NHS managers and the 2015 general election

A briefing for MiP members

managers in partnership

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Foreword

The NHS is once again at the top of voters' priorities as we head towards the general election. And of course it's at the top of MiP's agenda too. This briefing sets out what we think politicians need to do to make sure the NHS not only survives, but thrives, in the next five years.

MiP is the only specialist trade union for health and care managers, representing 6,000 members in healthcare organisations across the UK. We provide expert employment advice and representation, and make sure managers' voices are heard in discussions with employers, policy makers and in the media.

I love speaking up for NHS managers because I respect and admire managers who work as hard as anyone to keep the NHS show on the road. People who protect patients, nurture staff and make resources stretch as far as they can. People who believe the NHS should provide universal healthcare, free at the point of need. People who know the system, how the different parts fit together and how to change things when it's really necessary.

An NHS without expert, specialist managers would not be the NHS. Take away the manager and clinicians will struggle to do their jobs – and will certainly be less efficient. Take away the manager and it becomes impossible to reconfigure health services to meet growing demand and higher quality standards in the face of financial constraints. Take away the manager and patients will find it more difficult to navigate the complex health system and get services designed to meet their needs.

You know all this to be true. You know how hurtful it is to be pilloried by politicians and to have to listen to lies and half-truths about you, your colleagues and your job.

We need to make sure politicians and commentators know this too. This briefing summarises MiP's messages and policies on the key issues for the NHS during the election campaign and beyond. Use the facts and arguments in this paper along with the **HSJ-MiP Management Mythbuster** to challenge head-on the myths and stereotypes about NHS managers and what they do.

Please use these resources to stick up for yourself and other managers. Use them to back up questions to parliamentary candidates. And, above all, let them know what you do as a manager to keep the NHS as one of the nation's best-loved and best-performing institutions.

Thanks to everyone who had a hand in this briefing, particularly Craig Ryan at **Lexographic**, who undertook the lion's share of the research and writing.

Jon Restell
MiP chief executive
April 2015

Key messages about NHS managers

Our work during the general election is part of our wider "#Respect4Managers" campaign to shift public and political perceptions about NHS managers. Here are some key points we should all bear in mind when talking about managers and what they do, both in the election campaign and beyond.

Who NHS managers are

- **Only one in 35 people working for the NHS is a manager** — evidence shows the NHS is *undermanaged* compared to other healthcare systems and other large organisations.
- **Managers are not "bureaucrats" or "suits"** — more than half of NHS managers have a clinical background and 59% are women.[1]
- **There is no such thing as a "typical" NHS manager** — managers bring a huge variety of professional skills for the benefit of patients — they may be hospital consultants, GPs, nurses, physios, paramedics, accountants, IT professionals, scientists, statisticians or social workers.
- **Managers are not overpaid** — the average NHS manager earns just under £49,000, less than most doctors and far less than MPs.
- **Managers are hardworking** — they have to work for as long it takes to get the job done and most work far more hours than they're paid for.
- **Managers are in the NHS's DNA** — most managers have dedicated their working lives to the NHS, either as clinicians, professional managers or people who have worked their way up through the ranks.

1. NHS Managers – Busting the Myths, NHS Confed, March 2015.

What NHS managers do

- **Managers keep the show on the road** — as the "stage managers" of the NHS, they bring all the different parts of the system together to deliver services for patients.
- **Managers support doctors and clinical teams** by making sure they have what they need to get on with their jobs
- **Managers look after public money** by getting the best value possible for taxpayers and patients, and making sure money goes where it's most needed.
- **Managers fix problems** — they have to expect the unexpected and keep services running whatever happens.
- **Managers know how the system works** — most are seasoned professionals with many years of experience in the NHS.
- **Managers join up the dots** — building relationships between dozens of different services and professions, across the NHS, local government, charities and communities, is never easy.
- **Managers improve and develop services** using their specialist skills, experience and knowledge.
- **Managers decide** — juggling competing priorities and professional interests to get the best results for patients.
- **Managers take responsibility** for the services people depend on. When there are serious failings in the NHS, it's often managers who end up losing their jobs.

