The People's Inquiry: One Year On

Evidence presented by Rachel Maskell (RM) and Sarah Cook (SC)

Thursday 11 December
Queen Elizabeth II Conference Centre, Broad Sanctuary, London SW1P 3EE, Shelley Room

Present:

Roy Lilley (Chair; RL); Dr Louise Irvine (LI); Naledi Kline (NK); Dr John Lister (JL); Professor Sue Richards (SR); Polly Toynbee (PT), Frank Wood (FW).

RL:
You know the form. We're yours for the next 30 minutes.

RM:
I came to address the panel last time you met, so I really want to provide an update on the deterioration, particularly to start with of industrial within the NHS and the impact that that it's having. Since we met we are now formally in dispute with the NHS over pay. Pay has been constrained now throughout the term of this government, in fact in every consecutive year we've had below-cost-of-living increase in the NHS – a 15% pay cut for our members since the general election. That's the minimum, because if you go beyond that, we can look at the huge costs our members have, with cuts to the on-call system which our members experienced.

Our members now are really struggling as a result of those cuts. Plenty of our members still continue to earn below the living wage, and therefore face a real pressure on personal finances, with many having to resort to food banks and relying on the benefits system. So pay in itself has been a major issue, but if you move into dispute with an organisation it also changes the industrial relations with the organisation as well.

I think the thing that has really come to light for us is the fact that particularly a lot of experienced managers left the service under MARS (Mutually Agreed Resignation Scheme) and other systems, but we have now got a structure where you've got some very poor experience on the other side of the table of dealing with industrial disputes. So when trying to talk about issues around patient safety there's been a real inability to understand what that actually means, so that all the workforce have to turn out, ie we have to take industrial action. We have had to work through that.

The organisation at the heart of this, the NHS Employers, in effect part of the Department of Health, really do not know how to progress these disputes, and I think that's been the shocking issue for us, coupled with Jeremy Hunt's continual refusal to meet with the trade unions, which should be the first call of any minister in trying to address the dispute. It means there has been no engagement with pay despite this issue arising in March.

Therefore our members have been resolute that they will continue to fight this issue. Plus they have no choice now. For every challenge they take the industrial route, it's the way forward. Therefore we have had 2 days of strikes and we will be continuing that into the new year, and also Unite are currently in 8 weeks of working to rule. That is putting pressure back into the system. When you heard no doubt today that there were pressures on the system our members are saying 'actually enough is enough' and we've found the average NHS worker works 8 hours unpaid overtime. They're saying 'why should I give all that additionality when you're cutting my pay in return?'

On top of that there's also statistics out this week on the levels of stress in the NHS which nursing staff now experience. 60 per cent have experienced stress in the workplace last year. That obviously has an impact on wellbeing and the quality of care that is provided, a very serious situation that again has not been fully addressed. The Health & Safety and Wellbeing partnership group has produced paper guidelines – no more than guidelines – on dealing with stress. But clearly that is not having any penetration back in the workplace and the levels of work-related stress are going up, so the workforce really is imploding at this time.

There are some specific issues as well which I think do highlight the poor communication backed with the stuff on the workplace. If I can take a recent example the issue of Ebola. Survey work has found that over 50% of the workforce have not yet had any education, any information about how to actually deal with a situation should there be a percentage of them who could potentially have Ebola. We can see the breakdown both in industrial relations, but also a breakdown in communications with employees, which clearly lay our members at risk because we only need to extrapolate that to realise there is a real problem we've got there.

Two other issues have come to light, particularly with the employees. One has been around working longer, and pensions. Again this is about governmental management of the system and there's been no redress yet in the system for how people are meant to continue to work until they are 66, 67 – who knows when that will end. Therefore our members are very concerned about that – concerned about the impact on their health at working to what particular age, particularly people who are working in some of the high-stress, high-emotional pressures, and also high physical pressures that are placed on them. We see that there is a dispute in the Fire Service where we are talking about retirement at 60, yet people are also involved in heavy lifting and going to work until 67 currently.

So there are real issues there. But also we see a mismanagement in the system; the fact that our members have had their pensions cut in the course of this government on the promise that they are going to defer the changes to the pension to 25 years. However, the government have already had to come back to us to make further changes from April 2015 as a result of a shortfall now in the national pension pot for the NHS. Something that hitherto had a year-on-year surplus is now in deficit year on year, and projected to get worse. So we've again seen a real mismanagement of our members' terms and conditions.

