improved distribution of information will allow both patients and professionals to understand fully the side effects of taking painkillers long term and the other options available.

This will take time, but there are steps we can take in the immediate. Chronic pain is complex to assess and manage; ensuring the best possible pain management training is available for all healthcare professions at an undergraduate or postgraduate level could be beneficial in increasing our understanding on chronic pain, what services are available, and which are most effective for individual cases.

Considering chiropractic care could also help support the NHS. Integration of chiropractors within the NHS, such as in First Contact Musculoskeletal Practitioner roles, who have the competencies and skills as outlined in the recent Royal College of Chiropractors document, would allow the sharing of expertise to the benefit of patients and NHS colleagues, as well as providing another workforce to help reduce the increasing GP workload. Additionally, adopting an approach similar to the Danish Healthcare System where chiropractors are integrated within secondary care, integration of chiropractors within multidisciplinary pain management teams in the UK may help provide an additional range of treatment options for those suffering from chronic pain conditions.

In the short term, I believe we should be working to increase communication across the industry through interprofessional learning, to allow for better co-management to ultimately improve patient care. When armed with all the information, patients can work alongside their GP and other healthcare professionals through shared decision making, to make a more informed choice about their available treatment options and their effectiveness.

THE POWER OF COLLABORATIVE WORKING AND FLEXIBLE BUILDINGS

Eugene Prinsloo, *Developments Director, Community Health Partnerships*

Beckenham Beacon Health Centre is one of three hubs covering the population of the London Borough of Bromley. It serves around 100,000 people, providing urgent care, GP services and physical and mental health community-based services. It is a jewel in south east London's NHS estates programme, which is focused on providing well-utilised clinical space in sustainable and environmentally friendly accommodation, designed to meet the growing health needs of residents. Most importantly, it enables integrated clinical care to be provided out of hospital and in an accessible community centre well served by public transport links.

One Bromley, the local care partnership, is made up of Bromley Clinical Commissioning Group (BCCG), Bromley health providers, the council and voluntary services. It brings services together to provide personalised and joined up care for local people. The estates programme is crucial to ensure there are modern, high quality, accessible and affordable premises where integrated care can be delivered. Community Health Partnerships (CHP) worked with all the partners to meet the requirements of the CCG vision.

Deadlines were tight because the local Oxleas services, previously based in Penge, had been given notice to quit their existing accommodation before the end of December 2019, as the owner wished to redevelop the site.

The space has been transformed. On the first floor, the original office space has now been turned into fit for purpose clinical space to accommodate mental health services. In addition, rooms are available to service providers who can book space, increasing utilisation.

The scheme enables an improved mix of services to be delivered from facilities designed and equipped to deal with the ongoing healthcare needs of the local population and improve patient outcomes. It significantly contributes to strategic-level plans for BCCG by:

- Providing modern, high-quality premises for integrated healthcare in the area which are CQC compliant and meet the relevant standards, including for accessibility
- Delivering better-equipped accommodation for clinical services
- Allowing for the use of new technologies to save time and reduce workload for staff
- Providing increased clinical capacity
- Increasing utilisation at the Beckenham building

The project was led by the CHP Developments Team who worked with the stakeholders including the landlord (LIFT Company), Infracare South East London Limited, to ensure that the work was delivered to the highest standards within the strict timescales.

Mark Cheung, Deputy Managing Director of NHS Bromley CCG said: "The NHS has to continue to flex and develop around the growing and changing needs of the people we take care of. Providing more integrated care closer to home and out of hospital is a national priority.

"Having a community estate made up of buildings that are fully utilised for the purpose they were built, which are accessible and meet sustainability and environmental standards, supports the delivery of more joined up proactive care that will help people stay well and out of hospital.

"This was a huge undertaking and delivered in a very short space of time. It is testament to the professionalism and capabilities of all those involved that we succeeded."

Eugene Prinsloo, CHP's Developments Director, said: "CHP is pleased to have supported an urgent healthcare need; and to have been part of the collaborative team that made the changes possible. Maximising the clinical use of core healthcare buildings for health economies is key to what we do."

The £1.83m scheme was funded by a combination of a Section 106 grant and an STP Wave 4 grant. The variation should result in revenue savings of £275,000 to the CCG to help fund other priorities.

CHP has worked on 40 variations with a value of £16m in the past six years to ensure that our buildings are flexed to meet changing healthcare needs.

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005 Stewart Lucas

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003 Lord Victor Adebowale CBE

Chief Executive of Turning Point, Lord Victor Adebowale CBE, joins us for this on the go podcast to discuss the UK healthcare landscape and his new role as Chair of the NHS Confederation.

004 Mark Duman

Chief Patient Officer at MD Healthcare Consultants. He believes strongly in patient-focused care, explaining why we "need to personalise healthcare a lot more"

005 Stewart Lucas

Strategic Lead for Mind in Greater Manchester, Stewart Lucas, joins us for this on the go podcast to discuss mental health care in the UK and how he feels it is at present about 100 years behind where we are with physical health.

Coming up

006 Henry Jones

CEO, Big White Wall

007 Lindsay Courtney

Home Group

008 Michelle Nix

Parking Eye

STEP IN THE RIGHT DIRECTION

***Dr Sally Moyle**, Deputy Dean of the Faculty of Health & Applied Sciences, University of the West of England*

The Government's announcement that it will offer new grants for students in health-related courses is a welcome step in the right direction to support the next generation of health professionals.

From September 2020, all new and continuing degree-level nursing, midwifery and many other allied health students will be able to take advantage of the offer, with students set to receive at least £5,000 per year and some students eligible to receive up to £8,000 per year to help cover living costs. Importantly, the funding will not have to be repaid by recipients.

Some might criticise the plan as a political plaster to mitigate against the decision to remove bursaries in England in 2016 and an attempt by the Government to deliver on its pledge of an additional 50,000 nurses by 2025. There is no denying the NHS is facing a staffing crisis: across its trusts there are over 44,000 registered vacancies in nursing alone, according to research from the Health Foundation. In addition, the same report highlights further shortages among midwives, permanent qualified GPs, primary carers and more.

These figures underscore the severity of the skill shortage. How can we expect the service to keep pace with an ageing population, respond to outbreaks like the coronavirus, and manage other pressures – such as prolonged waiting times and bed shortages – if it is severely understaffed? Investing in a skilled NHS workforce is therefore a strategic necessity for the long-term health of the service as well as the patient care experience.

However, it is important to remember that a quality education equips our healthcare professionals with the best possible training, and this ultimately serves to enhance our society. Education provides a key avenue by which we can address the growing demands within the NHS. We need to consider how many students have missed the opportunity to pursue a healthcare career due to financial constraints. This is certainly a challenge facing mature students who already may have financial burdens and family commitments. Equally, we also know that we lose many excellent students due to financial hardship.

Providing financial support to students will improve access to education, thereby attracting excellent students and bolstering the national pipeline of talent in these in-demand areas, and ultimately strengthening the NHS as a whole.

If universities can leverage this new funding to strengthen the support framework they provide to students as part of their education journey, we can help train more healthcare students and address the pipeline shortage that is in currently in place.

At UWE Bristol, we welcome this financial support package and understand the significance it has on our current and future healthcare students. We welcome and encourage students from a diverse range of backgrounds. Alleviating the financial pressures of student life and placements will allow our students to focus on their training. And, if we can train more students to be nurses, midwives, paramedics and allied health professionals, we can help ensure the NHS has the staff it needs to provide effective and safe healthcare to all.

Enabling NHS estate transformation

Community Health Partnerships Ltd (CHP) was established to dramatically improve access to primary care and community health services across local communities through Public Private Partnerships (PPP).

CHP is wholly owned by the Department of Health and Social Care and a key member of the NHS Family. We enable the transformation of health, social care and wellbeing services by improving the NHS estate they occupy. Our 308 properties form 5% of the NHS property portfolio.

We plan to grow investment; linking public and private sectors, taking asset management to a new level, and providing exemplars of well utilised, fit for purpose infrastructure. We seek to deliver world-class services and outcomes for the communities we serve.

In 2013 we took on the role of Head Tenant from the former Primary Care Trusts. We have added to our already expert capability and worked hard to positively contribute to health outcomes through better management of our estate.

We are pathfinders and experts in working in partnership and we use our specialist expertise for estate planning, investment, design, construction and property management; offering 'cradle to grave' property investment and management services.

We will take the lead in developing community-based infrastructure which enables local delivery of care. We have the expertise to assess and implement the best solutions for individual communities and projects.

"This obesity clinic would not have been possible if it wasn't for this building

Dr Hendrow, CQC outstanding GP, Bransholme Health Centre, Hull

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NHS

Department of Health & Social Care

INVESTING IN COMMUNITIES, BUILDING FOR THE FUTURE

E-ROSTERING: IS 2021 A REALISTIC TARGET?

***Dr Ben Marchini**, Rostering Product Manager, Skills for Health*

In 2019, the government released its highly anticipated NHS Long Term Plan setting out the future ambitions that the service should achieve over the next ten years. The plan focuses on key development areas to support the growth and sustainability of a highly skilled and effective workforce, to meet the needs of the UK's public health system.