When talking about NHS managers

- **Emphasise managers' experience** and knowledge by prefixing statements with "managers know" or "managers understand". E.g. "Managers know that we can't go on squeezing staff pay forever without services buckling under the strain."
- **Use specific examples** whenever possible of how good management has led to better services for patients.
- **Name-check "star" managers** and talk about their specific achievements whenever possible – this will help to humanise NHS managers and can be particularly useful when individual examples of bad management are used to denigrate managers as a whole.
- **Do not use different language** when referring to NHS managers to those you would use when talking about other staff. E.g. talk about managers' "pay" not "remuneration". Don't make a distinction between the needs of NHS "staff" and "managers". Managers are staff.
- **Use everyday language** that people would use to talk about their own managers in other walks of life. E.g. "Most people who work for the NHS really value the help they get from their own boss, even if they're unhappy with the organisation itself."
- **Avoid talking about managers as outsiders** who have been "brought in", or as "agents for change" or troubleshooters. For most managers, the day job is about running services and keeping the show on the road.

FIVE QUESTIONS TO ASK CANDIDATES AT THIS ELECTION

- Do you support genuinely **independent pay review bodies** for NHS staff?
- Do you value **the role of managers in providing patient care** and how will you show your support for managers?
- Will you oppose any **top-down restructuring** of the NHS in the next parliament?
- Will you **provide the extra money that the NHS needs**, as recommended by Simon Stevens and other NHS leaders, and how will you fund it?
- Will you **oppose further cuts in public sector funding** which will have a direct or indirect impact on standards of NHS care?

1. Respect for NHS managers

Ill-informed criticism of NHS managers requires a robust response. When people claim the NHS is over-managed, or use false or exaggerated figures about managers' pay or the number of managers, we should call it what it is: *lying*. When people propose cutting the numbers of managers across the board, we should say that it's arrogant and hypocritical for politicians, who say the NHS should not be run from Whitehall (or the devolved administrations), to try to dictate local management structures or tell hospitals and community services how many managers they should have.

We should not be apologetic about demanding respect for managers. Managers are just as committed to patient care and to the NHS as doctors, nurses and other staff. NHS management is a caring, compassionate, patient-focused and extremely demanding profession. Managers make a distinct contribution as the people who organise care, fix problems and ultimately take responsibility for the services people depend on. Managers are the people who keep the show on the road, day-in day-out.

Always try to point to specific examples of good management – hospitals that have been turned around, community and mental health services that have been successfully reorganised around patient needs, innovative projects and public money saved – and name the managers responsible wherever possible. Naming and praising managers in this way will help to counter the "bad apple" argument – where an individual but notorious example of bad management is used to denigrate NHS managers as a whole. We should also challenge politicians to name and praise "good" managers in the same way.

In talking about NHS managers and what they do, remember the key messages set out on page 4.

KEY ISSUES

Too many managers?

- However you define an NHS manager, there are far fewer of them than people think or politicians claim.
    - Official figures show there are around 37,000 managers in the NHS in England.[1] This is just under 3% of the workforce. The **NHS Confederation** also uses this figure. Using ONS figures, **the King's Fund estimates** that 4.8% of the NHS workforce are managers, while the **Nuffield Trust** gives a figure of 4%. All sources agree that less than 5% of NHS staff can be described as "managers".
    - There is simply no evidence that the NHS is over-managed. The **Office for National Statistics** estimates that around 15% of the UK workforce are managers. So the proportion of managers in the NHS is less than a third of the level found across the economy as a whole.
    - Both the **King's Fund** and Simon Stevens have said the NHS has very lean management and, if anything, is *undermanaged*, compared to healthcare services worldwide.

1. HSCIC, NHS Workforce Statistics, October 2014, "managers" and "senior managers". (Raw headcount; full-time-equivalent figures are slightly lower.)

- The number of managers has fallen by 18% since 2010. Between 1997 and 2010, NHS spending doubled in real terms, but the number of managers grew by only 37%.
- Despite these figures, **a recent poll of voters by Lord Ashcroft** found that people believe the biggest problem facing the NHS is that "too much is being spent on management and bureaucracy". Ashcroft's report admitted that respondents had "greatly overestimated the proportion of NHS staff who were managers or administrators".
- There are severe staff shortages among managers as well as clinicians. More than a third of trusts have vacancies on their boards.[1] A recent King's Fund report found that the Lansley reforms have led to a "leadership" vacuum in the NHS.[2]

Redundancy

- 38,000 NHS staff were made redundant in England between 2010 and 2014. 3,950 people returned to work in the NHS after being made redundant between May 2010 and November 2013 – around 35% on fixed-term contracts, not permanent jobs.[3]
- The average cost of redundancy packages since April 2010 is £40,646. There have been 2,659 payoffs of over £100,000, and 370 of over £200,000.
- Under Treasury rules announced in October 2014, managers earning more than £100,000 will have all or part of their payoffs clawed back if they return to work in the NHS within a year. The Conservatives say they will cap redundancy payments for managers at £95,000 if they win the election.