The other industrial issue that I wanted to talk about was 7-day working which is now very much at the forefront of employers' minds as well as the Department's mind. The Health Secretary, Jeremy Hunt, has written to the Pay Review Body, of all bodies, which is perplexing in itself, to review 7-day working moving forward. We as trade unionists have jointly said that instead of looking at 7-day working we should look at 7-day services or 7-day care. But unfortunately there isn't this distinction. We are curious to know why the Pay Review Body has been asked to undertake that work, other than to realise they are talking about more cuts to members' unsocial hours payments. That could be the only remit that it could be involved, which actually is the remit of the NHS Staff Council, not the Pay Review Body.

We've had Bruce Keogh come and address us, and when we examined the employers' side, not a single employer could set out for us what they actually wanted with regards to 7-day services and how they wanted to change the system. They just wanted cuts to our members' terms and conditions. Now that is not an acceptable position and therefore we are very concerned the programmes based on reducing management in the NHS have lost all of its expertise, people who could have picked up some of these issues and progressed agendas. We've just seen that deficit on the other side of the table which is of concern to the service but also having a real impact on our

members' terms and conditions and wellbeing in the workplace. I don't know if Sarah you want to add anything about terms and conditions?

SC:
I was going to give you some more anecdotal information because I'm the lead organiser for health in London for Unite so I manage and work at the other offices. The last time I came I gave you a lot of statistical information that had come out about how people are feeling about working in the NHS and the experiences they were having. I was hoping that things might have changed, but the reality is, things haven't changed – in fact, if anything things have definitely worsened.

I would say that the biggest issue that's facing staff at the moment is the constant reorganisation of services I don't think there is a trust any of the officers that I work with are involved where there isn't a reorganisation going on almost every week, in every service eventually. The focus of these changed seems to be largely around saving money. They don't seem to have at their heart the issue of patient care.

This is obviously the push from the CCGs, where they say 'We're going to give you this much money, or we're going to give you this much less money and you're going to deliver whatever you can', and the trust is left with the task of restructuring the services. The result of this in terms of staff is continued down-banding. It's the biggest difficulty that we face. The trouble that we have is that to push somebody down one band is now seen as kind of acceptable, that's it's not a redundancy situation. Staff are having to swallow constant re-banding. What it's leading to is lower morale, definitely low morale. It's also leading to the more expensive staff and more experienced and slightly older staff looking at this and asking 'why am I doing this?' … and leaving the service. So we're losing a huge amount of expertise.

There are concerns about the ageing workforce: but if you get down-banded and the employer wants you to take that pension and you don't have pension protection, that has a huge impact as well as people look forward to their retirement and their income in retirement.

Trusts are also constantly re-negotiating pay protection schemes with the unions. Some of them are not particularly generous but some of them are quite good. Those are now coming down: where you do re-band stuff there are much smaller periods of time that they get any level of pay protection, because that's one of the things that trusts negotiate themselves, and isn't covered in Agenda for Change.

The other thing we're seeing is an increased use of sickness and absence procedures with staff. Now partly because there's an increased number of staff that are off on sick leave but I feel that it's being used in a much more punitive way than it has been perhaps in the past. The idea in my view is that it is all about very tight monitoring periods, shoving people from phase 1 to phase 2 to phase 3 and out of the door. The quicker you can get somebody out of the door who you think has become a burden to the trust then the quicker you get somebody new in at a lower rate of pay. The difficulty is there doesn't seem to be much of a focus around these adjustments of redeployment and keeping people who have developed disabilities, often because of the nature of their work in the health service. This seems to mean that the health service doesn't want to employ people with disabilities.

There's been a big rise the number of grievances that we deal with where bullying and harassment is defined as being the key issue. There's always a fine line between what is management and what is harassment. But bear in mind the number of times this is now coming up, and we're having to deal with this. The reality is that trusts all have these harassment processes, that's great, but they're not

very well set up for dealing with the outcome and practical process of taking that on board afterwards.

What we have is a very difficult process of raising a bullying and harassment complaint, but then getting to a point where it is largely – not every time but quite often – not upheld. Yet there is no process there to improve engagement, to improve communication generally. This links in with what we were saying this morning about the fact that the culture of openness and fairness at work and that kind of feeling isn't there [testimony from Roger Kline]. So we are getting a lot of people feeling clearly frustrated that they get bullied and harassed – and nothing happens. But when it doesn't get changed, no matter what they say about it to anyone – they think 'I might as well keep my head down or I might as well get out' and that tends to be the view.

