mip
managers in partnership

# healthcare manager

Issue 44
Winter 2019–20


## It's time for real leadership

**Reports from MiP's Summit in Birmingham**

## Steve Warburton

On the Mersey beat with Liverpool's trust chief

## Meet and greet

Your new MiP Committee

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issue 44
winter 2019-20

# healthcare manager

# inside

## heads up:2

**Leading edge:** Jon Restell on the challenges facing the new health secretary: 3

## your commmittee:8

**MiP National Committee:** Introducing your new team for 2020-21

## features:10

**Interview:** Steve Warburton, new boss of Liverpool's mega trust, talks to Matt Ross: 12

**Annual Summit:** Reports from MiP's yearly get-together in Birmingham: 15

## regulars:20

**Legal Eye:** Legal protections for union members and activists: 20

**Tipster:** So, when can I retire? 21

**MiP at Work:** How do we make health devolution work on the ground? 22

**The Sharp End:** Why are we weeding out the good managers and rewarding the bad? 24

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Managers in Partnership is the trade union organisation providing support and advice to senior managers in healthcare in the UK on employment matters, careers and management practice. We represent their views to policymakers, employers, the media and the public.

**You may notice that this issue is pretty light on the general election. Print deadlines dictated that we went to press shortly before polling day, so we decided to avoid speculating on the result and pay more attention to other things. That may come as a relief to many after a bitter, largely unenlightening and rain-sodden campaign.**

But whoever is in power by the time you read this will have to get to grips with the same stark realities about the NHS.

One, the NHS is underfunded, by both global healthcare and its own historical standards. Both main parties promised billions extra, but that money will still have to be found from somewhere—a significant task in an economy that seems stuck in second gear for the foreseeable future.

Two, the NHS is chronically short-staffed and it's as clear as mud where the people to fill more than 100,000 vacancies are going to come from. There's no quick fix and just crossing your fingers and hoping fewer staff leave certainly isn't going to cut it.

Three, the NHS—in England at least—is saddled with structures which simply don't fit the objectives politicians of all stripes want it to achieve. Some sort of legislative shake-up is inevitable sooner or later, but none of the major parties have shown that they really understand the problem, let alone that they have any coherent solutions.

Let's send some seasonal good wishes to Matt, Jonathan or whoever is the new Secretary of State. But we all know that the burden of sorting all this out is going to land mostly on health managers shoulders! So take a break while you can, have a happy Christmas and I wish you all the best for the new year.

**Craig Ryan,** Editor

# heads up

**News you might have missed and what to look out for**


**Pensions tax fix unfair—4**

**New social work watchdog—4**

**MiP on board for Guardian public service awards—5**

**Public service workers fear the chop—5**

**Latest on NHSE/I merger—6**


NOTICEBOARD

## TUC equality conferences

TUC Changing the world of work for good

**MiP is looking for members interested in attending TUC equality conferences during 2020. MiP is represented at TUC conferences as part of the FDA delegation.**

The dates for the 2020 TUC Equality Conferences are:

Women's Conference: 4-6 March

Young Workers' Conference: 21-22 March (members aged 35 or under are eligible to attend)

Black Workers' Conference: 24-26 April

Disabled Workers' Conference: 21-22 May

LGBT+ Conference: 25-26 June

TUC Conferences are a fantastic opportunity to network with colleagues from other unions, shape the policy direction of the trade union movement and hear about work going on in different sectors. The FDA will provide briefings and support to delegates for all the conferences, and you don't need to attend for the entire duration of the event.

If you're interested in attending any of these conferences, email Mercedes Broadbent (m.broadbent@miphealth.org.uk) at MiP head office by **10 January 2020**.

## HPMA Excellence in HR Management Awards 2020

Nominations are now open for 2020 HPMA Awards, which celebrate excellence in HR management and staff development. The awards, which are supported by MiP and NHS England among a host of other NHS organisations, will be presented in Belfast on 4 June 2020.

The Social Partnership Forum, which brings together healthcare unions, including MiP, and NHS employers, sponsors the award for partnership working between employers and trade unions. There are 15 other categories including HR director of the year, employee engagement, effective diversity and staff wellbeing.

Nominations close on **18 February 2020**. For further information visit: www.hpma.org.uk/awards-2020/

## Nominations open for five committee vacancies

**Nominations are now open for by-elections to fill five vacancies on MiP's National Committee. Successful candidates will serve on the committee until 31 December 2021 (meet the committee p8).**

The five vacancies are for:

Scotland (2 seats)
Wales (1 seat)
Northern Ireland (1 seat)
South Central England (1 seat)

Candidates must have been an MiP member since 4 September 2019 or earlier, and will need to be nominated by three members working in their region or country. If you are interested in standing in any of these seats, visit the MiP website (bit.ly/mip-nc-2020-byelections) where you can read our guidance note on the National Committee and download a nomination form.

Candidates may write an election address of up to 250 words, without pictures, to be circulated to members in their area. You will need to return your nomination forms and election address to the MiP chief executive by 5pm on 10 January 2020. An election will only be held if there are more nominations than vacant seats in the area concerned.

If you would like to know more about the being a membert of the National Committee, contact your national officer or email head office at: election@miphealth.org.uk.


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**Letters**
Letters to the editor are welcome by email, or by post to MiP, Ebbark House, 93-95 Borough High St, London, SE1 1NL Letters must be clearly marked "For Publication". We may edit letters for length. Please supply your name and address, which may be withheld from publication on request.

# leading**edge**

## Jon Restell, chief executive, MiP

**I'm writing this just before polling day, but by the time you read it we will have a new government and possibly a new health secretary. I won't be the big dumb and predict who will have won. It's fair to say, however, that the general turmoil in our politics will continue, and will affect the health and care system. And it's also fair to say that the policy challenges we face probably won't look that different in three weeks' time, whoever has the reins of power.**

The in-tray exercise for the new health secretary is a tried and tested classic for comment pieces. So if it ain't broke...

Here's what your union will be saying to the new government.

We hope the new government will maintain and invest in the NHS's long-standing commitment to social partnership working between employers and unions. A widely-admired feature of the NHS, these arrangements survived—if not exactly thrived—under the Coalition and Conservative governments. Partnership led to progress on workplace culture, especially tackling bullying and improving staff experience of system change. They have come back into their own with the workforce crisis and the resulting NHS People Plan. MiP will play its part in the national machinery and our workplace reps will do the same with local employers. Government should encourage trade union membership and participation to help make the NHS the best place to work.

We urge the new government to deliver on the leadership compact between national bodies and providers, and go further to support and train managers and leaders. Accountability of managers should bring support as well as challenge and any proposals for regulating managers need to be proportionate, fair and created through consultation and consensus. An important signal—which I believe employers also want sent—will be parity of value between clinical staff, especially doctors, and other staff such as managers. This is partly a matter of words but also of practical policy. The two tier approach to support staff (e.g. with pay and conditions in wholly-owned subsidiaries) and managerial staff (e.g. with the unfair pensions tax fix—*see page 4*) sends all the wrong signals. Treating everyone as part of one team must be a central plank of the People Plan.

> "We will be robust and constructive in our relations with the new government. In particular, we will be unafraid to speak up for the core principles of the NHS and public service.

Part of the workforce crisis stems from pay. Next year sees the last year of the three-year Agenda for Change pay deal. Health unions, including MiP, are starting to assemble the pay claim for 'year 4' in 2021. The 2018 deal was critical in breaking the pay cap and making overdue structural reforms to the pay system. But it must not be seen as a one-off investment: pay rises must continue if we're to avoid a boom and bust approach to pay. And MiP has outstanding issues with the unjust caps on awards for higher band staff and the failure to shorten the time it takes to reach the top of bands 8 and 9. We also want the NHS to remain a Living Wage employer. Funding a decent settlement in 2021 must be a priority for the new government.

On funding, our members call for a long-term funding settlement for social care as well as the health service. We need a higher-quality debate about the tax base required to provide decent health and care, and improve public services such as housing and education, which are key determinants of people's health. Managers, with their focus on the needs of the whole system and its workforce, are well placed to inform this debate.

Finally, legislation on the functions and structure of the health service now seems inevitable. NHS England has 'oven-ready' proposals. It's critical that form follows function, but this means being very clear about the functions of the system and what we expect from both integration and devolution (see page 22). We can then have a proper debate about accountability and consider carefully how the people side of any legislation is managed. What looks good on paper can become worthless if it results in unnecessary or badly-managed organisational change. As a union with wide experience of such reform, we hope the government (and parliamentarians) will draw on our expertise.

We will be robust and constructive in our relations with the new government. In particular, we will be unafraid to speak up for the core principles of the NHS and public service, and will argue workforce's corner, not least its hardworking, dedicated and skilful managers. ■

*Pensions*

# MiP condemns pensions tax 'fix' excluding non-clinical staff

**MiP has criticised the government's temporary solution to the pensions tax crisis affecting senior NHS staff as "unfair and potentially discriminatory" after NHS England announced the scheme would be restricted to clinical staff.**

TERRY CAMPBELL

ALEXDEVERILL

Under the government's proposals, announced in November, senior clinical staff facing large tax charges a result of government changes to pensions tax relief will be able to settle their tax bills out of their pension pot, and have the payments fully refunded on retirement. But staff without a clinical registration will be not eligible for the scheme.

"We are profoundly disappointed that committed, hard-working senior managers are excluded from this change. It is unfair and potentially discriminatory. It sends the wrong message to all those staff who do not have a clinical registration about the value the NHS places on them," said MiP chief executive Jon Restell (pictured left).