Professional regulation

- Professional regulation of managers could prove popular with the public. It's seen as a tried and tested method of public protection and it chimes with a perception that NHS managers face less scrutiny than other professionals working in the NHS.
- UKIP have proposed a "GMC for managers",[4] with a statutory licensing scheme under which incompetent managers would be barred from working in the NHS. The idea is also supported by individual politicians from other parties (mostly Conservatives) and has gained some ground in the wake of the Francis report.
- **The King's Fund commission on NHS leadership** came out against professional accreditation and a statutory disciplinary body, but in favour of stronger oversight of management standards by the CQC. Francis proposed Monitor be given the power to "strike off" incompetent managers but stopped short of statutory regulation. The **NHS Confederation** rejected formal regulation as costly and impractical but seems more open to a "negative licensing" system. Finally, the BMA overwhelmingly supported formal professional regulation of managers at its 2013 conference.

1. King's Fund, Leadership Vacancies in the NHS, Dec 2014

2. King's Fund, The NHS under the Coalition Government, Feb 2015.

3. Figures quoted in The Guardian, 26 July 2014. The DH says it does not have figures for how many of these staff were "managers".

4. UKIP health spokesperson Louise Bours, UKIP conference, Oct 2014.

CAMPAIGN MESSAGES

Key messages

1 in 35

Only one in thirty-five NHS staff is a manager. The NHS spends much less than 10% of its money on administration and just 3% on management.[1]

The NHS is one of the largest employers in the world. But there are fewer NHS managers than[2]:

- hospital consultants (approx 42,000)[3]
- managers in social care (50,000)
- actors & presenters (47,000)
- banking executives (79,000)
- journalists (60,000)
- professional musicians (41,000)
- sports coaches & managers (90,000)

Micromanagement

Setting arbitrary central targets for making managers unemployed or cutting management costs is the worst kind of micromanagement. It goes against everything ministers say about how they want the NHS to work. It runs against the interests of patient care, quality outcomes and value for money.

Singled out

NHS managers have been singled out by the government to bear the brunt of cost cutting in the NHS. One in six managers have lost their jobs since 2010. And with this year's pay cut, managers have sacrificed more pay than any other NHS staff, including better paid doctors.

Made unemployed

We simply don't understand why NHS managers who have been made unemployed through no fault of their own should be treated differently to every other worker in the country. Many have given their whole working lives to the NHS and, if forced to leave, should get the same protection as anyone else.

GMC for managers

We would welcome the idea of a "GMC for managers" in principle if a government is willing to do it properly. Professional regulation means developing professional standards and qualifications, education and training institutions, and professional bodies. The NHS would have to invest dedicated funding and the kind of continuous learning and development which doctors enjoy, and reduce other regulatory burdens on managers. All of this takes time and money, but without it, professional regulation is just another another political stick with which to beat managers.

Reckless reorganisation

It is ministers who should be held account for the money wasted on their reckless re-organisation of the NHS, not the staff who were made unemployed by it, and whose skills and experience are still needed. The money and management time wasted could have been spent on patient care instead.

NHS organisations should not be reorganised by political diktat but only if there is a real local need. And, because reorganisation directly affects them, staff and patients should be fully consulted about the new structures first.

1. House of Commons, Health Select Committee. See NHS Confederation, NHS Managers: Busting the Myths, March 2015.

2. Labour Force Survey 2014, unless otherwise stated.

3. HSCIC, see page 6.

Insecure jobs
NHS managers have very little job security, especially at very senior levels. The average tenure of an NHS chief executive is two and half years.[1] That's not much better than football managers.[2] Now, if you really want to talk about big payoffs…

No revolving door
Most people who lose their jobs eventually return to work in the same industry. This isn't a revolving door. Where do you expect professional NHS managers to find work? They often go through months of uncertainty and financial stress before finding a new job. And often those jobs are on the other side of the country, temporary or on lower salaries than the ones they lost.

We're ready to talk about sensible proposals for recovering redundancy payments when people return to work quickly in the NHS. But the real question is why such people were made unemployed in the first place when their skills were clearly still needed.