Privatisation I think is another big issue. In London there hasn't been wholesale privatisation of community services, but there has been big privatisation of pathology. This is leading to staff feeling very powerless. Staff don't want to be privatised but feel they get absolutely no choice. When somebody wins a contract, the staff go with the contract. There's no engagement with the staff as to where they want to be employed. What staff are concerned about there really, is partly the impact on their long-term terms and conditions because once you are out of the NHS you are out of Agenda for Change. Although you go forward [under TUPE] on your current terms and conditions, that doesn't have to be your long-term position, particularly because you lose out in relation to the good, well-negotiated policies and procedures which tend to be in the NHS. You don't get those in the private sector, in the Sercos and Group 4s and the Interserves. In fact quite the opposite.

The concern is about health and pay, and safety concerns with privatised contracts. We could talk at length about what's happening in Guy's and Thomas's and King's at the moment with regard to the privatisation of the staff there. The service itself has been in the private sector now for some years but the staff are on retained employment, and they are now being forced through into another company on TUPE. We are actually taking strike action over the Christmas holidays on that. One of the main issues that the staff have raised is that Viapath, the company, are actually failing on patient care. Those are the questions that we would like answered.

I've sat in a meeting with the Chief Executive there where we've raised these concerns and yet they do not seem to get answered, so that's what Roger was saying this morning, about people feeling that they can't raise issues, or if they raise issues they are not listened to. In my experience it is very true. And these are people who are actually saying that eventually there will be a dreadful mistake or a dreadful problem because the equipment is not being updated, and the system is going to cause delays and problems. There will eventually be something horrendous going on there. That's apart from the moral fact that staff should have some say where they work and who they work for.

In terms of the down-banding there's a general de-skilling of staff and I think that's a long-term issue isn't it, because if you down-band at this point in time, at change of service, that's fine: but if the change is to health service delivery needs in that area you've lost those staff, you've lost that expertise in the field and you don't get them back again. That's a real issue for us.

In terms of community care I think there's a real concern among our members who work in the community about the lack of funding and the lack of resources for delivering good community care, which is all part of the agenda about closing hospitals and moving out into the community. If you look in particular at health visiting – we obviously represent a lot of health visitors – the case load numbers are generally extremely high and we have been working in various areas to try to tackle that but also we have an ageing workforce in health visiting.

That's a real issue because you have a bottleneck of new trainees coming through and an ageing work force being down-banded through reorganisation and losing pension rights and people are thinking 'Why am I staying? At this stage it's probably better if I get out early' which they probably will. Eventually you are going to have that kind of gap between the services that are needed and being able to provide the staff to deliver them.

I've already talked about health & safety and care. Related to the privatisation issue is an issue around recognition. Our experience both with the big negotiations going on with HSL which is taking UCLH, North Middlesex and the Royal Free Hospital Pathology staff into a new organisation which is called HSL, in partnership with the Doctors' Laboratory[1]. It's creating huge difficulties, trying to negotiate recognition of unions there. They originally said they wouldn't recognise us. Although the timetable keeps moving they now say they will negotiate with us – but we have seen no recognition agreement on the table. Exactly the same thing is happening at Guy's and St Thomas's where we have been trying to negotiate a recognition agreement, get it in place prior to the transfer on 1 January. All they are saying at the moment is "We will have to ballot staff to see who wants to have the union effectively, and you can only represent the people who want to be in the union and you're not going to have that collective bargaining arrangement that you would have with the NHS."

Bearing in mind the staff are now going to have to bargain on pay, because they won't have the protection of Agenda for Change or the Pay Review Body, then that leaves us very worried about our ability in the future as trade unions to operate in that sector and to guarantee protection and collective bargaining rights for staff.

To return to what Rachel said about 7-day working, trusts are locally coming up with proposals around 7-day working, not just in services where you might argue there should be a 24-hour service (where there's been an on-call service perhaps like in pathology) but in other services as well. Our experience of where they have tried to introduce shift arrangements and move away from on call is that you end up putting a huge amount of pressure on a small group of staff because a number of staff will come up and say 'I can't work shifts, I have caring responsibilities, I have disability, I have whatever it is that takes me out of the rota', and you get a greater number, usually the young single staff because they're the ones who can't argue an excuse not to be part of the shift, doing a greater number of block shifts, late shifts, night shifts and weekend work. This interrupts both people's natural sleep patterns but also their social lives etc.