Restrictions on the annual allowance for pension contributions have resulted in tax bills of many thousands of pounds for some senior staff—including many general managers as well as clinicians—and have been blamed for some staff refusing to work additional shifts and turning down promotion opportunities.

Announcing the measure, NHS England chief executive Simon Stevens (pictured above, right) said clinicians who incur tax bills after exceeding their annual pension allowance would be able to choose a 'scheme pays' option—effectively paying the tax bill from their pension pot—so they "don't have to worry about paying the fee out of their own pocket".

The NHS would then pay such staff a "correspondent amount on retirement, ensuring that they are fully compensated for the effect of the 'scheme pays' reduction," Stevens said.

As well as the unfairness to non-clinical staff, MiP has raised other concerns about the sustainability and robustness of the government's proposals.

"It is not a long-term solution and has many practical challenges," said Restell. "For example there are questions about eligibility and whether it is wise to create such very long term obligations for employers.

"Tax policy—and its many unintended consequences—is the problem, and that is where the genuine solution lies," he added. "For example, we could use the lifetime allowance as the main way to restrict tax relief on high earners in the NHS pension scheme. We urge the incoming government to find a workable solution and to commit to reforming pension tax policy."

*Social Care*

## Unions welcome "collaborative" new social work watchdog

**Unions have welcomed the launch of Social Work England (SWE), which replaced the Health and Care Professions Council as the regulator of social work in England on 2 December.**

**The new body will regulate the practice of England's 100,000 professionally-qualified social workers, maintain and improve professional standards, and work to promote greater public confidence in the social work profession.**

**Colum Conway, Chief Executive of Social Work England (pictured right), said that SWE would "put collaborative working at the heart of everything we do". He added: "It's a landmark moment for the sector as our organisation takes over as regulator. We have been established under new legislation which allows us to be a modern, specialist regulator that builds and promotes confidence in the sector."**

**UNISON, which represents professional social workers across the UK, welcomed the collaborative approach and the way unions had been able to contribute to its development.**

**"SWE and social workers have high expectations of each other and, while UNISON has a few concerns to iron out, the union is very hopeful and will work collaboratively to help the new regulator bed in," said a UNISON spokesperson.**

*Jobs*

# One in three public service workers fear the chop


More than a third of public sector workers think they are likely to be made redundant in the next three years, with most seeing new technology as a threat to public sector jobs, according to a new survey commissioned by UNISON.

The *Skills for the Future* survey, carried out by researchers at the University of Exeter on behalf of the union, found that the fear of redundancy was greatest in public services that had already suffered big job cuts in the last decade. Half of employees in local government and utilities expected to lose their jobs within three years, as well as 44% of staff working in education services.

In the NHS, the fear of redundancy was significantly lower—but still widespread, with 20% of staff expecting to collect redundancy notices within 36 months.

While 57% of staff saw new technology as a threat to public service jobs, 78% believed they were most likely to lose their own jobs because of organisational change affecting their employer.

While more than 80% of staff were keen to learn new skills, more than half said their employers had failed to offer useful training opportunities within the last year, and a third said a lack of training was damaging their future job prospects.

**Read the full report on the UNISON learning website: bit.ly/skills-for-the-future.**

*Public Service Awards*

# MiP joins judging panel for prestigious public service awards

**Mercedes Broadbent, MiP's policy and communications officer, was among the judges for this year's Guardian Public Service Awards. Mercedes sat alongside Guardian staff and a range of public service experts to assess entries in the "recruitment and HR" and "workforce learning and development" categories.**

TERRY CAMPBELL

The awards showcase the projects, teams and individuals making a real difference to people's lives. They are open to everyone working in public services whether they are employed in the public, private or voluntary sectors.

The winner of the workforce learning and development award was Coventry City Council for their children's services social work academy. After being rated as 'inadequate' by Ofsted five years ago, the council knew it had to improve to achieve a 'good' rating and recruit more graduate social workers.

The council designed a new social work academy model with advice from local universities, which supported recruits at the point of qualifying—now all newly qualified social workers at Coventry spend their first six months attached to the academy. Sixty new social workers have gone through the academy since it was set up last year, and the council's use of agency staff dropped by 50% in the year to May 2019.

The runners up in the workforce learning and development category were the team running the Cabinet Office's civil servant talent accelerated development scheme, and the Northern Ireland Housing Executive asset management training programme.

The judges chose Kirklees Council as the winner in the recruitment and HR category for its In2Care programme, which matches prospective employees with suitable social care employers. The system has brought 530 local people into social care jobs—39% of whom were new to the social care sector.

The runners up for the recruitment and HR category were Hackney Council's apprenticeship programme and Newlon Housing Trust's residents' work placement programme.

*NHSE/I merger*

# Staff needs lost in rush to m

**The realignment of NHS England and NHS Improvement (NHSE/I) is being carried out at such speed that the circumstances and needs of individual staff risk being ignored, MiP has warned.**

"This process is being done on such a huge scale, and at such a pace, that attention to detail at the individual level can get lost," said Ruth Smith, one of the MiP national officers representing members affected by the merger, which is due to be completed by the end of 2019. She warned that the needs of staff on maternity leave, sick leave or a career break, or those with disabilities or caring responsibilities, were particularly likely to be overlooked.

At the time of writing in early December, the allocation of staff to jobs in 'Pool A'—posts where existing staff can simply be 'slotted in'—had been completed and attention switched to the 1,000 staff seeking posts in Pool B—where staff can 'express interest' in two posts within their own region or directorate. Around 40% of staff had found a post through this process by the beginning of December.

Ruth Smith: "This process is being done at such scale and pace that attention to detail at the individual level can get lost."

Staff who do not find a post in Pool B will be placed in Pool C, where they can put themselves forward for up to two posts in their band anywhere in NHSE/I. The Pool C process is being run on a grade-by-grade basis, which began with Grades 9 and 8D at the end of November, and is scheduled to be complete by the end of the year.

Smith explained that staff who are unsuccessful in Pool C would not necessarily be made redundant. "Any remaining posts will be filled by internal open competition, which basically means the normal NHSE process for filling vacant posts," she said.

# erge, MiP warns

## MiP acts to protect maternity rights in NHSE/I merger

**MiP has won assurances from NHS England that the rights of women on maternity leave will be fully protected in the merger with NHS Improvement, following complaints from members that pregnant women and new mothers were being forced to compete for jobs in the merged organisation.**

Under current legislation, women on maternity leave should not be have to compete with colleagues for jobs, where a suitable post is available in the new structure. Reports from MiP members suggest that these rights were not always being honoured at local level.

Following an intervention by MiP national officer Zohra Francis (pictured right), NHSE/I have now given assurances that women on maternity leave who meet the essential criteria for a job in the merged organisation will simply be offered the role.

TERRY CAMPBELL

"Members absolutely need to know their rights in this situation."
**ZOHRA FRANCIS**

"Earlier in the process, a number of members contacted me with complaints," Francis said. "The worst case was a women who had just given birth, who was told that she was had to attend an interview or she would forfeit her role in the new organisation.

"This is an important success for MiP," she added, "but members absolutely need to know their rights in these circumstances. They should challenge any attempt to make them compete for ring-fenced jobs and report it to MiP immediately. Just challenging it with your line manager can be enough to get the proposal withdrawn. But if not, contact your MiP national officer for help to get it resolved."

MiP raised a number of serious concerns at a joint meeting with management in late November, including whether posts being offered were within reasonable travelling distance, particularly taking into account personal circumstances.

"It has to be done on an individual basis," said Smith. "Where people have caring responsibilities, we fully expect a conversation to be had about the suitability of the post if it requires a change of base or more travel, and for that to be handled through HR leads."

She added: "We have been told that NHSE/I will encourage better use of technology to reduce the need for travel, and will challenge the idea that central posts have to be based in Leeds or London."

MiP is also encouraging members to report any "inappropriate" external advertising of posts before the process of allocating existing staff had been completed. "With a few exceptions, substantive posts should not be advertised outside during this process," said Smith. Those exceptions were "growth areas" for NHSE/I—such as midwifery—where there are likely to be more posts than existing staff. "In those cases, prior consideration should still be given to existing staff," she added.

MiP is also discussing a number of other issues with NHSE/I management, following complaints by members. They include:

- Rights for members on maternity leave to be slotted into new posts (see above)
- Emails and other communications about the reorganisation being sent to members outside working hours
- Out of date or incomplete job descriptions and job evaluation scores being used to assess people for new posts
- The implications for members on sick leave who may not be able to participate in the process

MiP advises members with concerns about either their future job in the merged NHSE/I structure, or the way the process is being carried out locally, to raise them with their line manager as soon as possible, involving the local leads for HR, implementation, and equality and diversity, where necessary. They should also contact their national officer at the same time.

"I can't stress enough that people need to raise any concerns with both MiP and their manager as soon as possible," added Smith. "This process is moving at 100mph and people may miss out on opportunities to put things right if they don't act quickly."

MiP members have recently elected a new National Committee to take office in the new year. Here, we introduce to the new committee's members and fill you in on how MiP's democratic structures work.

# Meet your new MiP Committee

**MiP's new National Committee, elected this autumn, will take over the running of the union from 1 January 2020. A mixture of new and old faces, the new committee members have a wide range of experience from different parts of the NHS—but there are five vacancies to be filled in the new year, so if you work in Scotland, Northern Ireland, Wales or South Central England, you still have the chance to help shape your union's future over the next two years (see page 11).**

But how does the National Committee work and how does it fit into MiP's system of governance?

## What does the National Committee do?

The 16-member National Committee oversees MiP's strategy, management and operations. Meeting face-to-face on a quarterly basis and more frequently via videoconference, the National Committee:

- Oversees our relationships with employers, government and other partners;
- Sets and implements strategy on recruiting and organising members and volunteers;
- Agrees policies for engagement with employers and within staffside and consultative forums;
- Advises and assists in developing key MiP services, such as our Members' Summit and our digital communications.