Diversity at the top
It's up to everyone in the NHS to make sure there is effective action to improve diversity in NHS management, particularly at the top. This means fair recruitment and promotion processes built on equal opportunity principles, training and support for line managers and investment in development programmes for black and minority ethnic staff and other groups.

Outcomes not processes
Aren't we supposed to be looking at outcomes not processes? Why are otherwise sane people obsessed with the number of managers in the NHS? Either the organisation delivers or it doesn't. And managers should be held accountable for that.

A job for the professionals
Running the NHS isn't a job for amateurs or for people who don't know the NHS. The NHS needs experienced leaders — both clinicians and career managers — who care about the service as well as their own careers. This is no time for novices.

Burdens on managers
There *is* too much bureaucracy in the NHS and much of it comes from politically motivated targets and regulation imposed from Whitehall. The competition rules are too complicated and lead to a lot of wasted effort. Government should concentrate on reducing these burdens rather than telling local NHS organisations how many managers they should have.

Invest in the best
If we want the best leaders in the NHS we have to invest in them. The NHS spends very little on training and developing its managers and leaders — only the tiniest fraction of what it spends on doctors, and far less than the private sector. But it demands a lot of responsibility and personal sacrifice from them.

Privatising management
Managers who have lost their jobs are often forced into casual or agency work. Many are replaced by more highly paid consultants — this amounts to a wasteful and expensive privatisation of NHS management. Those few who do return to work quickly in the NHS should probably never have been made unemployed in the first place: their skills are clearly still needed.

Clinical managers
Over half of NHS managers are doctors, nurses and other clinicians. But the government needs to invest much more in developing management skills for all clinicians. If politicians continue to blame everything that goes wrong on NHS managers, it's hardly surprising if doctors and nurses are reluctant to get involved in management.

1. King's Fund, Leadership Vacancies in the NHS, Dec 2014

2. Research by Football Perspectives found the average tenure of professional football managers over the last 20 years was just under 23 months.

MiP POLICIES

- **No central targets for cutting** or increasing the numbers of particular types of NHS staff. Local NHS organisations should be left to decide their own staffing arrangements and management structures in the interests of local people, local services and local staff — and be held accountable for their results.
- **A professional accreditation system** for healthcare managers along the lines of the GMC for doctors, but only if backed up with dedicated funding for learning and development and re-accreditation, and a commitment to develop professional qualifications and institutions.
- **Urgent action to tackle staff shortages on NHS boards,** including a leadership strategy which allows the NHS to grew more of its own management talent and engages more senior clinicians in management.
- **Recovery of redundancy payments** to be limited to those who return to work in the NHS within three months, with adjustment to take account of expenses such as training and relocation costs.
- **Effective action to improve diversity** among the NHS leadership, particularly in senior roles, including effective implementation of the Workforce Race Equality Standard,[1] with dedicated training programmes for black and minority ethnic staff and sanctions for organisations which fail to take action.
- **Reduce the regulatory burden** on NHS organisations by devolving more performance management to local level and reducing information demands and the number of national targets. This will help to keep the National in the NHS without throttling local initiative.
- **Significant additional, dedicated investment in management training** – raising NHS spending on training and development on managers by at least 25% in order to match the average in the private sector.[2]

1. See Healthcare Manager, Spring 2015, p18.

2. CIPD, The missing link: effective management and leadership training in the NHS, 2012.

2. A sustainable NHS

Our key message is that managers have made huge efforts to keep the NHS working during a time of unprecedented financial pressure. NHS managers are leading efforts to make services more cost-effective. But we cannot go on doing this by just squeezing hospital budgets and freezing pay. Instead, we need to invest for the long term in integrating services, developing new ways to care for patients and improving people's health so they don't end up in hospital in the first place.

Talk about "efficiencies" implies the NHS is inefficient and therefore badly managed. In fact, the NHS is already one of the most efficient healthcare systems in the world. When it comes to saving money and improving productivity, we have a good story to tell. The **Five Year Forward View (5YFV)** says that NHS productivity in England has improved by around 1.5% "in recent years", compared to the long-term average of 0.8%. It's NHS managers who have achieved this.

KEY ISSUES

- The 5YFV implies the NHS in England needs to save £22bn through productivity gains of 2-3% each year until 2020-21.
- The 5YFV says to do this the NHS must "take action on prevention, invest in new care models, sustain social care services, and over time see a bigger share of the efficiency coming from wider system improvements". It does not say the savings must come from freezing staff pay, making managers unemployed and squeezing hospitals, primary care, and community and mental health services.
- The King's Fund warned in January 2015 that "the two main ways used to reduce NHS costs over the last few years – limiting staff salary increases and reducing payments to hospitals – have now been largely exhausted".[1]
- The scale of the funding gap is partly due to the government's decision to end the historic above-inflation increases to the NHS budget during this parliament.
- Decisions by the UK government about the size and allocation of public expenditure budgets will affect the funding available for NHS services in all four nations of the UK.