Within the priorities outlined, a substantial focus considers the need to implement electronic rostering (e-rostering) across the NHS, reducing pressures and to ensure the workforce are in the right place, at the right time, to effectively meet patient demand and improve patient care.

The commitment to rolling out total workforce e-rostering across NHS Trusts in England outlines rather ambitiously, that in 2021 an electronic rostering solution for planning staff shifts should be introduced, moving away from paper-based systems.

Whilst adoption of e-rostering has been growing steadily, we have found through our recent research into NHS rostering, that there is still a significant amount, over 25% of participants from NHS Trusts and departments within trusts using paper-based rostering.

So, the big question is, is this 2021 ambition feasible? How will these Trusts be able to make the jump over the next 12 months, and do so in a safe and successful manner, across the entirety of their workforce?

Our research indicates it's not as simple as getting a system and signing everyone up. In fact, many factors can affect how a Trust would be able to effectively implement a rostering solution, and crucially getting staff well trained on how to use it.

Our e-rostering research also found that:

- Over 40% of managers who responded said they regularly spend time out of work creating and amending rotas, indicating that there's limited time currently available to effectively manage rota's during working hours
- If managers could reduce time spent amending rosters, they would be able more readily perform other critical tasks such as clinical duties, teaching, auditing, staff management and engagement, tasks closely linked to upskilling and staff retention
- 63% of participants claim their current organisational rostering process is not fit for purpose, indicating that significant investment is needed to develop rostering that really meets the needs of the NHS if it is going to be effectively adopted by 2021
- A quarter of respondents, which included participants from across multiple workforce groups, said they are still using paper-based e-rostering such as using word documents or spreadsheets, suggesting that the target of delivering electronic rostering across the NHS by 2021 may be too ambitious.

Our research into electronic rostering demonstrates that there is still some uncertainty around the development, implementation and adoption of e-rostering across the NHS.

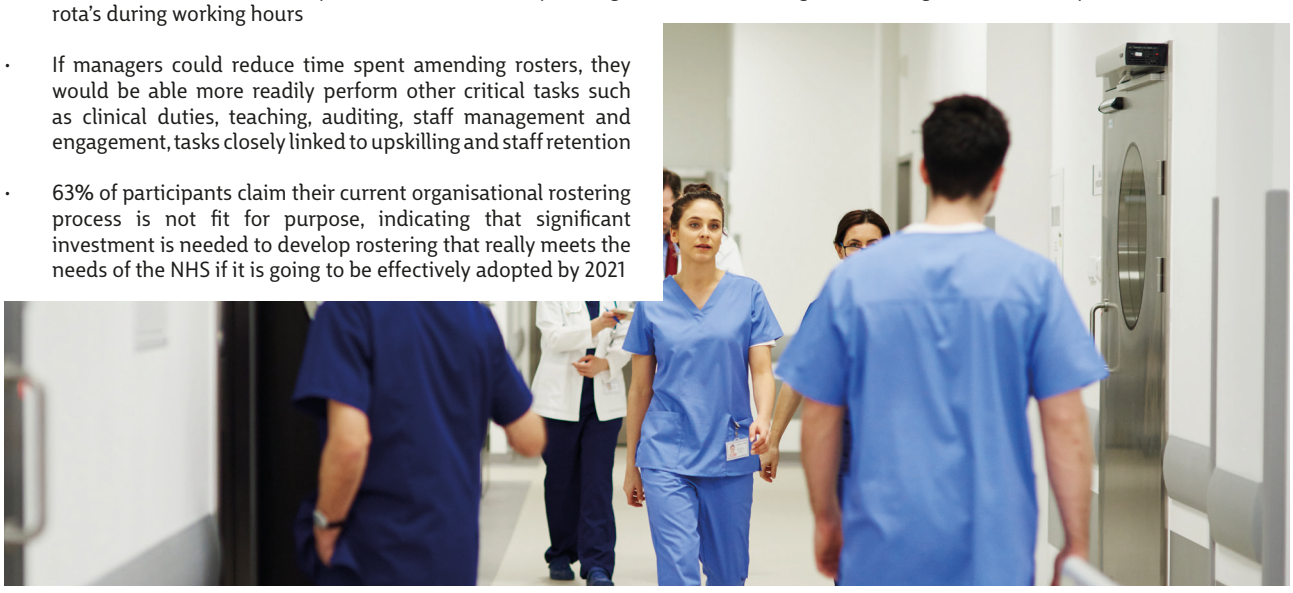
What can Trusts do about it?

E-rostering needs to be a total workforce solution. It affects more than just shift patterns and annual leave bookings. It's a cultural shift in how managers and leaders work with their workforce, allowing them to work with flexibility and in real-time. New system implementation needs careful consideration in how staff are expected to adopt the solution, manage their time and crucially ensure the benefits of e-rostering are realised. The critical thing is remembering, it's not the system, but the people who use it, who make it work for them.

The NHS long-term plan is a significant step forward in setting the service on a sustainable course for the next decade. However, the challenge remains in its successful delivery. Even with exceptional leadership and the continued commitment of staff, delivering the e-rostering needs for the NHS in such a short space of time is a daunting task.

Our expertise in workforce development and deployment means we have a deep knowledge and understanding of the challenges and opportunities that putting an effective e-rostering strategy into practice can cause. We know from experience how crucial it is to engage with experts who have been through this, who have lived it, and fundamentally are here to support the sector.

Step into our world of total workforce solutions, by speaking to an NHS e-rostering consultant, get in touch today.



EvoNorth Review

Health innovation: the next step

Across the UK health and social care industry, we are always looking for ways to maximise both the quality and efficiency of care we provide to patients. In the North of England, a combination of top academic institutions, innovative health organisations and trusts and a pool of pioneering minds have seen the region become a hub of health innovation. As such, in Manchester where some of the most significant innovation has been undertaken, EvoNorth gathered three such bright minds involved in the sector for a fascinating, insightful panel discussion.

With panellists Guy Lucchi, Director of Innovation for Health Innovation Manchester, Warren Heppolette, Executive Lead for Strategy, Greater Manchester Health and Social Care Partnership and Phil Jennings, Medical Director at NHS Innovation Strategy, all imparting their knowledge to the audience, attendees heard extensively about how Greater Manchester is realising health innovation and how we can filter those benefits out to a wider population.

Digital innovation was without question one of the shared identified locations where significant improvements could be made. Both Warren and Guy turned to the digital shift we're seeing in healthcare at present as way of the NHS continuing to improve patient care, as well as managing workforce challenges.

Guy told the audience: "Digitally, everything we do in our day to day life has been transformed. This level of transformation needs to be mirrored in healthcare for us to see positive change across the sector."

Ensuring GP practices are digitally-enabled was one key, achievable aspect of digital innovation in the near future. At present, Guy explained, some GP practices were digitally-enabled, but others were not, with a very patchy coverage map. That meant not all patients could take advantage of possible benefits including video consultations, which can make healthcare more accessible for a wide range of patients.

It's not just about spending more money on technology, however. Whilst advocating the healthcare service looks to innovation, Guy also expressed reasonable equal investment in people and processes: "The transformation needs to be controlled & my viewpoint on this is simple. If you spend £1 on #technology then you must spend £3 on people & process."

Tackling wider population health, targeting not just direct reactionary medicine but also patient wellbeing and implementing a wide range of preventative actions across entire social scope, there was a consensus belief that potential challenges and strain on the healthcare service could help be alleviate by improving aspects of patients' lives such as adequate housing or employment – which would actively impact and improve their health inadvertently.

Phil explained: "The biggest health intervention you can make is to give them a job."

That was very much the message. Innovation didn't just mean flash new technologies or machinery, but a real culture and thought shift. Healthcare needed to be integrated tightly with the rest of society. Warren told the EvoNorth crowd: "[The healthcare service] must be earlier to intervene. At present we have a system ready to intervene in a crisis rather than being good at responding to early signs."

The NHS also had to improve at adopting innovations faster, Phil told the room. Currently, in his eyes, the national healthcare service has no problems with discovery, but was very slow at adopting new innovations. Describing the current system as Byzantine when it came to understanding who was needed to speak with to introduce innovations, who made decisions and where the money to fund these developments came from, Phil stressed the need to accelerate that process of adoption and spreading that innovation nationally.

As was clear throughout the panel, all three experts were very clear and positive in the belief that health innovation was possible, happening every day and a real opportunity going forward, but it would require clear support and guidance to maximise its potential.

EvoNorth Review

Warren Heppolette

Warren Heppolette, Executive Lead for Strategy, Greater Manchester Health and Social Care Partnership

Health innovation always sparks fascinating conversation and the Digital Health Innovation panel at EvoNorth 2020 was no different. Afterwards, NHE grabbed a moment of Warren Heppolette's time to find out more from the Strategic Lead for Strategy at Greater Manchester Health and Social Care Partnership.

As heard from both Warren and his fellow health panellists Guy Lucchi and Phil Jennings, Greater Manchester in particular is home to some real, exciting health innovations, in part due to the burgeoning life sciences sector in the region.

As Warren described: "Health innovation, because of the size of the life sciences sector in Greater Manchester's economy, is a critical feature of us unlocking the economic potential of the region and potentially the North of England.

"It is also key to unlocking the potential of new treatments, and making them available first in Greater Manchester."