The MiP chair and vice-chair are elected from among the committee's members. You can find a list of all its current members on the National Committee Members page.

## How is the National Committee elected?

The National Committee comprises 16 member volunteers, nominated and elected by members for two-year terms. There is one seat for each English region and two for London—with two seats reserved for Scotland, two for Wales and one for Northern Ireland.

Candidates must be nominated by members in their own region or country. An election is held if more candidates are nominated than there are seats in that region. Elections are held under the Single Transferable Vote System, to ensure national committee members are as representative as possible of the members in their region.

At the moment, there are five vacancies on the National Committee. By-elections to fill these seats will be held early in the new year, with nominations closing on 10 January 2020. See page 2 for further details.

## What is the Management Board?

The MiP Management Board brings together our parent unions, the FDA and UNISON, to oversee the joint venture.

The board has six voting members, comprising equal numbers of elected officers nominated by each union. The Board works by consensus, and its key roles are to:

- Set the budget, over-arching goals, and performance targets;
- Consider high-level strategy and organisational development;
- Deal with 'rulebook' issues between the unions;
- Develop shared approaches to policy, strategy and campaigning.

## Other ways to have your say

To strengthen the input and guidance we get from members, MiP also seeks your views via regular member surveys and at our annual Members' Summit. As members of both the FDA and UNISON. MiP members can vote in elections for both general secretaries, and they also elect four representatives to the FDA's Executive Committee.

**To find out more about becoming a National Committee member, read our National Committee Guide at bit.ly/mip-nc-guide or get in touch with head office for further information.**

ALL PHOTOS : TERRY CAMPBELL

North East England

## Clare Bannister

Northumbria Healthcare Foundation Trust

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**Clare manages acute medical and critical care services at the Northumbria Specialist Emergency Care Hospital, the UK's only purpose-built emergency hospital. She has worked for the NHS for 35 years, and was an A&E nursing sister for ten years before moving into management.**

Clare has worked as a general manager in both medical and surgical services, in service development and commercial teams, and for a CCG and an ambulance trust. A member of the National Committee since 2018, Clare has been involved in setting up MiP's North Summit and the Women's Network, and is particularly interested in working to increase MiP membership in the North East region.

With two rugby-playing sons, Clare spends a lot of time pitch-side, bellowing instructions, and enjoys long hikes with her two Labradors in the beautiful Northumberland countryside.

KARL ANDRE PHOTOGRAPHY LTD

Yorkshire & the Humber

## Jeremy Baskett

Northern Lincolnshire & Goole NHS Foundation Trust

jerbas@sky.com

**Jeremy is a Governor for Northern Lincolnshire and Goole NHS Foundation Trust, which covers three acute hospitals in Grimsby, Scunthorpe and Goole.**

He was a flying NHS Chiropodist in the Orkney Islands before working as a manager in hospitals, Primary Care Trusts and CCGs. He was a founding member of the Yorkshire and Humber CSU before it was privatised. He holds an MSc in health and social care management.

Jeremy joined the National Committee in 2014, and is also a volunteer MiP rep, supporting members when required. He is also the staff side chair for the Joint Trade Union partnership forum for seven CCGs covering North Yorkshire and Humberside. His particular interests include NHS pensions, pay negotiations and changes in the provision of NHS services.

As a local councillor, Jeremy is heavily involved in the running of his local area and loves spending time with his family, walking, photography and travel.

North West

## David Cain

Independent consultant

David.cain@mft.nhs.uk

**David now works as an independent management consultant for NHS organisations, following a 40-year career in the health service. He has held chief executive posts in Manchester and Liverpool and was regional director of primary care for the North West.**

David is a founder member of MiP, having served on the committee of the FDA's NHS Managers' section before MiP was set up. He has been a member of the National Committee since 2005 and also represents MiP members on the FDA's national executive committee. He is particularly interested in the regulation and reputation of NHS managers, and is the Freedom to Speak Up Guardian for Manchester University NHS Foundation Trust.

In his spare time, David is chair of a large Academy High School, chair of the Pain Relief Foundation Charity, and deputy chair of a charity that runs a care home for disabled adults, where his brother is a resident.

Wales

## Helen Harris

Wales Renal Clinical Network

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**Helen is finance manager for the Wales Renal Clinical Network, and a fellow of the Association of Chartered Certified Accountants. She trained as an accountant with KPMG and has worked for a number of hospitals across Wales, the Merthyr Tydfil Local Health Board and the South East Wales Ambulance Service.**

As a new member of the national committee for 2020-21, Helen is keen to be the voice of "the hidden back office functions and support services" and promises to speak loudly about the work they do to make healthcare happen.

Helen has a fondness for crime fiction but still prefers the printed word to e-readers. She has an unrivalled collection of cook books and can be a good cook when she follows the instructions. Having recently discovered American Football, she is now an enthusiastic supporter of the Detroit Lions.

East Midlands

## Anthony Nichols

NHS England
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**Anthony is head of health and justice for NHS England in the Midlands region, leading the commissioning team for healthcare across the secure estate, which includes prisons, secure children's services, immigration removal centres and sexual assault services. As a career general manager, Anthony has also worked in mental health and public health services, and on equalities projects for the Department of Health.**

A member of the National Committee since 2014, Anthony has a special interest in promoting fairness, transparency and inclusion in the NHS. He sits on the National Partnership Forum, the NHSE Staff Side Executive and the senior leaders equality forum.

Away from work, Anthony likes gardening, keeps bees and chickens, and plays an active part in his local community.

West Midlands

## Yvonne Richards

NHS England/ Improvement
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**Yvonne works as a delivery and policy lead on the Ageing Well programme, focusing on delivering the new standards for urgent community response in community healthcare services.**

A career NHS manager with an MSc in healthcare leadership, she has worked in various provider and commissioning organisations and the West Midlands Ambulance Service, as well as leading projects related to World Class Commissioning, CCG authorisation and the Better Care Programme.

Yvonne was an MiP Link member for six years before joining the National Committee for the first time in January 2020. As a new committee member, she is keen to raise MiP's profile and improve the support that the union offers to NHS managers. As a self-confessed 'gym bunny', Yvonne finds that working out helps her "to focus and be in the moment". She is also learning Spanish by attending local evening classes.

East of England

## Stuart Quinton

NHS England/ Improvement
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**Stuart works for NHS England, managing all the GP contracts and practices across Suffolk and North East Essex. He works with local CCGs to ensure all patients in the area receive high-quality primary medical services.**

Apart from spells picking tomatoes and delivering newspapers, Stuart has spent his entire 34-year career in the NHS, mainly in primary care support services, working his way up the ladder in various administrative and managerial roles. He holds a CMI Level 5 Diploma in management and leadership.

A member of the National Committee since 2018, Stuart is also the MiP link member for the Suffolk CCGs, and has sat on the staff side of several partnership forums at local level. His particular interests include pay, conditions of service and pensions.

Outside work, Stuart spends time reading newspapers, walking, quizzing, going to classical music concerts and helping out at his local church.

London

## Richard Carthew

NHS Digital
richard.carthew@nhs.net

**Richard works as a 'business architect' in the enterprise architecture team and describes his job as "making sure that NHS Digital is delivering what it has been commissioned to do".**

A natural scientist by background (he has a PhD in palaeontology), Richard was a civil servant before joining the NHS in 1991, where he worked in acute and mental health trusts, and in district and strategic health authorities.

Richard has represented members in London on the National Committee since 2016, and is one of four MiP representatives on the FDA's Executive Committee. His main interests are organisational change, strategic approaches to management and—of course—digitisation.

In his spare time, Richard is an eclipse chaser—he's seen eight so far—and tries to stay fit through cycling and Alpine mountaineering.

London

## Sandie Belcher

South West London & St George's Mental Health Trust
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**Sandie is clinical lead for the patient experience team at South West London & St George's. Qualified as both a general and mental health nurse, Sandie has held various NHS management positions and has also worked on secondment for MIND, where she played a key role in saving a vocational rehabilitation unit in Guildford from closure.**

Sandie was previously assistant branch secretary for COHSE, one of the forerunners of UNISON. As a member of MiP's National Committee since 2010, she has worked to ensure mental health services and senior nurses are properly represented within MiP. She is also a trained mediator.

Sandie is a qualified rugby coach, mainly working in girls rugby, and is safeguarding officer for Slough Rugby Club. She also enjoys 'glamping' trips in her camper van with her husband and border collie.

South West

## Geoff Underwood

South Central & West NHS Commissioning Support Unit
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**Geoff is a programme director for the South Central & West Commissioning Support Unit, working on a range of projects with CCGs, NHS England, local authorities and a growing number of provider organisations.**

A career general manager, Geoff previously worked for North Bristol NHS Trust, planning its move to a brand new site, and has recently completed a secondment to University Hospitals Bristol.

Geoff was an MiP link member at North Bristol before joining the national committee in 2016. He aims to boost MiP's profile as a national voice for managers, promote positive leadership and management cultures, and encourage managers to speak up when they are working in negative situations.

Geoff's two young kids keep him and his wife very busy, but he enjoys cycling and hill walking, and is always reading, listening to or watching something. But, he says, "I spend too much time playing my Playstation rather than my guitar."

South East Coast

## Phil Kennedy

Queen Victoria Hospital Foundation Trust, Sussex
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**Phil works for the Queen Victoria Hospital, an acute trust specialising in burns treatment and reconstructive surgery, where he oversees the appointments and health records functions, and runs programmes to improve outpatient experience and access to services.**

Originally a qualified chiropodist, Phil has managed community services, including district nursing and health visiting, and worked on walk-in centres, emergency planning and NHS hearing aid services.