1. Richard Murray, King's Fund director of policy, responding to the rejection of the 2015-16 proposed hospital tariff by NHS Providers, 29 Jan 2015.

CAMPAIGN MESSAGES

Key messages

Booming productivity

Productivity growth in the NHS has doubled in recent years, while it has slumped across the rest of the economy. It is NHS managers who have led this remarkable achievement.

Efficient not cheap

The NHS is a complex and sophisticated organisation experiencing unprecedented pressure. Doctors, nurses and other health professionals need top quality support from managers in caring for more patients than ever before, and in delivering new and better services. This can be done efficiently, but it can't be done on the cheap.

We can't go on like this

You can't build a 21st century NHS on 19th century economics. Does anyone really think the NHS will be made better by impoverishing staff, stripping management to the bone and forcing hospitals to the brink of bankruptcy every year? It's obvious we can't go on like this. Instead of doing the same things ever more cheaply, let's invest in doing things better.

Invest to save

We need investment to maintain services, investment to improve services and investment to make services more cost-effective. Services that are permanently on the brink of collapse are neither cheap nor efficient.

Breaking point

Decades of under-investment has left mental health services at breaking point. Talking about "parity of esteem" means nothing to patients unless politicians give concrete meaning to it by investing in the services and staff on which patients depend.

Prevention is better than cure

Everyone knows prevention is better than cure. So do so few politicians taking investment in public health seriously? They need to honest with the public: the future of the NHS depends on all of us taking more responsibility for our own health

MiP POLICIES

- **All parties should pledge to meet Simon Stevens's additional £8bn funding requirement** and show clearly how they will fund it. Further increases in NHS funding to be linked to economic growth.
- **Active investment in prevention** and public health improvement by Public Health England, and equivalent bodies in Scotland, Wales and Northern Ireland, together with local authorities.
- **A major programme of investment in mental health services**, with an emphasis on prevention, and firm plans to achieve full parity which go beyond the usual rhetoric.
- **Consider reform of the NHS payments system** to address perverse incentives and avoid destabilising hospitals and other vital services every year.
- **Consider an independent transformation fund** (or series of local funds) for investment in integrated care and community initiatives, along the lines proposed by the Nuffield Trust.[1]

1. Nigel Edwards, Is a transformation fund really the answer for the NHS?, Nuffield Trust, Oct 2014.

3. Patients first

Here, we bring together some themes emerging from the Francis, Berwick and Keogh reports, particularly the "blame culture" in the NHS, patient safety and care quality, and getting patients and the public more involved in how the NHS is run.

Our key message is that NHS managers are leading the changes demanded by Francis and others. It is managers who must keep the show on the road, and who have day-in-day-out responsibility for quality and safety, however tough things get. Managers work with patients and the public on planning and improving services at local level. But they need more political support, from the Secretary of State down to local MPs and councillors, as well as practical help with investment in training, stable long-term funding and a more realistic approach to staff pay.

KEY ISSUES

Safety and quality

- The Mid-Staffs inquiry said a culture of care encompassing "transparency, openness and accountability" needed to embedded in the NHS through supporting local leaders.
- Both Francis and Berwick see improving care quality as primarily a learning and development issue, not one of regulation or structures. But training and development budgets have actually been cut since Francis reported.
- Francis found that the complex regulatory regime in the NHS had contributed to the failings at Mid-Staffs. There are at least six entangled lines of accountability for care quality: professional (e.g. GMC), managerial (boss), user (patient voice), regulatory (e.g. CQC), commercial (commissioners) and political (local and national).