Achieving this comes down to recognising the criticality of the relationship between industry, academic institutions and the health and care system across the region. Only collectively, through close collaboration, can we successfully unlock the potential that health innovation holds.

That collaboration must occur on multiple levels too, Warren explained to us. Collaboration between health and care providers and commissioners is still as necessary as ever, ensuring that everybody is on the same page and we get much-needed resources, capacity and ideas all facing in one unanimous direction.

However, to truly maximise the potential of not just Greater Manchester's healthcare scope but the wider North's, we must look further too. We have to think beyond the formal health and care system, to the contributions which can be made by academia, industry and wider public services to unlock what Warren described as the "alchemy of the health potential in the North".

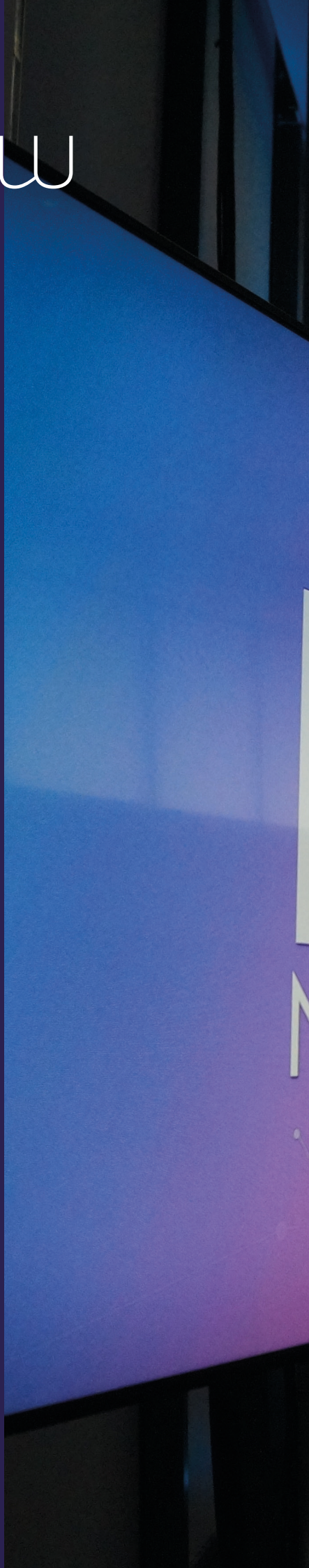
It's about growing the North and accessing that health and wealth paradigm, but in a manner, which still allows every resident in the North of England to participate in the benefits of that growth. That comes through collaborative working across all sectors.

Warren described it simply: "The key thing is to be open to where new ideas might come from. Be humble, because everyone has expertise.

"There's a lot of expertise in the health sector, but its not always as open as it might be as to where innovation and bright ideas may come from outside the health sector [even though] these could be a critical part of our long-term sustainability.

"It's thinking about if the NHS is there just for when people fall over, or is there an opportunity for us to prevent people falling over in the first place. So, it's thinking differently about whether we're a crisis response or whether we're alert to the first signs of symptoms of declining health and whether we're able to organise a very different response.

"Some of that might not be formal medical care. Some of that might be more of a social intervention because that probably is what prevention looks like and if the healthcare system is going to be sustainable over the coming decades, we've got to think much more seriously about shifting the balance of intervention towards early help and prevention."

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OUR LIVES ARE BETTER WHEN THEY'RE SHARED

Alex Fox, *Chief Executive, Shared Lives Plus*

With latest figures showing delayed transfer of care (DToC) at its highest quarterly level since 2017 – reversing years of progress - the concept of shared living, in which people can be cared for in the professional carer's own home, is being touted as a way of resolving an issue that many senior NHS staff probably thought was behind them.

It may surprise some of them to know that Shared Lives Plus, the national charity and membership body for over 150 Shared Lives schemes across the UK, has been working closely with NHS England since 2016, helping to try and discharge more patients back into the community, as part of a pilot scheme working with seven CCGs across England.

With the project due to finish this month, Alex Fox, Chief Executive of Shared Lives Plus, wants this to act as a springboard for further growth: "We now know that Shared Lives excels in challenging situations, such as acquired brain injuries or mental ill health, or where there are combinations of conditions where the traditional NHS model doesn't quite fit.

"But the biggest benefit is that it's personal – allowing people who want to leave hospital to continue to receive support from a specialist carer, in a family home and community they have chosen, rather than traditional care options."

Shared Lives has a 40-year history in social care and for much of that time has traditionally supported people with learning disabilities, although based on recent experience, Fox is keen to highlight a much more flexible model: "The project achieved some inspiring and heart-warming outcomes, although it was also clear that several factors, such as access to good information and expert advocacy, as well as buy-in from existing Shared Lives schemes, are also essential.

"We also found out how challenging it can be to change the system and persuade busy NHS teams to understand, value and use a very novel approach to health care."

To coincide with the project's conclusion, an evaluation report, published by Shared Lives Plus and with a joint foreword by Alex Fox and James Sanderson, Director of Personalised Care, NHS England, has also been released, identifying key findings and conditions for success, such as strong senior leadership, a commitment to partner with local Shared Lives schemes and a jointly owned communications strategy: "We are realistic about the challenges, which are clearly detailed in the report, but we also recognise there is huge potential to change how we think about patient journeys and outcomes.

"Personalised health care is about people who make extended use of health services getting more choice and control over their support, through personal health budgets and other mechanisms, but also about creating new opportunities for people throughout the health and social care world to get the support they need.

"Shared Lives has certainly proved its worth in social care and we believe it has a future as a life-changing and ground-breaking option for NHS patients, and we are passionate about scaling Shared Lives as a new choice of health care."

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ACCESSIBLE INFORMATION IS POWER

***Michael Wordingham**, Policy and Campaigns Officer, Royal National Institute of Blind People (RNIB)*

As part of my role as a Policy and Campaigns Officer for the Royal National Institute of Blind People (RNIB), and as someone who has sight loss, I speak to many fellow blind and partially sighted people about the barriers we face as we try to manage our health.

When the NHS Accessible Information Standard (AIS) came into force in July 2016, it was supposed to mean that information about our healthcare or appointments would be provided in accessible formats, such as digital formats or large print. It was intended to allow those of us who have a reading disability to access health services and make decisions about our health, wellbeing, care and treatment independently.

However, three years on from the introduction AIS, many people with sight loss still do not receive health information in a format they can read. In fact, a quarter of all calls to RNIB's campaigns hotline are about inaccessible health information.

NHS England published comprehensive guidelines in the summer of 2017 which identified "significant qualitative and financial benefits of the AIS, including some which are potentially cash-releasing." They showed that, by using the AIS, Health Trusts can give us the ability to fully participate in decision making and allow us to take ownership of our health care – increasing compliance overall.

Numerous benefits come from the AIS, including:

- Ability to understand and follow information regarding medication management, care, treatment, etc. independently
- Primary care services being used more often and effectively
- A reduction in complaints around information being inaccessible

But, due to a lack of compliance with the AIS, a lot of these benefits are not being realised. All too often as blind and partially sighted people we are being put in humiliating, distressing and dangerous situations.

Rachael from the East of England told me: "I have had a chronic pain condition for 17 years and I was discharged from the pain clinic because I missed two appointments due to them sending me letters, I couldn't read. I have also had my pain medication withheld by the pharmacists, as they have been told by the doctor that I missed a medication review."

Our confidentiality is being regularly breached, as Bernie told me: "Following the procedure, I was given a report by hand, which I couldn't read. A carer I had never met before had to come and read it to me. It was such a sensitive situation; it could have been really bad news."

People with sight loss are even making difficult journeys to appointments, only to be turned away due to appointments being changed and the letters sent notifying patients being inaccessible. This is what happened to Kerry, who told me: "I turned up expecting to be seen at the eye clinic one afternoon as arranged only to discover that my appointment had been changed."

Blind and partially sighted people have even resorted to legal action against their Health Trusts, and as Nigel Evans MP wrote in a letter to a trust in his constituency: "My constituent should not have to battle in such a way to receive the information he is entitled to."

As UK health officials grapple with the spread of coronavirus, the outbreak is a stark reminder of the importance of effective communication between health care providers and their patients. With one in five people aged 75 and over living with sight loss, failure to implement the AIS puts the most vulnerable members of society at unnecessary risk.

NHS England are undertaking a review of the AIS this year. It is vital that our voices as patients, who cannot read standard print, are at the heart of this review. Training, effective procedures and monitoring need to be put in place to fully implement the AIS. Ultimately, this will enable people with sight loss to feel empowered, stay safe and effectively able to manage our health, treatment and wellbeing.

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Simon Stevens,
Chief Executive, NHS England

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PREPARING FOR THE NEXT MEDICAL REVOLUTION

***Tim Powlson**, Senior Business Consultant, Entec Si*

Artificial intelligence (AI) and robotics is set to transform the healthcare landscape, however, in doing so it stands to create challenges for the sector. So, what do healthcare trusts need to bear in mind when considering the next medical revolution?