Phil joined MiP's National Committee in 2016, having previously been a rep for the Society of Chiropodists and Podiatrists. Phil has a particular interest in combating lazy stereotypes about NHS managers in the media. He represents MiP on the National CSU Partnership Forum.

Phil enjoys watching live music and sports, hacking his way around a golf course and military history. He is also a member of the Campaign for Real Ale.

Your Area

## It could be you!

Your job
**Your email**

**Would you like to join MiP's National Committee? There are currently five vacancies on the committee for members to represent the following areas:**

Scotland (2 seats)
Wales (1 seat)
South Central England (1 seat)
Northern Ireland (1 seat)

MiP will be holding by-elections for these seats early in the new year. If you want to stand, you will need to get your nomination form and election address in by **10 January 2020**. For full details of the election process, see page 2.

If you want to know more, why not have a chat with your national officer? You'll find their details on the MiP website: miphealth.org.uk.

The creation of Liverpool's new 'mega-trust' is an important part of the regeneration of the city, and central to moves to get public services working together across Merseyside. **Matt Ross** spoke to the trust's new boss, Steve Warburton.

# You'll never work alone

**Just east of Liverpool city centre stand two Royal Liverpool University Hospitals. One is a vast, crumbling 1960s hymn to concrete brutalism, and the other its brand new replacement: a towering, stylish development designed as the UK's largest single-patient room hospital.**

The starkly contrasting buildings appear to illustrate the dramatic renaissance Liverpool has enjoyed since Steve Warburton joined Mersey Regional Health Authority as a graduate finance trainee back in 1989. "The city is unrecognisable," he says, pointing to "the regeneration that's taken place in the centre; the amount of construction work going on; the cultural offer. This is a great place right now."

And Warburton—who in September became chief executive of Royal Liverpool and Broadgreen University Hospitals NHS Trust, the product of merging Liverpool's two acute trusts—says NHS services have improved along with the city. Even after nine years of austerity, he notes, "most patients are still getting relatively timely access to services, and these services are generally of a very, very high standard."

Zoom in, though, and there are obvious weaknesses in Liverpool's regeneration, in its health services, and in its shiny new hospital—which looks set to overshoot its original 2017 completion date by at least four years. Built by Carillion under a PFI deal, it was unfinished when the firm collapsed; and as hospital administrators took over the project, they found serious faults in its construction. "Structural defects in the concrete work have required some really innovative solutions" to avoid partial demolition, says Warburton, and now "problems with the external cladding have been identified: we're still working through the engineering solution."

> "Following the collapse of Carillion and the transfer of the assets back to the public sector, what had been somebody else's problem has now become our problem"

How did project management go so wrong? "It's a question we would like answering," responds Warburton. Under PFI, he explains, trusts are kept at arm's length until building work is complete—with the PFI company and funders, in theory, carrying the risk. "But following the collapse of Carillion and the transfer of the assets back to the public sector, what had been somebody else's problem has now become our problem": he expects the government to fund the work required, but "we're still a couple of years away" from completion. Meanwhile, the hospital staff must struggle on in their 1960s home—despite "bits of concrete falling off the outside."

**Meanwhile, the two newly-merged trusts—Aintree University Hospital and Royal Liverpool and Broadgreen University Hospitals (RLBUH)—have been facing spiralling demand for services.** "In north Liverpool, around the Aintree catchment, the health indicators are all going the wrong way," Warburton explains: life expectancy is falling, infant mortality rising, and "the people presenting at the front door are getting sicker".

These problems "directly correlate with deprivation levels," he adds, noting that the city council's budget has fallen by nearly two thirds since 2010. Although the council has done a "sterling job in trying to prioritise adults' and children's social care and social services", he believes the "knock on impacts [of service and benefits cuts] have had a direct bearing on the level of demand."

In this environment, it made no sense to have two big acute trusts competing for work: both were struggling to attract the volumes required to support specialist services, and finding that emergency work was displacing planned operations. In 2013, when Warburton was deputy chief executive of Aintree trust, he worked with his counterparts at RLBUH

to merge the trusts' vascular and lab services. "But we had to wrap complex joint ventures around them," he explains. "There were in excess of 20 services with the same level of duplication, and we didn't want to set up 20-odd joint ventures! Having separate organisations was getting in the way of a rational configuration of services."

At a clinical summit bringing together consultants from both trusts, he recalls, "the consultants were absolutely unanimous that we had to merge". Doing so, they argued, would enable them to separate emergency from elective work, to cut wasteful duplication, and create centres of expertise big enough to support sub-specialisation among consultants. "This is a clinically-led merger," insists Warburton. "We've got some fairly modest financial savings in the business case, but that's about taking out duplication." Indeed, he's clear that the two trusts' high volumes of non-elective work—whose tariffs, he says, do not cover the costs of delivery—will leave the merged organisation in the red for years to come: by 2023, he expects the combined underlying deficit to have fallen only from £85m to £50m.

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**In 2015, Warburton became chief executive of Aintree trust—which was not in a good way.** "In the winters of 2015 and 2016, Aintree was in a permanent state of crisis," he recalls, with "huge increases in demand" overwhelming capacity. He increased bed numbers and addressed the CQC's concerns about safeguarding, winning back the trust's 'Good' rating—lost in October 2017. Then, working with RLBUH, he began the painful process of securing approval for the merger.

This involved winning support from the Competition and Markets Authority (CMA), charged with encouraging the inter-trust competition enshrined in former health secretary Andrew Lansley's 2013 reforms. And the CMA's test, Warburton explains, was not "whether there was a real loss of competition: [the merger] was always assessed against the theoretical loss. It didn't matter whether competition was working in practice, because the competition element had been enshrined in legislation."

Although "there's nobody left defending the Lansley reforms now," he says, these regulatory obstacles remain. So the two trusts relied on the support of NHS Improvement/England (NHSIE), which "understood the strategic importance" of the merger and helped them develop the business and patient benefit cases. NHSI's backing was crucial, he adds, but nonetheless "it's been really, really challenging. The system is now becoming easier to work with, but this merger's been achieved in spite of the system—not because of it."

In August, the CMA finally gave the marriage its blessing—and a month later, Warburton became chief executive of the merged trust. Now things are moving: the first departments to merge are trauma and orthopaedics, with Aintree taking over emergency work while non-elective cases go to the former RLBUH's Broadgreen Hospital. Next will come a series of consultation exercises, testing opinion in local communities and among staff. "Staff side [unions] have been involved all the way through," he says. "There's been good engagement meetings, and we would see [the unions] as an essential partner going forward."

There will, he adds, "be a period of change, and we're trying to work through that with staff in a sensitive way." The merger of corporate teams such as

finance and HR is, for example, creating "a degree of anxiety—though I don't think anybody thinks it's the wrong thing to do". So good management of the change will be crucial: one early task, he explains, is "developing a new vision for the organisation, and defining how that's underpinned by values and behaviours. We want that to be co-developed with the organisation." This framework, he adds, will ensure that "those of us in senior leadership positions can be held to account for continual demonstration of those values and behaviours".

And staff will benefit from the merger, Warburton says—not least from a "richer career structure" offering better opportunities for promotion or specialisation. "A lot of staff turnover used to be people transferring between the two organisations," he notes.

There are concerns, though, that those opportunities may not be distributed equitably. Aintree trust's last CQC report called for work to "improve diversity and equality across the trust and at board level", and Warburton acknowledges the need to "systematically look at some of the reasons why we struggle with that." Senior leaders are not representative of the workforce, he says: "We're about to commission a piece of work to see what some of the barriers might be, because clearly a passive approach has not got us to where we would like to get to."

**The new trust's leaders will also have to consider the merger's impact on other providers, such as the district general hospitals—some of which are running "potentially fragile services" dependent on a tiny teams of consultants.** "It's really important that we're not seen to be pulling up the drawbridge, particularly around medical staffing," he says. "Increasingly, consultants want to go into the bigger centres—so we've got to make sure that what we do isn't to the detriment of the wider system."

Such collaboration is, he says, increasingly prevalent across Liverpool: the city's health, social care and housing bodies have formed a Provider Alliance to "make sure we're all working together—and that work is at a more mature level than it's been for a very, very long time." By improving systems and relationships, he adds, members can address the "artificial barriers and budgetary constraints" that distort care: "It does not make sense, and it's not good patient care, to have a patient stuck in an acute hospital bed for the lack of a minor adaptation that needs to be undertaken in their home," he comments.

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"Talk to GPs, community staff, hospital staff—they'll all tell you the same story. The fact that the vast majority of patients are still getting a great service which is down to the staff, who are working under immense pressure."

Until recently, national bodies' approach to performance management would have made such collaboration difficult: individual organisations would be penalised if reforms designed to improve the wider system weakened their own metrics. But Warburton says that today's NHSIE is taking a more "nuanced" approach. "Increasingly, we're looking to move from organisational performance management to whole system management," he says, building a system more suited to "the circumstances we're operating in".

Those circumstances, though, remain difficult. Health services, Warburton stresses, can't be seen "in isolation from the wider determinants of health"—such as poverty, poor housing and drug use. "We would be in a better position if we could do more of that upstream work, so we didn't have such high levels of demand in the hospital sector."

Meanwhile, he says, trusts are maintaining service quality thanks to the commitment and dedication of their staff. "Go to any part of the health service; talk to GPs, community staff, hospital staff—they'll all tell you the same story," he says. "The fact that the vast majority of patients are still getting a great service is down to the staff, who are working under immense pressure."