Patient voice

- Everyone agrees that patients should have more say over both their own care and the way the NHS is run, but there is no consensus on how to go about it. There is little public understanding of how NHS organisations are accountable to local people. Both Francis and Berwick identified the lack of a powerful patient voice as a factor in poor care standards in hospitals.
- The King's Fund says patient power can save money and lead to better care: "It is time to make shared decision-making between doctors and patients a reality; when patients are fully informed about their options, they often choose different and fewer treatments."[1]
- There is widespread recognition that, despite Francis, the NHS complaints system remains cumbersome and largely toothless. The Patients Association recently described the Health Ombudsman as "unaccountable and wholly ineffective".[2]

1. King's Fund, Priorities for the Next Government, Sep 2014.

2. Patients Association, The People's Ombudsman: how it's failed us, Nov 2014.

Blame culture

- The 2013 Berwick report said "fear is toxic to both safety and improvement" and the NHS should abandon blame as a "tool" for change.[1] Publishing his 2015 report on NHS whistleblowers, Robert Francis QC said: "We need to get away from the culture of blame and the fear that it generates to one which celebrates openness and commitment to safety and improvement."[2]
- Managers are often made scapegoats for failings in the NHS because there is no one else to blame. Ministers cannot blame their own policies and it's politically unacceptable to blame doctors and nurses.[3] Opposition politicians have limited scope to blame the government because their own policies aren't very different.
- Francis says the NHS has a "serious problem" in dealing with whistleblowers:[4] "There was near unanimity among staff, managers, regulators and leaders who assisted the review that action needs to be taken."
- The **2014 NHS staff survey** found that 68% of staff were confident about raising concerns about patient care, but only 57% were confident their concerns would be addressed and 44% that they would get proper feedback.

1. Improving the Safety of Patients in England, Aug 2013.

2. Robert Francis QC, press conference, Feb 2015.

3. The King's Fund said that "if the government believes its designs are right, it can only blame the people when things go wrong".

4. Improving the Safety of Patients in England, Aug 2013.

CAMPAIGN MESSAGES

Key messages

Scapegoats

Managers get the blame for everything that goes wrong in the NHS because politicians can't admit they got it wrong and they don't want to blame doctors and nurses. Safety and compassion are responsibilities shared by managers, clinical staff, commissioners, regulators and the public itself.

Listening to staff

If someone in the NHS has to blow the whistle on their organisation, we have failed. Staff need crystal clear policies for dealing with their concerns. They need to know that they will be listened to, that necessary action will be taken and that they will get proper feedback. A board member should take overall responsibility for dealing with staff concerns and report regularly to the board.

Supportive managers

Most people who work for the NHS really value the support they get from their boss. The latest NHS staff survey shows satisfaction with line management continues to rise. We should accelerate this trend with dedicated investment in line management training. Supporting staff who have concerns at work is just one area where good middle management really makes a difference.

Well-run but over-regulated

Managers understand that a good NHS service isn't good because it's well regulated, but because it's intrinsically well run. If managers could spend less time trying to please so many different regulators, they would have more time and money to spend on improving care.

Care outside hospitals

The media and politicians focus on quality in hospitals, where care is at its most visible. We need to pay just as much attention to safety and compassion in primary care, community services, mental health and adult social care.

Open culture
We can't have an open culture in the NHS if managers are sacked or moved on every time something goes wrong. We need to learn from the mistakes, not shuffle all the blame onto one individual.

Supporting people who raise concerns
Managers who raise concerns themselves, or support staff who do, face the same toxic blame culture as everyone else. Whistleblowers and the managers who support them need a much more supportive culture as well as the additional protection proposed by Francis. Without proper protection people will be too scared to raise concerns about patient care.

Nobody's listening
Managers know we need to dispel the climate of fear hanging over the NHS. There are too many regulators breathing down the necks of staff and local managers, and too many targets without the staff or resources to meet them. People feel orders are shouted down to them, but when they shout back, nobody at the top is listening.

Standing up for standards
It's a manager's job to maintain high care standards, get the most from taxpayers' money, look after staff and keep the system running smoothly. Sometimes that means standing up to doctors or other powerful interests. To do that they need support and resources, not abuse and political interference.

Learning organisations
The one single thing that would most improve the quality of care would be for NHS organisations to embrace wholeheartedly the idea that they should be learning organisations. And to show they really mean it by coming up with dedicated money.

Managers work with patients
Managers know we need to listen to patients and get them fully involved in how services are run. But local NHS leaders need to be given the freedom to develop their own arrangements with patients, rather than implementing schemes devised in Whitehall or imposed by national regulators.

Learning from mistakes
Most patients who complain aren't looking for someone to blame. And good managers know that complaints are vital learning opportunities. They make sure patients' complaints are investigated properly and acted upon. They report back to patients and make sure the individual, the team and the whole organisation learns from the mistake to stop it happening again.