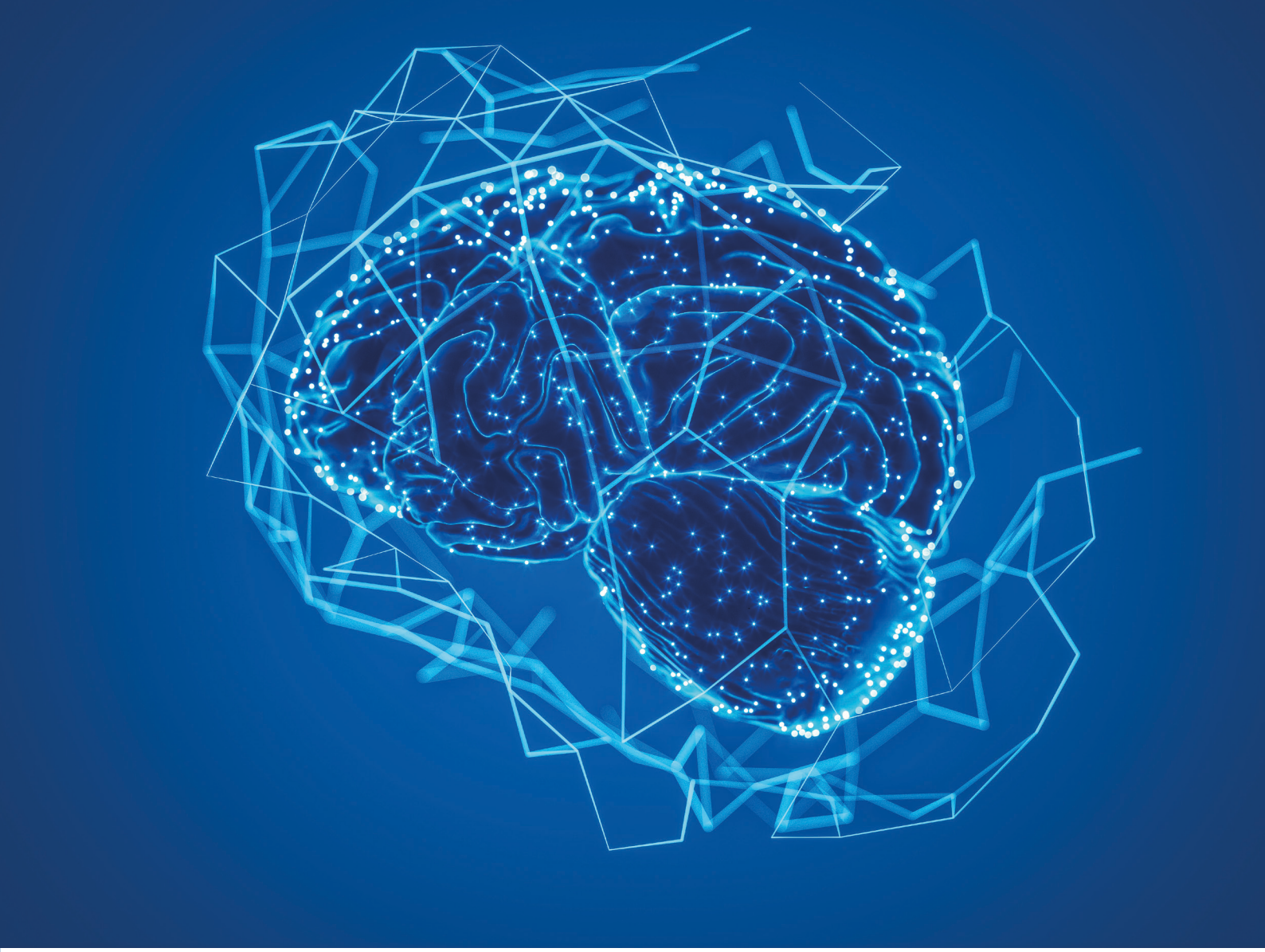
Although AI is not yet widely used in the healthcare sector, it is on the horizon, with the potential to transform a host of areas, from detection to diagnosis. However, before these more advanced technologies can become widespread, the correct resources must be available to support their use, and those using it must understand both the process and the benefits for rolling it out.

In 2017, a paper was released which described how AI could be trained to diagnose skin cancer with the same accuracy as a dermatologist. However, following its publication, the authors of the study noticed a bias in the algorithm – the AI was far more likely to mark an image as malignant cancer if there was a ruler in the image. Dermatologists use a ruler to measure the size of a skin lesion if they are concerned about it, a photo with a ruler in it is therefore more likely to be cancerous. This proves that people must first understand how an AI works before they can fully explore its capabilities.

With many healthcare sector organisations operating under tight budgets, another challenge when looking to make use of AI is cost. To introduce such technologies successfully, they must add value – for the patient or the health care provider. For example, if AI is able to assist with the treatment of chronic conditions, which make up around 70 percent of the healthcare sector's costs, then it could certainly be worth the investment. However, the human element of care is still vital, meaning that people must learn to work successfully alongside any new technology that is introduced.

When it comes to creating long-lasting change, it is essential to consider all elements that will impact the organisation's workforce. Unless the people involved are onboard with change and understand both the process and the end goal, it can be extremely difficult to implement and sustain a change successfully. In the case of introducing new technology, some people (patients and staff) may have an "if it ain't broke, don't fix it" attitude, which can slow down or prevent the adoption of new processes and tools.

To tackle this, the healthcare sector should prepare for transformation by putting users – both those who receive care and those who provide it – at the heart of any changes made. Honest and clear communication, as well as listening to questions and concerns as new tools and processes are brought in, will play a critical role in ensuring that they are engaged and onboard with the project.



Another hurdle comes in the form of technology, or the lack of it. Outdated IT systems, practices and infrastructure are common in organisations that have prioritised front-line delivery over "back-office" investment. Many trusts grapple with out of date applications, old hardware and slow Wi-Fi all affecting the user experience and detrimental to successful digital transformation. Keeping electronic records should be encouraged, as it can lead to improved patient safety and care, plus improve the effort taken on administrative tasks in the long run, but without fast reliable Wi-Fi, tablets, laptops and mobile workstations cannot be used efficiently, or at all.

As the healthcare sector looks to establish a more digital approach, security and data security is set to be another important area to address, both in terms of its financial implications and considerations around patient trust. Keeping patients' data anonymous may seem like the clear answer, but even then, for data to be valuable, detailed information about a patient is needed. If only one person fits a description in the system, then it can be possible to reverse any anonymisation. As a result, security must be multi-layered, requiring investment in technological resources.

Time will always be tight when delivering change in the healthcare sector, with the majority of employees usually incredibly busy. Those in the caring profession will always put the wellbeing of their patients before the adoption of a new system that could take precious time out of their day. In order to convince them that embracing technology will benefit them and their patients in the long-term, a problem-solving approach can focus effort where it is most effective. Using a goal-based improvement process, such as the DMAIC system – Define, Measure, Analyse, Improve, Control – can help with this.

This process begins by providing an objective, for example, increasing the speed in which patients are discharged. The DMAIC cycle of improvement is then implemented, with an original benchmarking figure taken at the beginning which can then be compared to a figure taken after the introduction of an improvement, like a new system or process change. This cycle can be repeated with different improvements until the original objective is met. By having an end goal, people can more easily see how the change will benefit them, increasing the chances of gaining their support.

As with any type of transformation, the introduction of new processes and systems – like an AI – requires clear communication and a solid understanding of the expected outcome. People need to understand three things: why the change is happening, what the change will be, and how it will benefit them. Taking a care-focused approach is key; if doctors and nurses know how the introduction of new technology will assist them in treating their patients, they are more likely to embrace it. If patients can see the improvement that the change will bring then they are more likely to participate.

The healthcare sector is constantly evolving, but there are still many barriers when it comes to the implementation of new technology, whether it be stretched resources, the current pandemic, out of date IT systems or poor Wi-Fi signal. Understanding that care will always be the sector's priority and making the process as straightforward as possible for those involved, will be vital to achieving successful digital transformation in the coming years.

DIRECTOR DIVERSITY: TIME FOR ACTION

Joan Saddler, *Director of Partnership and Equality, NHS Confederation*

NHS boards which better reflect their workforce and are accountable to their communities are more able to improve patient care, but why aren't these bodies more diverse than they currently are?

Currently, this group of leaders is insufficiently diverse across gender, race, disability and age to be as effective as they need to be. Boards generally across the UK and those with an international reach are seeking to create better diversity and promote women into board roles.

A small number of companies actively seek to recruit skilled BME board members from a 'go to' database of names with the correct characteristics and background who are judged to be ready and able to perform such roles.

Yet last summer the NHS Confederation's BME Leadership Network published a report which found that appointed chairs and non-executive directors on boards that run NHS organisations in England had become less diverse over the previous 15 years.

Although the latest figures show that the number of non-executive directors from black and minority ethic (BME) backgrounds has increased there is still further progress to be made.

The report highlighted two factors that may have played a part.

The first was the abolition of the NHS Appointments Commission in 2012. The Commission oversaw appointments to a range of NHS public bodies and brought a degree of rigour and consistency to the recruitment of senior leaders. It was never replaced, although NHS Improvement does have some limited influence over some chair appointments to NHS foundation trusts.

The second was the creation of foundation trusts in the mid-2000s. From the outset, foundation trusts were conceived as independent public benefit organisations, which meant any appointments to their boards would not be considered public appointments. Although overseen by elected Boards of Governors at local level, non-executive appointments made by foundation trusts are therefore not subject to further scrutiny and oversight.