Demand is unlikely to ease up anytime soon. But as services are reshaped across the new trust, care pathways are improved with other providers and the Royal Liverpool settles into its gleaming new home, the system should become better able to meet it. Then the battered 1960s building will be torn down, and the trust will oversee the huge plot's redevelopment. "I wouldn't see this as being a commercial development," he explains. "I'd want to make sure that it was aligned with the academic health campus and the requirements of the university."

In time, the creation of Royal Liverpool and Broadgreen University Hospitals NHS Trust should help plug some of the gaps in Liverpool's revival—improving health and care services, while extending the city's physical regeneration eastwards. "I've long felt that competition in healthcare wasn't an effective way of delivering services—and now we're starting to see collaboration," says Warburton. "There's horizontal integration, with providers increasingly working together; and there's vertical integration with communities, local authorities, social services. Everything's going in the right direction."

"We've got huge ambition for this new organisation," he concludes. "Now we've got to take our people with us."■

# Managers must "learn and act together" to take on populism


MiP members from across the country gathered in Birmingham for the union's annual Members' Summit on 7 November 2019. As well as hearing from keynote speakers Andrew Foster and Jon Restell, delegates took part in a range of debates and in-depth discussion groups on every aspect of management life, helping to set MiP's course and priorities for the year ahead.

Reporters: **Mercedes Broadbent**, **Alison Moore**, **Matt Ross** and **Craig Ryan**.
Photos by: **Tom Campbell**

**Andrew Foster: 16**
**Panel debate—equality & organisational change: 18**

**Discussion groups:**
**Diversity: 16**
**Agenda for Change: 16**
**Leadership: 17**
**Women's network: 18**
**Organisational change: 19**

**Managers must "learn and act together" to tackle toxic workplaces and preserve NHS values in a hostile political atmosphere, MiP chief executive Jon Restell told delegates in his keynote Summit speech.**

Restell warned that the rise of "political populism" was a "profoundly challenging and disturbing development" which had created a potentially "toxic environment inside the NHS" to which managers needed to respond.

"The political culture is setting our weather inside the NHS," he said. "Managers trying to tackle bullying are working in a setting where bullying is the normal political currency. Managers trying to deal with racism and sexism are working in a political culture where racism and sexism is sanctioned and openly used in debate."

He cautioned delegates against "trying to respond with a populist edge of our own" or giving into the temptation of "disengaging from the public debate by slowly switching off to what's happening". Instead, he argued, managers need to look at what they can do individually and collectively to defend NHS values at work.

He said: "Many managers don't think they can deal with racism and sexism in the workplace—that it's a societal problem that's bigger than them—but in reality there are things we can do by learning and acting together to change the culture in which we are operating in this country."

MiP as a trade union will "give you the space to do that and to be yourself—to live your values and act and learn together," he said. "We're committed not just to take on the individual case but to take on the bigger issues too—but we need to be aware of the broader political context within which we are operating."

Restell cited the post-war Labour prime minister Clement Attlee as an example of the kind of leader who had been lost to British public life. "He was completely uninterested in public relations and was the ultimate uncharismatic leader," he said. "But he managed a group of Labour politicians who were complete egomaniacs for 20 years.

"He wasn't an ideological socialist… but through social work in the East End of London he had developed a strong set of values which he applied pragmatically," Restell added. "Attlee never walked away from difficult decisions. And he made life better for the people of this country. I think a lot of our political leaders have lost those qualities."

DISCUSSION GROUPS: DIVERSITY

## How can we promote a just culture in NHS management?

**Summit delegates discussed ways to improve diversity at senior levels in the NHS in a session entitled 'A just, inclusive and respectful culture: if not now, when?'**

The discussion was led by MiP vice chair David Cain, National Committee members Geoff Underwood and Sandie Belcher, and MiP's policy and communications officer Mercedes Broadbent.

This session looked at attitudes to disciplinaries and organisational learning, diversity in NHS management, the experience of managers with protected characteristics, and bullying and harassment. Delegates explored what they could do to promote diversity as managers and union members, as well as the key interventions and campaigns MiP should be backing.

One of the biggest issues raised by delegates was poor recruitment practices, particularly in respect of job descriptions and jobs advertised on the NHS Jobs site. Delegates reported that job descriptions are often either too generic to be useful or so specific that far too few people could possibly fulfil the criteria.

Delegates discussed the recent example of an advert for a chief nursing information officer at NHSX. This had such narrow criteria that it all-but-guaranteed that BME applicants would be unable to meet them; the original advert required candidates to have "proven and significant experience at director level"—something very few people from a BME background have, because of the very low levels of BME representation among NHS senior management. This was a clear example, delegates agreed, of a job person specification not being fully thought through from an equalities perspective.

Some delegates also criticised the practice of only advertising vacancies on the NHS Jobs site, which has a readership mainly confined to existing NHS staff. Taken together with job descriptions that are often written in NHS jargon and require very specific NHS experience, this made it unlikely that people from outside the NHS would apply. Delegates felt this would perpetuate the under-representation of certain groups of people at senior levels in NHS.

# Foster promises a "more enl leadership style from the to

**Few NHS documents are as eagerly anticipated as the promised people plan—which is likely to be published in the new year.**

Andrew Foster, former chief executive of Wrightington, Wigan and Leigh Foundation Trust, who has been appointed by NHS England to lead on the development of parts of the plan and associated proposals for a compact for senior leaders, gave the opening speech at the 2019 Summit. Although general election purdah limited what Foster could say, he gave MiP members an insight into the thinking behind it and how it could help to ease the workforce problems in the NHS.

Foster promised a "much more enlightened" style of collaborative leadership characterising the old style as "dictatorial" at times.

NHS staff are driven by strong values and a belief in the value of what they

are doing, he said. Aligning leadership goals with these values can drive improvements—for example, by focusing on quality improvement. And it was not "being soft" to treat people with respect, he insisted.

Foster reported that roadshows had shown that NHS staff wanted the leadership compact to be published as a single-page document available in a number of formats "rather than 200 pages coming out of the centre".

DISCUSSION GROUPS: AGENDA FOR CHANGE

## Managers unhappy with grading and on-call payments

Delegates criticised the use of job evaluation within the NHS and called for more consistent policies for on-call duties during a Summit discussion on the Agenda for Change pay system.

Delegates attending the session, led by MiP chief executive Jon Restell and Unison head of health Sara Gorton, discussed the inconsistent banding of jobs across the country and the widespread perception of job evaluation as a way of downgrading jobs and cutting costs.

Delegates from London described how jobs were often upgraded to attract and retain staff. While this may sound superficially attractive, it makes it very difficult for staff to move to other parts of the country—

or even other organisations in London - where equivalent roles will involve a significant pay cut. People end up being stuck in jobs they can't afford to leave.

There was also a tendency, some delegates pointed out, for job specifications to get "lost" in organisational restructures or to exist only on paper, making

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In a question and answer session, delegates pointed out the gap between the vision Foster had sketched out and the handling of the merger of NHS England and NHS Improvement, which is expected to result in significant redundancies. One delegate described the merger as the worst example of organisational change they had ever seen. Foster replied that senior leaders on these bodies were aware of the impact on staff and wanted to see improvements in the way change was managed.

Asked about the importance of self-reflection in changing workplace behaviours, Foster stressed that continuous reflection would be a part of future leadership plans. He also highlighted the Wigan trust's work on understanding the organisation's culture and identifying "hot spots." This involved a methodical approach with quarterly surveys of 25% of staff and thorough analysis of the results. ■

it difficult to compare jobs between organisations or regions.

Several delegates raised concerns about the quality of job evaluation boards, particularly the dominance of HR managers over operational managers. Gorton said having trained assessors sitting on these panels was important and training is available for MiP members, but she criticised "a lack of willingness from the centre to create the capacity to do job evaluation well".

A number of delegates also raised the issue of of clinical backgrounds being required for jobs for which did not seem necessary, such as requiring staff running e-rosters to have a nursing qualification although the job does not involve any nursing duties.

The discussion revealed widespread dissatisfaction with the on-call arrangements for managers, which often do not reflect the onerous nature of on-call commitments. One example given was that a manager on-call for a hard-pressed department on a winter Sunday can end up spending 12 to 15 hours in the hospital. When no time off is offered in return—as is often the case—these terms risk breaching the European Working Time Directive which stipulates that workers should have a minimum of 11 hours off between shifts.

Delegates also pointed to many inconsistencies between organisations over which on-call sessions are paid for and whether very senior managers receive on-call payments. Some delegates also raised fears over patient safety, citing examples of on-call managers being left to make decisions about parts of their organisations with which they were unfamiliar.

DISCUSSION GROUPS: LEADERSHIP

# Delegates offer broad support for leadership compact

"Hands up," said Joseph Smith, "if you've experienced really bad management." Everybody at the Summit session on leadership raised their hand. "Really good management?" A reassuring 90%. "And are you optimistic about management in the future?" The audience was not: just 25% expected things to improve.

As an NHSIE policy adviser working on the forthcoming NHS leadership compact, it's Smith's job to improve those figures. The compact, he explained, came out of the Kark Review of the 'fit and proper person test' (FPPT) applied to NHS leaders. Tom Kark QC made seven recommendations—of which the government accepted two: to introduce a set of competencies for board members, and to create an employment database to track very senior leaders. The NHS is consulting on his other proposals.

Summit delegates clearly welcomed action to improve management quality. During votes on the Summit floor, 58% backed the need for greater professionalisation; 7% wanted statutory regulation of NHS managers; and 35% called for both. Staff must have the tools to challenge bad management at an early stage, said one delegate in Smith's session: "We wait before feedback becomes nuclear before we have difficult conversations, leaving it until monsters are created," she commented. "There are people who keep moving around, and nobody ever has that conversation with them."