Just from the union's point of view, we see a greater and greater difficulty to recruit and keep reps. I think that's because members see the difficult job that the reps are doing and the amount of case work that they have to deal with, the amount of complicated cases they have to deal with, and the difficulties in the work place – and nobody wants to come forward necessarily and be that person. That makes it much more difficult for the trade unions because our way in is through the representative structure. We can have as many full-time officers as we like sitting on the outside of a trust, but the reality is that the reps are the people who deliver in the trust. Also from the trade union's point of view how we get our information on what's going on. So that's really important to us. The fact that that's proving to be quite difficult I think is a real issue in terms of democracy and in terms of representation. So that's really all I have to add.

RL:
That's extraordinary. Can we go back to the beginning? I'm sure my colleagues would have some questions, but let's go back to probably what is the most pressing matter and that's the strike and

[1] Health Services Laboratories (HSL) describes itself as "a partnership between University College London Hospital NHS Foundation Trust (UCLH), Royal Free London NHS Foundation Trust (the Royal Free) and The Doctors Laboratory".

the pay. I have said that it's inconceivable that we're approaching an election with half the NHS on strike. But it seems to me that the Department of Health just want to sit this one out and see what happens, because just to play the devil's lawyer for a moment, we've had a couple of days of action or inaction or strike. For obvious reasons you can't make the impact that you could, the action is totemic more than anything, bringing to the attention of the public the fact that you haven't had a pay rise and all the rest of it. A lot of members of the public haven't had a pay rise either, and all of you are in the same boat. How is this going to end? It seems to me that the trusts are going to get fed up and start negotiating local pay and conditions, which I would have thought is the last thing you want.

RM:
A lot of trusts in one sense have budgeted for the pay increase. Many employers have said that they have gone to pay the 1% and looking at next year again they have said they believe that NHS staff should have a cost of living increase.

RL:
So would you take a trade-off? What would you say if a trust said to you OK we'll give you the 1% now and negotiate local pay and conditions for the future?

RM:
We're not saying no agreement at a local level. Some local employers have introduced a living wage and recognised the effect that has on their work force and obviously we've worked with them to implement that.

RL:
We forget trusts, all trusts, since the 1989 Act in fact, can negotiate local pay. Some wanted to introduce pay and conditions and there was that thing down in the West Country last year where that fell by the wayside. How do you see this ending?

RM:
We have been called in to some talks on Monday. Private talks, we don't know the remit for that. It's the first thing we've seen from the Department, so obviously the concern is building and it's not just like you said strike action it's very much about our impact on the public, raising awareness, and because we can't pull out a hospital – there was never any thought that we'd do that – but what we are looking at is affirmation in the new year of industrial action. The action short of a strike is having real impact. As an example, just this week more staff are being taken on as a result of our members working to rule. It is having an impact, not an easy impact for employers to recognise but I think the thing that we learnt is that the employers don't recognise their role in trying to bring people back around the table. They're very much passive in the process, saying well it's a government problem, as opposed to being very much active which you would expect from a quality organisation.

RL:
Well it suits them doesn't it, at the moment from the budget point of view, to sit it out?

RM:
Well the government might see it suiting the employers, but the government obviously don't want bad publicity on the NHS around the general election. Obviously we will continue to be on their heels.

RL:
So there will be a resolution before the election?

SC:
Obviously it's 146 days, I think we are now, and counting, but I think the government are going to have no choice but to find some resolution similar to Wales, who were able to agree a 2-year deal on pay with the unions which took in recognition low pay and addressed some small increase for this year. In the financial constraints that Wales are in we believe that England could make a similar concession but they just won't engage in a dialogue.

RL:
It looks like they've started to.

SC:
We don't know the remit of it, whether it's to tell us off or what it will be, but we will find out. One of the things that we're both focused on is that agency spend in the NHS has gone up by £1 billion in the last year, so that in itself is an area that we will be focusing our attention. Because obviously if you're paying staff well, you keep more staff in work, and if you keep more staff in work you won't need to depend on agency. There are opportunities for direct pay-off if you concentrate the minds of people.