Shortly after the publication by the NHS Confederation's BME Leadership Network of the aforementioned report, *Chairs and non-executives in the NHS: The need for diverse leadership,* NHS England and NHS Improvement chief executive Simon Stevens

used his keynote speech at Confed19 in Manchester to announce new impetus to the Workforce Race Equality Standard (WRES).

This included asking boards to set targets for implementing improvements for which they will be held accountable. Sir Simon has done a lot of work to move this agenda forward, introducing frameworks and initiatives across a number of protected characteristics, such as the WRES and Workforce Disability Equality Standard (WDES).

The rest of the work is down to us. We, as NHS leaders, can all stand up to the challenge, and it is great to have the support of NHS England and NHS Improvement in this.

The report's key recommendation was that a lead chair should work with the NHS Confederation to make recommendations to ministers for addressing the diversity deficit in NHS boards.

With this in mind, the NHS Confederation along with the BME Leadership Network last month launched an Independent Taskforce to help increase non-executive director diversity in the NHS.

If we want the NHS to increasingly deliver relevant care with communities through a diverse range of leaders and staff, the non-executive community has a fundamental role in doing so and must take this opportunity.

Some organisations are already doing this, and we want to support and share their approaches.

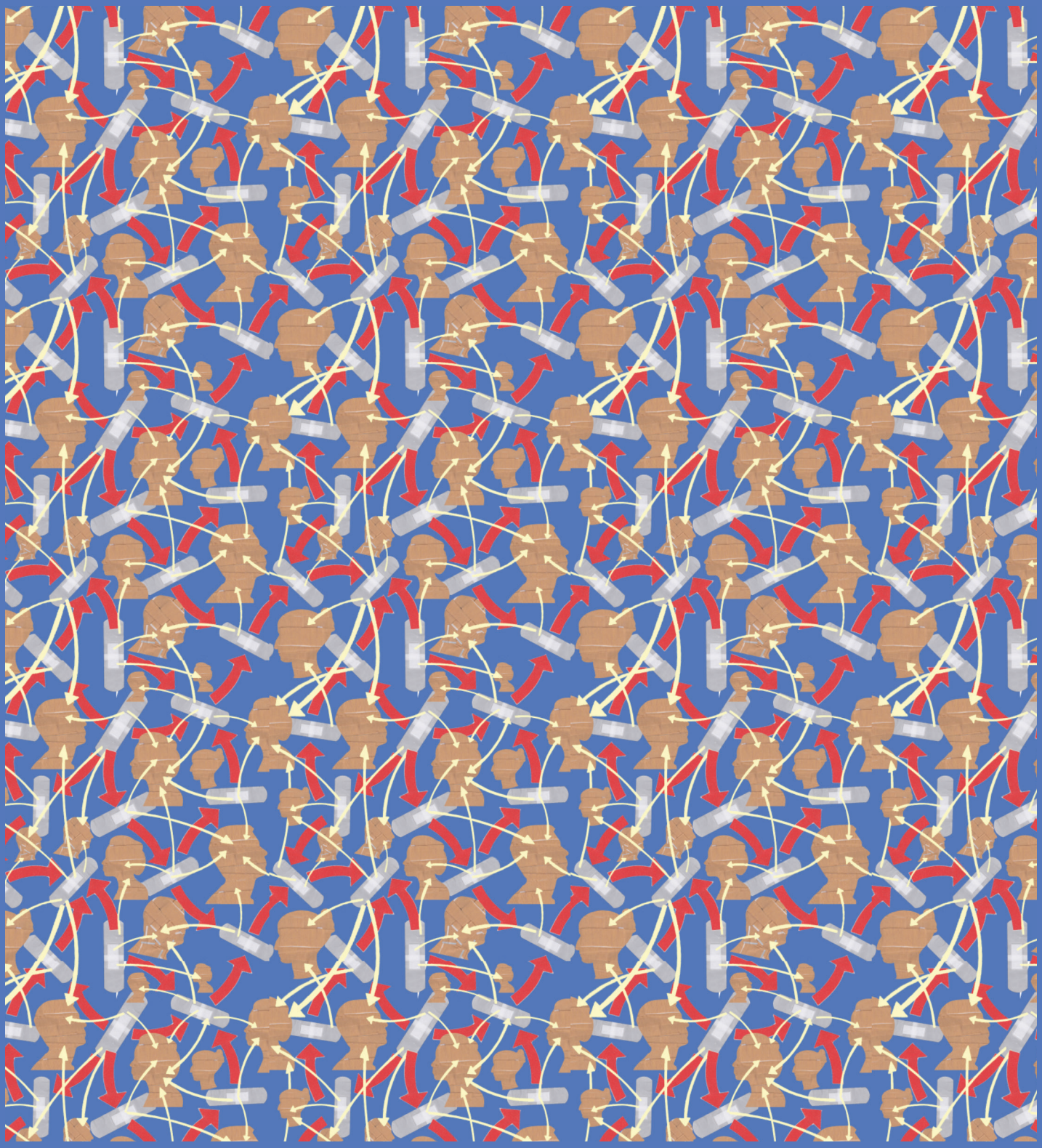
The Taskforce will consider what good processes look like in the recruitment and retention of chairs and non-executive directors. It will help further the EDI agenda in the NHS, supporting organisations to fulfil their legal responsibilities and, most importantly, develop an inclusive workplace offering care to all.

The NHS Confederation is serious about encouraging more diverse leaders. In addition to the BME Leadership Network and Health and Care Women Leaders Network, it will be launching an LGBTQ Network this year.

The time for action to make NHS boards more diverse to improve patient care is now.

CARING FOR OUR HEALTHCARE SERVICE

***Faye McGuinness**, Head of Workplace Wellbeing Programmes, Mind*



Improving mental wellbeing in the workplace has to be implemented from the top-down, with NHS leaders making it a priority and not just a promise.

The mental health of our health service is at breaking point and its time that its leaders sat up and paid attention to it. The latest statistics from NHS Digital reveal a worrying trend of staff citing poor mental health as a reason for taking sick leave, with managers most likely to mention stress, anxiety, and depression as their reason for absence.

If the NHS is losing 348,028 working days due to anxiety, stress and depression in just one month, it's clear that something isn't working. These numbers are much higher than for employees in other sectors and yet we all rely on NHS staff being well enough to come to work to care for us, our families and friends.

The numbers also demonstrate that the NHS is not making good on its commitment to embedding the core and enhanced mental health standards outlined in the 2017 government-commissioned "Thriving at Work" report. Despite vocal support at the time of its publication, these statistics show that little progress has been made in improving staff wellbeing.

The NHS again committed to supporting the mental wellbeing of its staff at the beginning of this year in the Pearson Report but its "recommendations have been left gathering dust", while staff mental health continues to suffer. And while it has been encouraging to see efforts towards improvement being made, for example through the development of the NHS Workforce Health and Wellbeing Framework, we need a clearer understanding of what progress is being made.

The importance of the mental wellbeing of NHS staff can't be overstated.

It is what can make the difference between someone receiving good or poor quality care and impacts chances of recovery. This is true for all parts of the NHS, but none more so than in mental health services, which entirely rely on staff to deliver them.

While other parts of the health service might be able to use technological developments and advanced equipment to complement staff efforts, mental health services are entirely reliant on employees who are motivated and well-trained enough to meet people's needs.

These concerning statistics come at a time when we know there is increasing pressure on the health service, particularly in mental health where demand continues to grow. This year we have seen NHS leaders lay out ambitious improvement plans to meet these pressures but none of them will become a reality without the right workforce. These leaders must acknowledge that the recruitment and retention of happy and healthy staff is just as important as fresh strategy.

Mental wellbeing in the workplace has to be implemented from the top down, with leaders making it a priority and NHS managers who are mentally well enough to create the right environment. The role of managers is crucial, because we know there are often extra barriers for healthcare staff when disclosing mental health problems, such as fears about being deemed unfit to practice or feeling like they have to be immune to ill health.

Mind's Blue Light Programme, supporting the mental health of staff across the emergency services, has shown what is possible with the right investment. By the end of the four year programme, we saw a 64% increase in staff saying their organisation talked openly to them about mental health, a 19% increase in employees saying people with mental health problems were well supported in their workplace, and a 19% increase in staff awareness of support offered by their organisation to improve mental wellbeing.

Our work in emergency departments has also shown how good working conditions inspire loyalty and high performance from staff. We found the right environment can also prevent people developing mental health problems, and support those living with them to thrive. Our conclusion from the one year pilot we delivered within emergency departments was that positively managing and supporting employees' mental wellbeing meant emergency departments could ensure that staff performed to their potential.

In order to get these figures down, all NHS trusts must put in place preventative measures to keep staff well at work, not just support them when they need to take time off. Having the right workforce, with the right skills, in the right place is central to achieving the NHS Long Term Plan's ambition to improve services and take a more joined up approach to healthcare. To do this, staff need to feel supported by their employer.

This means promoting staff wellbeing, tackling the work-related causes of mental health problems and offering support to employees who are struggling with their mental health. NHS staff are vital and can make a real difference to the experiences of people accessing help. We have heard enough promises, it's time that change becomes a reality.