Previous attempts to improve managers' skills and behaviours, delegates commented, have failed to take root. "The code of conduct is just a line in my contract; it's never come up since I joined the NHS," said one. And another pointed out that the FPPT has "no teeth. If a trust allows someone to hold a position and another manager doubts whether they meet the criteria, all the Care Quality Commission can do is ask the trust to show that they've complied with the regulations." Compliance should instead be policed by an independent organisation, she argued.

One delegate, noting that her membership of the Chartered Institute of Management requires ongoing training and development, argued that "we need to bring some accreditation into the system." But with many NHS managers already overseen by specialist clinical and professional bodies, warned another, "there's a question around double jeopardy."

The diversity of NHS managers' and clinical leaders' roles certainly make it difficult to create a single, universal set of rules for qualifications, skills and behaviours. One member warned that any system "has to recognise non-traditional entry routes. If someone's come up through a community trust, that experience needs to be recognised alongside more traditional experience." And another delegate, recalling the days when 28 different inspection bodies pored over each hospital, warned that the system must not over-burden managers: "There's a place for regulation, but it has to be common sense," he warned.

Yet by the end of the session, Smith had found broad support for the compact's development. "I've heard quite a lot about the benefits of professionalising NHS management; and that the consequences of not doing this are problems with bullying, diversity, people wanting to leave," he said. "That's a burning platform if ever I saw one.

"I'm proud of what's in the compact at the moment," he added. "But most powerfully, what I've heard is that making this stick will take consistent, continuous effort."

DISCUSSION GROUPS: WOMEN

## MiP to set up women's network

**Following a group discussion on women in leadership, delegates agreed to set up an MiP women's network to share experiences and support women managers in developing their careers.**

"We want to draw on everyone's experience of the challenges we face as women leaders," said MiP national officer Claire Pullar, who led the session. She warned that "the climate for women leaders in the NHS is, if anything, getting harsher at the moment". By way of example, she cited statistics showing that older women were far more likely to lose their jobs during organisational change than older male colleagues.

Delegates drew on their own experiences to describe some of the barriers women leaders still face in the NHS. One trend noted by several delegates was for women leaders to be given new responsibilities, only to find they were denied the support or pay that male colleagues had received when doing the same job previously.

"I think we as women members and managers have a degree of responsibility to change that cultural behaviour," said one delegate. "An MiP network, to share that experience and come up with solutions, would be a valuable extra support."

Several delegates argued that the NHS needed to give more support to carers. "The expectations from the employer are often unreasonable," said one delegate. "As a mother, there are times when you have to drop everything, and employers often don't respond well to that. Women need to feel supported in terms of being able to do that."

One delegate described how her employers refused to permit any senior managerial job to be done part time. "I have one senior colleague who's just had a baby and she's been told there's no chance—you have to come back full time or not at all."

Pullar said employers often downgraded women's contributions because of their caring responsibilities. "We have people who are nervous—or actually scared—about starting a family because of the effect on their career."

Among the other issues which the group suggested that the new network should tackle were bullying and harassment—which disproportionately affects women staff—along with the lack of support for women going through menopause, and the difficulties they faced discussing it with male colleagues.

**Visit the MiP website for further information on the new MiP women's network in the new year: miphealth.org.uk.**


# Why aren't we better at organisational change?

**When Summit delegates were asked to vote on a series of questions during the panel debate session, they provided some worrying answers. Some 58% said that their employer is not making progress on equality and diversity. More than three quarters said that bullying within management is a problem in their organisation. And a disastrous 88% said that their employer does not manage change well.**

Panellists and audience members highlighted the connections between these three problems: tackling discrimination, for example, can help address bullying and ensure that jobs go to the best candidates—improving change management.

Part of the solution on equality issues, said MiP committee member Yvonne Richards—also the delivery and policy lead at NHSIE—is the creation of better metrics to track diversity: "We need to be able to take the temperature and say: 'What difference has that made?'" she said. "There's a significant amount more to do, and part of that is about having the evidence."

MiP chief executive Jon Restell agreed, suggesting that "we need to hold individuals to account more closely for outcomes. It's very hard to challenge individual recruitment decisions: people can show they've followed the process. But if across 100 appointments you're not seeing a balanced intake, then the question needs to be asked of individuals."

But it's hard to maintain progress on such initiatives, said Restell, in an environment of continual disruption. "Our number one issue as a union is the constant reorganisation of management structures," he said. "It's hard to invest

**Panel session: Paul Maubach, Yvonne Richards, Jon Restell, Paul Jennings and Sara Gorton**

properly in your organisation if you know it'll all be knocked down again in a year or two. And people's day jobs stop while systems are changing; the NHS could achieve so much more if it had more stability."

Bidding members goodbye during her last Summit as chair, Sam Crane emphasised the problems around weak consultations and poor staff engagement during change programmes. "There are some good examples out there, but mostly what we're seeing is people being 'done to' rather than real change processes," she commented.

And when organisations are changing on every front—embedding new systems, filling empty roles, building new capabilities—they lack the stable platforms, experienced staff and management bandwidth to manage that change well.

In the words of Paul Maubach, chief executive of Dudley and Walsall CCGs: "You would have thought, given the amount of organisational change we've had—certainly on the provider side—that we'd be better at it by now."

"Why aren't we? Maybe it's because of the amount of organisational change!" ■

DISCUSSION GROUPS: ORGANISATIONAL CHANGE

# "Command and control" approach risks botching reforms

**Structures are shifting across the health service—and at a Summit session on mergers in the commissioning and regulatory systems, MiP staff and delegates warned of serious problems with how organisational changes are being handled.**

The melding of NHS England and NHS Improvement has reached its third phase, explained national officer Corrado Valle, affecting 7,380 staff. And his colleague Stephen Smith pointed to similar changes among commissioning support units and clinical commissioning groups. The number of CSUs has shrunk from 23 to seven since their creation, he said; and as CCGs pass on funding cuts, those CSUs that remain appear to be entering into "gentleman's agreements" to specialise in different services. Meanwhile, CCGs are increasingly sharing leadership teams in order to find economies of scale and map their boundaries more closely to those of Sustainability and Transformation Partnerships.

Affected staff, Valle stressed, should research their redundancy rights—including the rights to a 30-45 day consultation period, and to be given the option of 'suitable alternative employment' (SAE) rather than redundancy. SAE offers must provide jobs of equivalent pay, status, content, skill levels, terms and conditions, and access to work, he explained. So it's important that managers ensure their job descriptions are kept up to date or any SAE offered to them won't fairly reflect their current roles.

In NHSIE, Valle warned, changes are being "very much driven in a command and control way," with a "desire to deliver on a certain timeline, come what may." But HR staff are ill-equipped to push through such massive change on this timetable: "HR functions have lost senior staff and a lot of expertise," he said. "They're not sufficiently prepared—and that's a result of previous changes designed to save money."

Agreeing, one NHSE/I staffer noted that "official correspondence from HR often includes a series of mistakes, and there's no accountability for those errors. Your day job becomes monitoring its accuracy." Another delegate commented that "senior managers will say to HR: 'Just get it done.' That's why it's important to have union members in HR: because there are a few of us who'll stand up and say: 'That's not right.' We'll question the templates, the processes and the people involved."

Members also questioned NHSIE's consultation process, with one saying that "people don't feel they've had a voice" and criticising the "platitudinous answers" to employees' questions. Many staff, said another, feel that the consultations "are not meaningful"—with senior leaders determined to follow pre-existing plans.

Asked about industrial action, one member replied that it "goes against the grain," but asked, "How long do we stay silent? I know there's a cost to industrial action, but things need to change. We need to know that people are listening, rather than just playing the part of listening."

For if organisational change processes are driven at breakneck speed and consultations aren't meaningful, there are negative outcomes both for organisations—which may botch their reforms—and for staff, who can be treated unfairly and suffer from problems such as bullying.

"I've been in the NHS for a long time, and I never thought I'd be in the situation I am now—with some quite exceptional bullying behaviour over a number of months," said one member. "So I just wanted to say: 'Thank you!' to MiP. Without you, I certainly wouldn't be in employment delivering services to the population."

In these situations, highlighting the problem risks drawing more fire. "I've got a number of colleagues who've had the same problems, but aren't willing to put their heads above the parapet because they've seen what's happened to me," she continued. "But if it gets some kind of results for my colleagues, speaking up is the right thing to do."

# legal**eye**

It's illegal for your manager or employer to victimise you for being a member of MiP or carrying out MiP activities. **Rachel Haliday** explains the legal protection available to union members and activists in the UK.

**Membership of a trade union is a human right. If your employer seeks to target or discriminate against you simply because you are a member of MiP or any other union, the law is there to protect you.**

The Trade Union and Labour Relations (Consolidation) Act 1992 states it is unlawful for someone to refuse to employ a person because they are a trade union member.

While in employment, the law says:

1. **Workers have the right not to be subjected to a "detriment", if the employer's main purpose is an "unlawful purpose"**

   A detriment means a disadvantage. Examples of a detriment include being demoted, being asked to work extra or unsociable hours or having disciplinary action taken against you.

   Subjecting a worker to a detriment is unlawful if the employer's main purpose is unlawful. It would be unlawful if it was to prevent, deter or punish trade union membership, taking part in union activities or making use of trade union services.

2. **It is automatically unfair to dismiss someone if the principal reason for the dismissal is an "unlawful reason"**

   If the employer's main reason for the dismissal was that the employee either took part, or even just proposed to take part, in trade union activities or made use of trade union services, the dismissal would be unlawful.