Local accountability
How is the NHS accountable to local people? It isn't really. There are mechanisms, but no one knows how they work. They were locked in a room during the Lansley reform and have probably rusted up by now.

MiP POLICIES

- **Place the support and development of line managers** at the heart of quality and safety, building on their role in supporting staff well-being, addressing concerns and nipping problems in the bud.
- **Implement the Francis whistleblowing report in full**, particularly:
  - extend legal protection for whistleblowers, including protections against discrimination when looking for NHS jobs
  - a national officer to investigate whistleblowers' concerns
  - local "freedom to speak up" guardians to give independent support and advice to whistleblowers
  - Chief executives to personally review complaints by staff
- **Reduce the administrative burden on NHS organisations** by streamlining regulation and reducing the number of national targets and information reporting requirements.
- **Investment in developing a learning culture** within all NHS organisations as recommended by the Francis and Berwick reports.
- **Transparent staff-patient ratios** to be agreed locally in accordance with scientific evidence and published, as proposed by the Berwick report.
- **Reform of the NHS complaints system,** including devolution of some of the powers of the Health Ombudsman to local level and making complaints procedures simpler to use for patients and staff.
- **Strengthen the local accountability of NHS organisations** by giving seats on the boards of non-foundation trusts and CCGs to patient and public representatives, and reviewing local accountability mechanisms in partnership with patients' organisations.

4. Hardworking NHS staff

Our key message is that people who work for the NHS have been singled out for an on-going and punitive pay freeze that doesn't apply to other workers, even in the rest of public sector. Within the NHS, managers have been singled out again for unfair and short-sighted pay cuts, and restrictions on redundancy payments that don't apply to anyone else. As there is simply no evidence that NHS managers are overpaid compared to other NHS staff or managers in other industries, there is no reason why they should be targeted in this way.

We don't deny that NHS managers are paid more than many other staff. This is no different to any other industry or any other part of the public sector: prison governors are paid more than prison officers, council chief officers are paid more than social workers, ministers are paid more than backbench MPs. We can and should point out that the ratio between the salaries of the highest and lowest paid employees in the NHS is much narrower than in private industry.

It's misleading to describe the government's NHS pay policy as "pay restraint" or a "pay cap". People who work for the NHS have always been restrained in their pay expectations, and there is always a "cap" on pay. With inflation and increases to pension costs, most NHS managers have seen the value of their pay cut significantly since 2010.

It's important that managers (and hence MiP) speak up for all NHS staff, both as custodians of NHS values and because they are NHS staff themselves. NHS managers have consistently backed the Living Wage and been prepared year after year to take a smaller piece of the pie to help much lower paid colleagues. But just taking money from managers to tackle low pay will never be a sustainable solution. Managers' pay must be set at the right level to reward and retain managers. It's not a function of the money needed to lift other staff off poverty wages.

KEY ISSUES

Managers' pay

- While the average earnings of NHS managers as a whole have risen by more than those of other staff since 2010,[1] this is down to the average being pushed up by the cuts in many junior and middle management jobs. Individual NHS managers on Agenda for Change, like other NHS staff, have received only below inflation pay awards (if any) since 2009.[2]
- The pay offer for 2015-16 means that NHS managers in England have faced the most severe pay squeeze among all NHS staff. With higher pension contributions, most managers' take-home pay has actually fallen *in cash terms* since 2010.
- The highest paid staff in the NHS are doctors. Figures from Income Data Services show that median total pay for medical directors at NHS trusts was £175,000 in March 2014, compared to £172,500 for chief executives and £127,500 for finance directors.

1. Comparing average annual earnings in Oct 2014 to May 2010, the figures are: "senior managers" 14.5%; "managers" 10.5%; doctors 4.2%; nurses 4.9%; paramedics 4.9%. (Health & Social Care Information Centre)

2. Since 2009, the relevant pay awards for AfC managers are (with CPI in brackets): 2009: 2.4% (2.3%); 2010: 2.25% (3.7%); 2011: 0% (4.5%); 2012: 0% (3%); 2013: 1% (2.4%); 2014: 0% (1.8%). (Source: NHS Employers/ONS)

- The 2011 Hutton review, **Fair Pay in the Public Sector**, found that the ratio between the highest salaries and the average salary in NHS organisations was usually under 6:1. This is narrower than many other parts of the public sector (including the civil service, the military, higher education and local government) and far lower than in the private sector. In most FTSE 100 companies, the ratio was higher than 100:1.