NK:
Being devil's advocate. I don't know if you remember, but 10 plus years ago, the Australian unions decided enough was enough and they took strike action. But they were much more direct in what they did and didn't do. They would only cover I think something like ICU. The other thing was if there was going to be an incident then they would just be off. It didn't take a week for the government to change their mind and give up.

RL:
So the question is, do you see an escalation of the strike action?

NK:
The other thing that doesn't help what you are doing is that some of your colleagues negotiate some of these things with the managers outside your normal staffside arrangements, and persuade some other people to agree to A or B. So members are quite unhappy because of what they see as backroom deals. One of those members did a presentation to us last year.

FW:
I was in a meeting yesterday at my hospital, which is King's College Hospital, and I am very rarely surprised but I was surprised that my hospital had 1340 vacancies. I thought 'that's more than I expected'. Not only is it alarming in terms of recruitment but I just wonder are we seeing this in most other hospitals? Are we seeing this level of empty lockers?

RL:
Dare I mention their name in your presence, but the RCN reckon there are 20,000 nurse vacancies.

RM:
The issue of workforce planning is a long-term issue within particularly the NHS in England because there is no statutory obligation around the way that workforce planning is put together. Therefore there is no proper planning. In Scotland we have partnership working to look at workforce planning. That obviously doesn't happen south of the border. Therefore it is a big issue.

If we look at district nursing as another example where the number of commissions in district nursing – despite everything having to move back into the community – is actually reducing year on year. So we are not getting the workforce. As Sarah said, the ageing workforce in particular professions is creating a cliff edge, and because of the changes in the pension scheme a lot of people will be handing in their notice in January. The NHS is only just waking up to the fact that this will be a real issue.

RL:
Looking at the issues you've raised. Down-banding, which is obviously a very significant issue, the pay protection period, the sickness and absence procedures, the health and safety issues. All of this really is just employers just trying to squeeze the last drop they can out of what they've got because of the money isn't it? It's all about the money.

RM:
70 per cent of trusts are expecting to be in debt by the end of the year.

SR:
What's come through to me from what you've said is that there is an issue of competence at a system-wide level. Your issue of agency staff and its relation to money, that's just a classic example getting it wrong and ending up having to pay for it, and various other things that you suggested.

PT:
It just surprises me that they can get away with it. Down-banding: if you'd suggested that 30 years ago it would have been out of the question. You couldn't 'down band' people. How has it happened that they get away with that?

RL:
It's the only place that nurses can work. So it's either that or no job.

SC:
I think it's difficult to understand the morale issues in the NHS from the outside. You think 'well why can't people be more angry, why can't they refuse this, why aren't they just walking out of the doors?'. But the reality is people are just so fed up and so demoralised. I think they just feel there's no way out of it. They can't do anything else, and a job is a job and if you look at the economy now, where else are you going to go as a nurse? Unless you get a job at BUPA or something. If you have a family here you're not going to be able to go abroad.

PT:
Agency and they'll hire them back?

RL:
But that's what they do. You can get paid more as an agency nurse, you've got flexible working, you can fit it in with your kids, you can work when you want, you're not trapped into a shift pattern. It's much more attractive.

RM:
You lose out on a lot of the benefits you get from continuous employed service.

LI:
There's quite a link between this and privatisation. I know a senior child mental health nurse, very senior, 20 years' experience, who was sacked along with some of her colleagues, to make the mental

health trust ‘tender ready’. So that they would be fit to compete if the services were put out to tender with the private sector. So they got rid of a layer of experienced and more expensive staff and got in younger and less well-paid staff. What she said was not only did the service lose their experience but also younger staff coming in don’t have those role models as mentors. So it’s a double loss. And it’s ‘tender ready’.

RM:
That’s been seen through the statutory regulatory bodies as well: we’ve had an example where a speech and language therapist has been before the body because they’ve gone into an organisation without the senior leadership to try to develop staff. and therefore they didn’t develop the competencies and made errors on their work.

RL:
To move slightly off piste, do you know what happened as Serco are pulling out of their clinically facing services, which means there will be ex-NHS people who have been TUPE’d across to them. Do we know what the plans are, or is there a plan ‘B’? Do we know?

RM:
This is in Suffolk. I don’t know.

SC:
They are pulling out of community services aren’t they? Because they are still very much in the pathology services.

RL:
Yes, they are in pathology services but they are pulling out of the clinical professions.

SC:
That’s correct.

RL:
Listen, you’ve given us enormous food for thought. Thank you so much.