3. **It is automatically unfair to dismiss someone by reason of redundancy if the principal reason for selecting them for redundancy was an "improper purpose".**

For the courts to find that a detriment or dismissal is unlawful the employer has to have an improper purpose. In assessing this, tribunals look not only at the effect of their actions but also at the objective they were aiming to achieve.

Factors which might support a claim that the employer has an 'improper purpose' include: evidence of anti-union bias, a failure by an employer to follow the normal procedural steps or if the employer is unable to give a credible explanation for their actions.

## Trade union activities: Your rights

To be protected, trade union activities must take place at "an appropriate time." This usually means outside the worker's working hours, or at a time within working hours when the employer has agreed to the employee taking part in trade union activities—often called 'facility time'.

The tribunal, using its "industrial common sense," will decide what constitutes a 'trade union activity', but usually the following activities are protected:

- Participating in bargaining, consultation, grievance handling and disputes procedures
- Having discussions with full-time union officials
- Representing members and having discussions with them
- Engaging in the recruitment of new members
- Undergoing approved training
- Putting up union notices and distributing union literature
- Voting in a union election
- Attending branch meetings or national conferences.

## Claims that trade unionists can bring

If you believe you have been treated unfairly at work due to your trade union membership or activity, you may be able to bring an employment tribunal claim. Normally, the deadline to start the employment tribunal claim process is three months less one day after the act you are complaining about.

If you were dismissed and a claim for dismissal is successful, tribunals have the power to award a minimum basic award and compensation for financial loss caused by the dismissal. ▪

**If you believe you have been victimised for your MiP membership or for carrying out union activities, contact your MiP national officer immediately for advice. You'll find their details on the MiP website: bit.ly/mip-team**

**Legaleye does not offer legal advice on individual cases. MiP members in need of personal advice should immediately contact their MiP rep.**

# When can you afford to retire?

A timely session on pension planning examined this fast-changing topic at this year's MiP Members' Summit. **Dale Walmsley**, who led the session, sums up his advice for NHS managers looking towards retirement.

## 1. WORK OUT WHAT YOU NEED

Know what you will need—or want—to live on in retirement. This may sound like the $64,000 question, but the Pensions and Lifetime Savings Association suggests a minimum of £10,200 for a single person, with £20,200 providing a moderate income and £33,000 a comfortable standard of living. For couples, these figures increase to £15,700, £29,100 and £47,500. See www.retirementlivingstandards.org.uk for more details.

## 2. EVERYONE HAS DIFFERENT NEEDS

Consider any extra commitments you might have in retirement. You may want to help younger family members through university or with a deposit on a house, or have care costs for an older relative. You might even have expensive hobbies!

## 3. ASSESS YOUR LIKELY INCOME

Once you have a figure in mind, work out your likely retirement income and see whether the two match. Look at your NHS, state and any other pensions, plus other sources of income such as rents from property. You might also consider doing some part-time work in the early years of retirement or dipping into your savings.

## 4. DON'T FORGET TAX

You will still have to pay tax—but not National Insurance (NI)—on your retirement income, so your gross income will need to be higher than the post-tax figures above. As a guide, if you have an income of £80,000 before retirement you will have about £4,040 in your pocket each month. To reach the same net income in retirement you will need a gross monthly income of £5,000. That's £60,000 a year.

## 5. CHECK YOUR STATE PENSION

The full state pension is worth nearly £9,000 a year and is an important part of your pension planning. When you can claim it depends on your age now; how much you get depends on your contributions record. Check your entitlement at www.gov.uk/check-state-pension.


PAUL THOMAS

## 6. MIND THE GAP

If you're planning to retire between 60 and 65 with an NHS pension you will have to wait before you can claim your state pension, so you will need plans to bridge this income gap. If you are in the 1995 section of the final salary scheme, you will get a tax-free lump sum on top of your pension which may help. You can also withdraw up to 25% of your pension savings tax-free in one go regardless of which scheme you are in—but be cautious because this will reduce your yearly pension in the future: if you withdraw £12,000 in cash, your pension will drop by £1,000 a year.

## 7. GOT A HOLE?

You may be able to fix it, as long as you're some distance from retirement. If there's a gap in your NI payments affecting your state pension, you may be able to pay voluntary contributions to make up for this. Anyone who spent time at home caring for children or other people should check their NI record to ensure these responsibilities are reflected. You can also pay for an early retirement reduction buy out to reduce your NHS retirement age—but this may be costly. If nothing else, you can build up other savings to support you in retirement.

## 8. GOOD NEWS FOR SOME...

There are likely to be changes to the 2015 NHS pension scheme which will benefit some younger people. The Supreme Court has established that, when comparable schemes were introduced in other parts of the public sector, younger members were discriminated against because they did not benefit from the protections given to older members. The government has promised to rectify this, which is likely to mean more generous pension rights for younger members.

## 9. ...BUT UNCERTAINTY FOR OTHERS

Not all changes may be good news. Once the government has dealt with the past discrimination against younger people, it will need to think about how to avoid such discrimination in the future. This will be an area of great interest and no one knows what will happen next.

## 10. THINK TWICE ABOUT LEAVING

Huge bills for breaching the annual pension allowance have attracted much press coverage and led to many senior managers and clinicians leaving the NHS scheme. But, depending on your circumstances, it may be better to stay in even if you're likely to get a tax bill. This is a complex area and one where you need to take specialist advice. ▪

Dale Walmsley is an actuary with First Actuarial. For further information visit www.firstactuarial.co.uk or email Dale at: dale.walmsley@firstactuarial.co.uk

# How do we shift power to local communities in the NHS?

The integration of health and social care, and devolution of power to city-regions, has massive implications for NHS managers. To make sure your voice is heard, MiP has joined an independent commission looking at how the new structures could work.

**MiP is joining forces with politicians and healthcare experts to take part in an independent investigation into the devolution of health and social care in England. The Health Devolution Commission, chaired by Greater Manchester mayor Andy Burnham, will examine how power, control and accountability will function in new integrated health and social care systems.**

The union's chief executive, Jon Restell, has been appointed as an advisory commissioner to the inquiry, which began work in December. As well as Burnham, other members of the commission include former Conservative health secretary Stephen Dorrell; Norman Lamb, former Liberal Democrat social care minister; David Behan, chair of Health Education England; and representatives from healthcare think tanks, local councils and the voluntary sector.

The commission will focus on issues of power and control in the emerging structure of devolved health and care systems in England, drawing on the recent experiences of Greater Manchester, the West Midlands and London, as well as the devolved governments in Northern Ireland, Scotland and Wales, where integrated approaches are already well established.

The commission aims to contribute to policy making at national, city-region and local level by developing possible solutions to challenges facing politicians and managers in implementing integrated health and care budgets, joint commissioning, managing integrated teams and delivering more personalised services.

> "There are really big questions to be answered about how devolved healthcare systems can be accountable both to local people and up through national NHS structure. NHS managers have a huge role to play in making integrated systems work."

As a specific case study, the commission will also look at the impact of integration and devolution on cancer care services in different parts of the UK.

"There are really big questions to be answered about how devolved healthcare systems can be accountable both to local people and up through national NHS structure," said Restell. "I'm really pleased to be asked to join in the work of this inquiry. NHS managers have a huge role to play in making integrated systems work and MiP will make sure their voices are heard loud and clear."

## NATIONAL V LOCAL

One of the key questions the commission wants to address is the relationship between central government—the Department of Health and Social Care, HM Treasury and Number Ten—and NHS England. In what way is the secretary of state meaningfully accountable for the performance of local health and social care systems, especially as more power is devolved to local bodies under Integrated Care Systems (ICSs)?

The relationship between NHS England—both the central organisation and its regionary directorates—and local STP/ICS partnerships is also increasingly unclear. As local systems acquire more autonomy and flexibilities, in what circumstances will NHS England be able to intervene?

The commission will also consider what changes will be needed in the inspection and regulation regime as local health and care systems become increasingly autonomous. If the role of central regulators like Monitor and the CQC is to be reduced, how will local inspection and regulation regimes be developed to take over their role?

It will also examine the evidence on whether a more visible and accountable political leadership at local level will allow the health and social care system to take 'difficult' decisions, such as merging services or closing hospitals.

The commission draw on the lessons about power and control that can be learned from the experience of devolving and integrating health and social care in Scotland and Wales, as well as Northern Ireland—where the two services have been integrated for decades.

## LOOKING LOCAL

Health and care devolution will inevitably mean local government playing a bigger role in the NHS. But the nature of the relationship between local NHS leaders, on one hand, and local politicians and council officials on the other,

## GETTING TO GRIPS WITH DEVOLUTION

**The issues being discussed by the Health Devolution Commission were spelled out in the essay collection, *Is Devolution the future for health and social care*, published in June 2019. Here are some of the key issues for NHS managers.**


RICHARD SHEPPARD / STOCKIMO / ALAMY STOCK PHOTO

**Engaging managers fully in the process and using their expertise, so they can become "agents of devolution"**

**Embedding collaboration rather than competition as guiding philosophy of the health and care system—and how that shift is reflected in law**

**Combining the civil and clinical leadership strcutures without giving rise to conflicting priorities and agendas**

**'Blending' NHS and local authority budgets across a geographical footprint**

**Addressing NHS managers' concerns about working in devolved systems and improving their career opportunities**

**Avoiding a 'postcode lottery' in devolved health and care systems**

**Fostering a collaborative spirit and managing integrated teams drawn from different services, professions and employers**

**Developing a new role for large acute hospitals as 'community anchors'**

**Ensuring a strong patient voice in devolved systems**

**Using outcomes from the vanguard areas as the evidence base for reforms**

**Resolving the chronic underfunding of social care**

Read the full devolution essay collection, including MiP's contribution on the role of managers, on the MiP website: bit.ly/hcm42-essay.

remains unclear.