Given how much of our lives are spent at work, and how common poor mental health is, it's not surprising our working environment can have a big impact on our mental health and wellbeing. This report shows the link between prioritising staff wellbeing and improved loyalty and productivity; and decreased sickness absence and resignations. However, it shows a rise in 'presenteeism' – unwell staff spending unproductive hours at work rather than taking time off. As presenteeism costs three times more than sick leave this has to change, but first staff need to feel able to take time off when they are unwell.

A Mind survey of more than 1,700 people with mental health problems found less than half (44%) were aware that a mental health problem could be classed as a disability under the Equality Act 2010, meaning staff are missing out on important workplace rights and protections to help them thrive at work.

The Equality Act gives disabled employees the right to not be discriminated against in work, and a right to reasonable adjustments if they need them. But poor understanding of this leaves employees unable to challenge their workplace if and when they face discrimination on the grounds of a health condition. The Government need to make this law clearer so more disabled people have the workplace rights they are entitled too.

The current Statutory Sick Pay (SSP) system is out of date, inflexible and does not provide enough financial support for disabled people, including people with mental health problems. Nobody should feel they are being punished, or stuck needing to work while unwell. But over a third of disabled workers told us when faced with the rate of statutory sick pay (£94.25 per week), to cope financially they'd have to keep working or return to work before they feel ready. And two thirds of people with a mental health problem who received SSP said it caused them financial problems.

The current sick pay system is making people's mental health worse at a time when they are already unwell. No-one should pay such a high price for having to take time off for their health. The Government needs increase the amount of Statutory Sick Pay (SSP) staff receive when they're off sick.

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SUPPORTING PATIENTS, BOTH PUBLIC AND PRIVATE

***Dr Andrew Vallance-Owen**, Chair, PHIN*

I trained as a surgeon in the NHS many years ago, and throughout my career I have always advocated for clearer information for patients. Since giving up my clinical practice I have focused on making that a reality. Nowadays, amongst other things, I chair the Private Healthcare Information Network (PHIN). This organisation collects data on activity and clinical performance from all private hospitals and NHS pay bed units across the UK, turns it in to useful information and publishes it on the PHIN website.

The collection of clinical performance data is really important to support patient choice, both in the NHS and the private sector. While most private hospitals collect this sort of data, they have traditionally done it in different ways. Often there has been little information published on their websites, or in their promotional literature, to enable prospective patients to make informed choices about which hospital to go to and which specialist consultant to see. This lack of transparency has often been criticised and led to an investigation by the Competition and Markets Authority. Following this investigation, in 2014 new requirements were laid on providers to provide appropriate data to PHIN for analysis and publication on their website.

Good but rather slow progress has been made since 2014. A huge amount of work had to go in to agreeing standard definitions and standardising processes across the private sector. This effort, however, is beginning to help patients to make informed choices, to enable more fact-based peer review of doctors, and drive continuous clinical quality improvement.

When the recent independent Inquiry into the work of the now notorious surgeon, Ian Paterson, was published recently, there was again criticism about the lack of transparent information that might have led to him being caught earlier, and the lack of a joined-up approach between the NHS and the private sector. The good news, however, is that PHIN has been working with NHS Digital for some time now, through the Acute Data Alignment Programme (ADAPt), which is looking to adopt common standards for data collections across both the NHS and private healthcare. Sadly, this work comes too late to help Mr Paterson's patients.

Many of the performance measures in healthcare relate to when things go wrong rather than when they go well. Examples are death rates, unexpected readmissions after treatment, infection and incident rates; the important aim being to reduce these to ensure better safety of patients. One way, however, in which PHIN is trying to publish information which may perhaps be more helpful to patients, by indicating the benefit fellow patients received from their treatment, is by the use of Patient Reported Outcome Measures (PROMs).

Patients are asked to complete a short survey before their treatment, indicating the issues that matter to them; then, three to six months after treatment, they are asked to complete the same survey again. The difference between the two scores shows the benefit gained from the treatment. This information is now available on PHIN's website, and will continue to develop over time.

PHIN is working with private hospitals to provide better information for patients and with the NHS to build a common approach with the NHS. This should mean that problems will be picked up more quickly and, with the help of PROMs, that patients will be able to understand better the benefits that both specific treatments and hospitals can bring.

UNDERSTANDING POPULATION HEALTH

***Matt Roberts**, Editorial Lead, National Health Executive*

Modern health encompasses far more than just treatment, with prevention and personal wellbeing beginning to be given the same degree of attention in healthcare planning and resource allocation. If we can tackle health challenges before they emerge in the population, we can alleviate some of the burden on our strained healthcare service.

All of this neatly falls under the banner of healthcare's latest buzz word – 'population health'. But what does population health truly mean?

At its most basic, it represents an approach to defining health which understands it as wider and more encompassing than the traditional definitions. This is due to including the whole range of determinants of health and wellbeing, many of which sit distinctly separate to health services, such as town planning or education.

Appreciating the impact these aspects of life can have on determining a person's health then allows health practitioners to not only identify at risk patients more easily, but implement early preventative measures which will hopefully keep them out of hospitals. It's early intervention, even earlier than the preconceived understanding of early intervention caregiving.

The change in narrative from public health to population health also creates the added benefit to shift responsibility off just public health professionals onto the wider society.

The King's Fund defines population health as: "An approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people within and across a defined local, regional or national population, while reducing health inequalities.

"It includes action to reduce the occurrence of ill health, action to deliver appropriate health and care services and action on the wider determinants of health. It requires working with communities and partner agencies."

Population health is all about creating this collective sense of responsibility across many organisations and individuals to improve patient care and health, in addition to the work being done by public health specialists.

There is no clear blueprint for a local population health plan, with each area needing to evaluate its own specific needs and capabilities to best create a bespoke plan if we are to maximise the potential population health could bring the general populace. However, that doesn't mean going in blind.

Already we are seeing devolved areas and regions creating healthcare plans by sustainability and transformation partnerships (STPs) or integrated care systems (ICSs) – which often include several local authorities and clinical commissioning groups – which have great potential to improve population health.

For example, in Greater Manchester there has been a population health plan outlined and fully integrated into broader plans for economic development, growth and public service reform for the region. The GM plan is rooted firmly in a set of principles and values reflecting the overall approach of the region's devolution, and setting out ambitious plans and programmes.

STPs and ICSs across the UK are already starting to build up system-wide implementation plans for the first five years of the NHS long-term plan, presenting a key opportunity to strengthen their focus on population health, utilising 2019/20 as a 'foundation year'.

As part of the NHS Long Term Plan, every ICS will be required o streamline commissioning arrangements to enable a single set of commissioning decisions at system level, typically involving a single CCG for each ICS area. In doing so, CCGs will become leaner, more strategic organisations which look to support providers to partner with local government and other community organisations to realise population health goals, service redesign and implementation of the aforementioned Long Term Plan.

Yet, these population health-conscious ICSs which the Long Term Plan has established have a duty not just to act as an NHS body, but at least at a regional level build cross-sector partnership approaches as a priority, building on the work already being done by STPs to establish these.

With population health, we have a huge opportunity to address health concerns before they become problems. In effect, we can get ahead of the game and be preventative in our approach, rather than reactionary – it will just take the right approach and commitment from all parties involved.

SUPPORTING A POPULATION HEALTH MOVEMENT

***Jonathan Field**, Spinal Extended Scope Practitioner and Member of the British Chiropractic Association (BCA)*

We know that movement is fundamental to human life and everything we do. In fact, it's one of the priorities for Public Health England (PHE) to encourage movement for people because it improves quality of life across a whole range of domains – from quality of sleep and psychological wellbeing, to disease specific conditions, such as Type 2 diabetes and cardiovascular disease.

What's more, movement has been shown to lead to a 20% reduction in joint and back pain. The latter affects 10 million people in England and Scotland alone, according to a recent report published by Arthritis Research UK, and yet for most of these cases, physical activity isn't even an option, let alone their primary course of care.

Pain and movement

Evidence confirms a huge relationship between pain and movement. A particularly interesting study in 2019 looked at whether marathon running could improve knee damage of middle-aged adults. The researchers looked at the health of people's knees before they started training and identified people with pre or early degenerative changes in the knee.

Over the course of training, they found that these pre-arthritic changes had improved. The idea is that our bones and cartilages are living tissues, just like muscle, and if you exercise and subject them to loads, they respond in a positive way; they get bigger and stronger.

In terms of how the relationship between pain and movement develops as we age, professors Stephen Hartridge and Norman Lazarus recently stated: "We often confuse the effects of inactivity with the ageing process itself, and believe certain diseases are purely the result of getting older. Actually, our modern sedentary lifestyles have simply sped up our underlying age-related decline."

If we think of people who play an active sport until their mid-40s and then stop because it's a 'young person's game', they start to feel stiff and achy. But, one of the reasons they've started feeling stiff and achy is because they've stopped doing a sport.

Activity resources

The UK Chief Medical Officers recommend that adults should aim to minimise the amount of time spent being sedentary, and, when physically possible, should break up long periods of inactivity with at least light physical exercise or standing. Typically, just half an hour of moderate activity five times a week, or 75 minutes of vigorous activity once a week can have a massive impact on our quality of life.

At the same time, Sports England has launched a new campaign called 'We Are Undefeatable', with the aim of inspiring and supporting the one in four people in England with a long-term health condition to build physical activity into their lives. It has also developed across the country what it's calling 'active partnerships', whereby it's working with sports centres and community organisations to increase the provision of opportunities for physical activity.

Increasingly, we're recognising that it's the little things that are happening in our communities in places like the village hall, like Thai chi and yoga, that can make a marked difference to society's health. But, by and large, the idea of healthcare professionals working closely with the population to keep them healthy has yet to come to fruition.

In the chiropractic industry, the Royal College of Chiropractors Public Health Society (PHS) conducted a survey to investigate the current level of engagement that chiropractors had with a variety of public health topics. In relation to physical activity, chiropractors scored highly with a majority routinely collecting this information from their patients and helping them make changes in health behaviour through promoting physical activity and getting regular exercise in their contact with their patients.

Following the outcome of the survey, the PHS Chair John Stephens stated: "There is strong evidence with increasing physical activity for managing and preventing future episodes of MSK conditions. If clinicians can help identify patients who need support and guidance on getting the right amount and most suitable type of regular exercise, this can not only help their patients mechanically but also holistically with wider health improvements from exercise and movement."

Bridging the gap

This gap between community support and more central services provides a great opportunity – first, we need better communication between community resources and the NHS to help GPs know what's going on locally, and similarly empower them to refer relevant patients to community classes as the first point of care – and, if necessary, manual therapy to enable people to do exercise and remain active.

Improving communication between community resources and the NHS will take time – something GPs don't often have. But from April 2020, there will be three new NHS-funded roles within general practice to help facilitate conversation: Social Prescriber, Health and Wellbeing Advisor and MSK First Contact Practitioners (FCPs) The onus here is on those in these roles to find ways that they can upskill themselves to advise patients about the benefits of physical activity and to gain knowledge of what's going on locally too, so they become involved with providing in the community.

Public Health England through their Physical Activity Clinical Champion program are looking to help; with training available to NHS practitioners nationwide on engaging with patients regarding the benefits of being more active and how to guide them towards their goals.

What's more, we need to encourage people to stop and think about what they want from treatment before they reach out to a GP. If it's accurate information and advice, the GP practice might not be the best and most appropriate place to get it. Fundamentally though, for all conditions, moving more is going to be helpful – and even the smallest of changes to a patient's activity levels can make a massive difference to their health.

LINKING ACEs AND PHYSICAL HEALTH OUTCOMES

***Dr Kirsten Asmussen**, Lead Author of the Report and Head of What Works, Child Development, Early Intervention Foundation*

Adverse childhood experiences (ACEs) are a set of 10 negative childhood circumstances involving child maltreatment and family disruption that have been consistently shown through research to increase the risk of adult mental health problems and physical diseases.

Over the past 20 years, studies have repeatedly observed a 'dose-response' relationship between ACEs and poor adult outcomes, showing that a history of four or more ACEs increases the risk of diseases such as diabetes, stroke or cancer by up to three-fold. These findings have generated a powerful narrative which has helpfully increased public awareness of how childhood adversity may negatively impact adult wellbeing, with many arguing that ACEs are a possible 'root cause' of many life-threatening physical conditions.

In our recent publication, Adverse childhood experiences: What we know, what we don't know, and what should happen next, we examine the extent to which research evidence supports this conclusion. Our analysis has found that while ACEs indeed predict a wide variety of adult problems, the strength of this predictive relationship may not be as strong as many have assumed. This is because much of ACE research is based on surveys conducted retrospectively with adults.

While these studies are useful for gaining a crude understanding the life-time prevalence of ACEs, they are subject to high levels of bias and are inadequate for understanding causal relationships.

A more robust understanding of the relationship between ACEs and adult outcomes comes from prospective studies which track children at regular intervals throughout childhood and adulthood. While these studies show that ACEs are predictive of poor mental health and behavioural outcomes, their association with physical outcomes is far less clear. These studies in fact show that the relationship between ACEs and negative physical outcomes is much weaker than what has been observed in retrospective studies, and in many cases is non-existent.

Studies also show that poor physical outcomes are often better predicted by negative childhood circumstances not encompassed by the 10 original ACE categories. These circumstances include low birth weight, low family income and community deprivation. Studies show that these negative circumstances not only increase the likelihood of ACEs, but also increase the risk of poor physical outcomes in a manner similar to a history of four or more.

Nevertheless, prospective studies continue to confirm that ACEs are strongly associate with negative mental health and behavioural outcomes. In this respect, prospective studies show that a history of child abuse and neglect often more than doubles the risk of substance abuse, mental health problems and criminal behaviours by over three-fold. We must emphasise, however, that this increase in risk is relative, meaning that for most people, a history of ACEs does not inevitably lead to adult mental and behavioural problems.

Collectively, our analysis suggests that ACEs may not be the root cause of physical health outcomes in the way that many have assumed. The implication is that prevention efforts targeting ACEs may help reduce mental health problems but may have less impact on physical health outcomes.

Additionally, the fact that ACEs are not the only contributor to poor adult outcomes means that an over-reliance on the original 10 ACE categories risks obscuring or minimising our understanding of the impact of other important childhood adversities. Future studies should therefore look beyond the original ACE categories to consider the combined impact of multiple negative childhood circumstances on adult outcomes, ideally through prospective study designs involving large, representative samples of the child population.

RENEWABLE ELECTRICITY:

OUR FIRST STEP TOWARD A GREENER NHS ESTATE

Cameron Hawkins, *Head of Energy and Environment, NHS Property Services*

With the United Kingdom hosting the 26th UN Climate Change 2020 Conference in Glasgow in November, the climate crisis can be expected to move even higher up the national agenda with increased public and political attention on environmental issues.

For its part, the NHS has already committed to accelerating its efforts to tackle climate change with a series of co-ordinated measures to reduce carbon output. Chief Executive Simon Stevens has called on the health service to embolden staff to lead discussions with the public about wider measures needed to address climate change.

This is an important message given healthcare's impact on the environment is not negligible. According to research released in September 2019 by the NGO - Health Care Without Harm and Arup, healthcare's climate footprint accounts for 4.4% of the world's net CO2 emissions. If healthcare were a country, it would be the fifth largest emitter on the planet.

With over 3,000 properties and 5,000 employees, accounting for approximately 11% of the NHS estate, NHS Property Services (NHSPS) takes seriously its responsibility, and legal requirement with increasing legislation, towards reducing the environmental impact of its buildings and creating awareness amongst its people to help it do this.

Having the ability to access renewable electricity has been a key priority for NHSPS in this regard and in February this year we announced that announced that our new central energy contracts would include 100% renewable electricity from April 2020.

Following hot on the heels of the launch of the 'For a greener NHS' campaign, this move is part of NHSPS' concerted effort to transform the NHS estate so that it can provide sustainably-run buildings that help to deliver excellent patient care. In making this change, we will offset 40,000 tonnes of CO2 per year and demonstrate how NHSPS, as the overseer of a significant chunk if the NHS estate, can make a difference.

The use of renewable electricity will not increase costs to either NHSPS tenants or NHSPS itself. With the implementation of a new procurement strategy, ensuring we benefit from some of the best prices in the market, while managing risk and maintaining budget certainty.

As well as reducing our environmental impact we will remain cost competitive, with our independent broker, Inspired Energy, employing its buying power on our behalf to secure not only the best rate but also the best supplier in terms of billing and debt handling.

Managing energy costs is a key challenge for us, with both domestic and international pressures increasing commodity and non-commodity costs into the foreseeable future. By establishing a long-term strategy, we will give our tenants access to the best prices in the market, as well as greater transparency in costs and budget certainty, as well as the benefit of clean electricity.

As well as switching to 100% renewable electricity by April 2020, NHSPS is also committing £1.5m in 2019/20 towards an LED upgrade programme and a further £1.8m in 20/21, among other Energy efficiency measures. At a time of major change and increasing demand for the NHS, we intend to embed more green and efficient energy solutions into our business to create a more fit for purpose estate, generating vital funds, all of which are reinvested back into the NHS estate to support improvements in frontline patient care.

THE RETIREMENT REVOLUTION

Ever-increasing life expectancy means larger retirement pots are now needed. This means the age-old practice of stopping work at 65 is being replaced by phased retirement; many are reducing hours or responsibility, but extending their working lives by several more years, bringing with it a host of new financial considerations.

So, for the generation now contemplating retirement, the trick is to plan ahead so that pension provision meets both your financial needs and wider hopes for personal fulfilment.

Contact us for further information.

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A 21ST CENTURY NHS

***Sean Hopkins**, Head of Programmes and Technology for Employment Services, NHS Shared Business Services (NHS SBS)*

In a recent speech to the Health Tech Alliance, the Secretary of State for Health and Social Care, Matt Hancock, reiterated the role that all health professionals must play within the digital transformation of the NHS, stating that "every medical director and chief nurse needs to know how technology is going to transform what their teams do and lead that adoption".

As NHS organisations consider what this means at a local level for their own workforces, it is important to note, I believe, that transformation does not always mean investing in and introducing brand new technologies.