The commission wants to look at which decisions will be the responsibility of the NHS leadership and which will fall to local authority leaders, and what will happen when there is a conflict between the two. There is clearly a risk that lines of accountability between NHS bodies and local authorities could become blurred in an integrated health and social care system.

There are also key questions over money, particularly how budgets funded from national taxation for free universal healthcare will be combined with local authority budgets for means-tested social care. How will such 'blended' budgets managed and accounted for? The commission will also look at wider options for funding locally integrated systems.

A key question for MiP will be how NHS managers feel about being partly managed by locally-elected councillors, and what implications this will have for their careers and professional practice.

The commission will also examine how large acute hospitals can be made accountable within an integrated system and whether their future role as 'anchor community organisations' in local areas will make them more accountable and open to partnership working, or give them even greater influence and control over the whole system.

### PATIENTS AND CHARITIES

Giving patients an effective voice within the NHS is a key aspect of the reforms and the commission will examime how integrated and devolved systems can empower individuals to have more control over their health and social care.

This includes looking at ways to give patients a voice at different levels of the health and care system, and the impact of new systems on the use of personal health and personal care budgets.

Another key question is the impact of a more integrated system on the charity sector, social enterprises and the independent sector as providers and partners in health and social care structures.

The commission will consider the evidence on how these groups are engaging in a collaborative way with the new Primary Care Networks, ICSs and Sustainability and Transformation partnerships, and how they are influencing local policies, procurement methods and decision making. ▪

Updates on the work of the Health Devolution Commission will be published in *Healthcare Manager* and on the MiP website. If you would like to contribute to MiP's work on the commission, contact MiP head office: info@miphealth.org.uk

# We are rewarding the wrong behaviours

The NHS needs top-class leaders, but our approach to performance management and promotion filters out the good managers and favours the brow-beaters and manipulators.

**Great leadership is central to great patient care, but in today's NHS effective managers are as scarce as resources—and that's because the incentives actively promote poor practice.**

I've worked for NHS commissioners and providers for 30 years, culminating as a departmental head. Of my ten line managers, just two were role models: smart people who knew leadership was about supporting and motivating staff, not browbeating or manipulating them. Only these two had my full respect and made me want to be more like them.

Authenticity, accountability and humility really matter. If staff see leaders with these qualities, they want to help them succeed. But if they view managers as self-interested, treacherous and unaccountable, they'd rather see them fail. Ultimately, every organisation's success rests on the commitment, enthusiasm and support of its workforce.

What's more, when leaders show the wrong behaviours, the effects reach well past the organisation. We're not just members of staff; we're spouses, siblings, parents, sons and daughters. And if stress at work seeps into the home, people's morale falls further—feeding back to affect their working lives.

Poor leadership is not unique to the NHS; but too often, NHS recruitment systems and incentives for managers encourage all the wrong behaviours. People are promoted because they hit delivery targets like the four-hour A&E waiting time—yet that's no measure of their skills in strategic leadership, building a positive organisational culture or motivating staff. Behind positive performance metrics, it's common to see high levels of staff turnover, sickness absence, internal strife and disciplinaries. Selection processes focus on ticking boxes about qualifications and experience. There's little attempt to focus on character, weeding out the narcissists, sociopaths, micromanagers and bullies.

Too many leaders seek personal advantage by setting colleagues against one another, monopolising credit for successes, and shifting blame for mistakes onto more junior staff—with the result that people stop being honest about their errors, or experimenting with new working methods. Sadly, this approach carries these individuals to the top—where they perpetuate this unsafe back-biting culture, setting an example which cascades down the organisation. What incentive do managers have to change their behaviours, when bullying is rewarded rather than challenged?

JOHN LEVERS

Values-based behaviour systems are created, at great expense. Yet leaders seem to forget that their behaviour is under constant scrutiny—and when their actions cut across those values, staff sniff out the fakery and lose trust in the system. Then these frameworks deteriorate into tick-box exercises, rather than thriving systems helping to grow and challenge behaviours. There are vital lessons here for the development of the new COMPACT agreements.

Occasionally, a great leader does make their way up through the system; and they're easy to spot. They are willing to take flak to protect staff, and assume responsibility for things that go wrong. They trust people, giving effective staff autonomy in their work, and offering those who are struggling private support—not public humiliation.. They are confident enough to welcome constructive challenge, rather than seeing it as a threat. They are humble enough to understand that they can learn as much from their staff as their staff can from them. And they get better results: their teams aren't just happier, but also more likely to hit their clinical targets.

To identify and promote these people, we must change the NHS's approach to recruitment and performance management. Professional skills can be taught more easily than character attributes. So rather than simply judging people against performance targets, we should promote candidates based on their characters, then provide the support and training they'll need to thrive in the role.

Character is hard to measure, but we can track its effects: there are plenty of clues to individuals' leadership styles, and we should make better use of them. Alongside performance metrics, we should be examining staff attrition rates, sickness and disciplinaries within a manager's teams, and pulling in staff engagement figures from the staff survey. And we should recognise and promote the value of exit interviews—which are often too honest for comfort, and end up buried deep in HR files.

NHS staff want to serve the public, support their colleagues and strengthen our health services. With the right leadership, organisations can become brilliant places to work, drawing on people's skills and commitment to deliver amazing care. But as Simon Sinek wrote in 'Leaders Eat Last', in a weak culture we veer away from doing "the right thing" in favour of "doing the thing that's right for me".

Changing the way the NHS identifies, promotes and supports the next generation of leaders is not an easy task. Yet if we don't do so, we will never tackle this deep-rooted problem—and in a sick culture, it's very hard to make people healthy. ■

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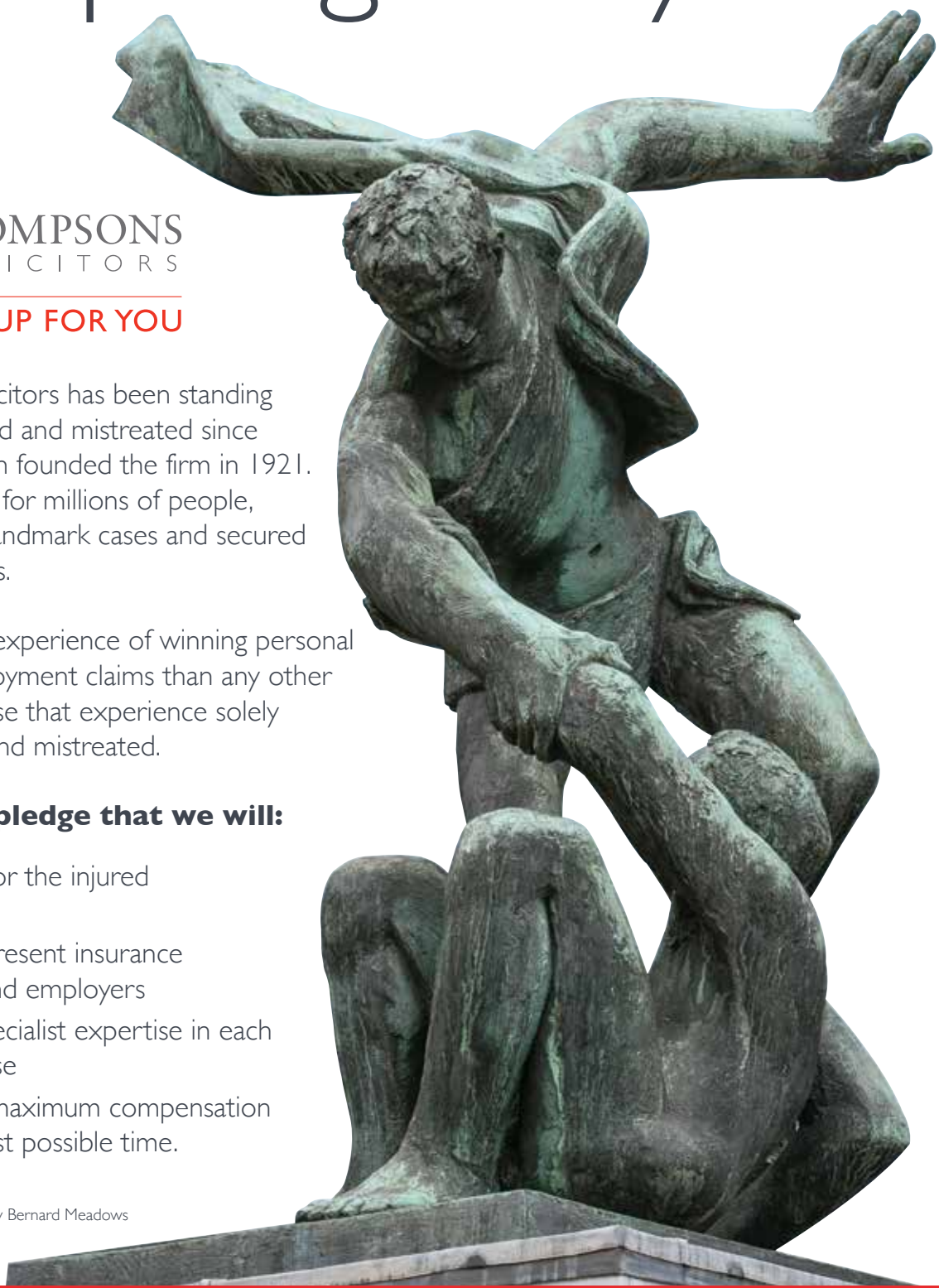

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