In fact, nearly every NHS organisation in the country has an incredibly powerful system already in place. The Electronic Staff Record (ESR) has the potential to drive efficiency, enhance data security, improve productivity, and save money. But, as things stand, many NHS organisations are just about scratching the surface of its capabilities.

Unrealised potential

In 2008, the ESR was rolled out to NHS organisations across the country. At the time it was known as the 'biggest programme of its kind in the world'. I was one of the original team employed by McKesson, the company which created the system, to lead this ambitious national rollout on the ground. Our team traversed the country to train users, migrate huge amounts of data from countless other HR and payroll platforms, and implement the system effectively.

Living and breathing ESR from the very beginning, we understood better than most how it had the potential to transform the NHS via one single, 'end to end' workforce planning tool.

Fast forward to 2020 and the frustrating reality is that, whilst ESR has the functionality to provide comprehensive HR systems, employee and manager 'Self Service', learning management and more, a significant proportion of NHS organisations are only using the payroll module. It means that many of the day-to-day benefits of ESR go unrealised across the NHS.

Successful streamlining

In an attempt to change this, the NHS SBS workforce consultancy team is partnering with NHS trusts to review their workforce roadmaps. Through this work, we are seeing time and again that multiple systems and processes are used for HR, workforce data, learning and development, and much more.

Systems that do not talk to each other. Systems that require data to be inputted multiple times. And systems that have often been procured at significant expense – despite the organisation already having access to what they need through ESR.

Today, a huge opportunity exists for forward-thinking NHS organisations to make a 'leap of faith' and bring in critical friends who understand the art of the possible and the streamlining potential of ESR.

One such tech-savvy NHS organisation is Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust. We have been working closely with the Trust on its ESR reporting requirements.

Mark Brookes, the Trust's Associate Director of People and Organisational Development had told us that: "It was taking significant resource each

month to run reports and get them into the required formats for our board reporting packs".

He added that this meant the workforce team was "running a multitude of separate reports every month and then consolidating the data into the required format".

Working with the Trust, bespoke reports were created to consolidate the data into fewer reports thus saving a considerable amount of time and resource.

This resource was then used to support other workload priorities. Mark explained; *"Thanks to these improvements, we were able to release resource to work alongside the NHS SBS project manager to successfully implement the ESR Manager Self Service functionality in October last year"*.

A number of other NHS organisations are now following Doncaster and Bassetlaw's example. Employee and Manager Self Service – or ESS and MSS for short – are key elements of ESR that can be far better utilised.

ESS enables NHS staff to update their own employee records, such as a change of name, in real-time. The reduced reliance on paper is a major benefit. MSS, meanwhile, enables managers to access live workforce reports, easily update contracts, and monitor competencies and training requirements – all in one place.

In my experience, this vital information is commonly held on different NHS systems and is time-consuming to update – not the case if all the ESR modules are being used effectively.

The future is now

When the Interim NHS People Plan was published last summer, it pointed to the fact there "are significant opportunities to help healthcare teams work more productively, releasing more time for care, helping provide fulfilling working lives and enabling every NHS pound to go further in improving access to – and quality of – care".

And it could be argued that one of the most obvious and easiest to implement has been right under the nose of most NHS organisations for some time.

The Health Secretary's Tech Vision for the NHS states that "we should be using the best off-the-shelf technology [...] and not building bespoke solutions where they are not needed." A sentiment that seems to define the missed ESR opportunity to date.

In the end, the overarching aim for us all is to enhance patient care. For every NHS organisation we help to get more from ESR, there is greater resource available for the frontline.

Making ESR work as it was designed to across the NHS would deliver huge workforce efficiencies for hospitals up and down the country. The technology already exists – it's just a matter of turning it on.

NEVER GET BORED OF FRAUD

Matthew Jordan-Boyd, *Director of Finance & Corporate Governance, NHS Counter Fraud Agency (NHSCFA)*

NHS LOSES OVER A BILLION POUNDS A YEAR TO FRAUD

I have written several articles about the work of NHSCFA and that tends to be from my fairly technical angle as a figures person, an accountant who has worked in the NHS for almost 20 years.

When I discuss the need to be more vigilant with fellow finance professionals and leaders in the NHS, and to take more vigorous action to prevent fraud, it can help to speak in their language, which comes naturally to me. This may mean looking at the issue a bit drily, suggesting that they undergo a cost-benefit analysis to recognise the significant impact it would have for their organisations, and recognise that spending adequately on counter-fraud measures is an investment that pays dividends in other areas of business.

Now that is all true. But I am equally aware of the need to be fluent in other languages – moral, ethical or medical, for example. NHSCFA is constantly looking for new ways to drive home the anti-fraud message and avoid "fraud fatigue" – people will stop hearing the counter fraud message otherwise.

Because it is a hidden crime by definition, involving skulduggery (does that word wake you up more than "deception"?), victims tend to have already suffered a financial loss by the time they spot it.

Well into our third year of operation, NHSCFA is currently shaping our 2020-2023 strategy, from which all our business plans must flow. While I cannot pre-empt the publication of this strategy, which is not far away, a few key issues are already clear.

The fight against health service fraud is not getting any easier.

Fraud is an evolving threat, with criminals constantly monitoring the NHS to exploit any possible weaknesses, updating their methods accordingly. We estimate the NHS loses over a billion pounds a year to fraud, and was never a 'victimless crime'. It impacts directly on patient care.

The damage done to things like trust and confidence in an NHS service matters too. These things still count, even if they are harder to quantify than pounds and pennies.

Opinions differ about whether NHSCFA should keep shouting about the scale of the problem or speak more about, and be an integral part in the implementation of the solutions. We must do both.

Since our establishment in November 2017, working in partnership with the wider NHS counter fraud community and beyond that, other law enforcement bodies, has been a powerful weapon against the criminals. We need to continue this, and do more.

Wherever possible, we have reduced fraud losses through effective prevention and enforcement action, and strengthened our intelligence gathering to sharpen our knowledge of fraud risks and the best ways to curb fraud.

There are many examples of NHS organisations fully shouldering their responsibilities – doing so with a passion that goes far beyond ticking the boxes they are "marked on" by NHSCFA.

Yet, more needs to be done.

Not all NHS bodies consistently apply a proactive, risk-based approach to counter fraud. When they do, the quality and effectiveness of counter fraud provision will rise further.

Our 2020-2023 work plan will contain pioneering new initiatives and ramp up the shift in culture that is still needed. And in NHSCFA we'll be leading by example in getting the most out of our people, our greatest asset. Watch this space!

Industry Voice

Gill Walton

Chief Executive, Royal College of Midwives (RCM)

Would you talk us through your career in the healthcare industry, both your current and previous roles?

I trained as a nurse but my real passion and calling was in midwifery. So I trained as a midwife, qualifying in 1987. I have been in midwifery in the NHS ever since. My last job before the RCM was Director of Midwifery and Maternity services at Portsmouth Hospitals. I have worked on a number of national projects such as the Midwifery 2020, England Steering Group and was a member of NHS National Stakeholder Committee.

I became RCM Chief Executive in 2017. My focus has always been to put women right at the centre of care and organise maternity services around them and their needs. There is no better place to do that on a national and international level than here.

The RCM job is one I relish; representing nearly 50,000 midwives, student midwives and maternity support worker members across the UK. We are a union and a professional organisation so it is a job with many facets. It is about ensuring our members get the best working conditions, the right resources and fair pay for the work they do. It is also about professional standards and giving our members the resources to support their professional practice. Ultimately this is about supporting our members to deliver the best possible care for women.

What is the biggest change you've seen within maternity and midwifery throughout your career?

The way midwifery is regulated is certainly one area of great change. Also actually asking women about their maternity care such as the CQC survey of women's maternity experiences is another. This changes the way care is delivered because it is about getting the services right for those receiving it, not those delivering it. That is a profound and important move.

What is your proudest moment working either in or alongside the NHS?

I think this is a continual one. Seeing the dedication of my midwifery, maternity support worker and medical colleagues deliver some of the best maternity care in the world inspires and makes me proud every day. On a personal note, becoming the RCM's CEO was an incredible moment also. I love the organisation and I am proud of the passion and dedication of the members we serve. I am also proud of how the RCM supports its members to in turn support women to have the best possible pregnancy and birth; the pregnancy and birth that is right for them.

What would you say is the biggest challenge currently facing the healthcare industry and how do we overcome it?

Getting the right resources and staff to deliver the safest and best possible care is probably top of that list. This is a challenge for all of the NHS I know but if we can get care right at the start of life, we can reduce the impact on the NHS for decades in the future. I really believe investing in maternity care pays dividends and saves the NHS money in the short term and for the future.

What does the future hold for healthcare in your opinion? Are you optimistic?

I am hopeful, and we are working to achieve this, that we will see our maternity services resourced and staffed and fit for purpose. The NHS has one of the best maternity services in the world and is improving despite increasing demands. Much of this is due to the hard work of our maternity teams; midwives, maternity support workers and obstetricians and a whole group of other professionals alongside them.

I think we are seeing wonderful cooperation and collaboration with our obstetrician colleagues and I want to see this develop and grow even more. Working together, with other professions and organisations involved in maternity care we can really have an impact. We have started a collaborative group called One Voice to this end. We need to invest in maternity so that we can empower staff to really support women and their families. That is the way forward.

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