Pay freeze

- NHS staff have not had a real pay rise under this government, and have done slightly worse than average. Since May 2010, average earnings for all NHS staff have fallen by 5.5% in real terms,[1] while average earnings across the economy have fallen by around 4%.[2]
- There is a growing consensus that the NHS pay freeze is not sustainable. In October 2014, Simon Stevens said: "Over the medium term, the NHS has to pay in line with pay rates across the rest of the economy if we're going to be able to continue to attract some of the best and most committed staff."
- The UK government has consistently ignored the recommendations of the independent pay review bodies for staff in England, despite insisting that they should take "affordability" into account. The governments in Scotland, Wales and Northern Ireland have honoured the review body recommendations.

Staff shortages and over-working

- 38% of NHS staff report stress-related illness and 25% say they are pressured to work when unwell. Almost half of NHS staff report high workloads and staff shortages.[3]
- MiP's online survey of members in February 2015 found that 93% work more than their contracted 37.5 hours and 30% work more than 48 hours a week.
- In July 2013, **a King's Fund** report described the potential staff shortages in the NHS as "breathtaking" and warned they were a threat to introducing new models of care.

Regional pay

- The new Greater Manchester Combined Authority will "be responsible for determining its skilled workforce, capacity, education and training needs".[4] This may open the way to regional pay and conditions in the NHS and undermine national structures.

1. HSCIC average earnings for all NHS staff, adjusted by the CPI, for Oct 2014 compared to May 2010.

2. ONS average earnings (all employees) adjusted by CPI, Nov 2014 compared to May 2010.

3. Nuffield Trust/ Health Foundation, Quality Watch Annual Statement 2014.

4. Memorandum of Understanding between the Association of Greater Manchester Authorities, Greater Manchester Clinical Commissioning Groups and NHS England, Feb 2015.

CAMPAIGN MESSAGES

Key messages

Singled out

This is the first government in history to deny hardworking NHS staff a pay rise to meet the cost of living every single year it's been in office. Everywhere else, it says rising wages are good news. Why is the government singling out NHS staff for punitive treatment?

Doubly singled out

Within the NHS, managers have received the harshest treatment of all. They have seen the value of their pay cut every year since 2009 and, once again, this year most will receive no pay increase at all.

If the average earnings of managers as a group have risen, it's because so many junior and middle managers have lost their jobs, leaving a higher proportion of senior managers at the top.

Self-defeating

Freezing and cutting NHS pay is unfair, short-sighted and self-defeating. It just leads to staff shortages, deterioration in patient care and money being wasted on expensive agency staff.

A cop out

We fully support moves to end poverty pay for NHS staff. That comes first. NHS managers have willingly made sacrifices, but robbing Peter to pay Paul isn't a policy, it's a cop-out. In the end, this about the values of the NHS: politicians must decide whether they think it's acceptable for people who work for a caring organisation like the NHS to be paid below the Living Wage.

As long as it takes

Despite the photo-opportunities, ministers don't have a clue about how hard people in the NHS work and the many hours of unpaid overtime managers put in every week. They are the only NHS staff who have to work for as long as it takes to do the job. A third of MiP members work more than 48 hours a week. Overworking staff like this is short-sighted and counter-productive and it's patient care that suffers in the end.

Gambling with staff loyalty

The government is gambling with the loyalty of staff and their commitment to patients in order to plug its funding gap in the NHS. Most don't expect to earn as much as they could in the private sector. But they don't deserve to have that sacrifice turned against them and used as an excuse to cut their pay year after year.

Failure to value managers

If we accept that we have to pay competitive salaries to get the best doctors, we need to do the same to attract the best managers. As the economy recovers, more and more money is being wasted on employing agency staff and consultants to plug staff shortages. The government is paying a high price for its failure to value NHS managers.

Having it both ways

The government already insists that the review bodies take "affordability" into account, then uses it as an excuse to ignore their recommendations. If the governments in Scotland, Wales and Northern Ireland can honour their commitments, why can't the UK government do the same for staff in England?

Beyond warm words
Talk of a new deal for NHS staff must go beyond warm words. Staff engagement and morale is now the number one factor in caring for patients. But people are drifting away from working in the NHS because it gives the impression as an employer that it doesn't care about them.

Workforce strategy
All NHS organisations need effective workforce strategies, so they have the right people in the right place at the right time, and provide high quality training and development so that all staff can develop to their full potential. We can't keep managing our workforce by the seat of our pants, and from one month to the next.

National service, national pay
The NHS is a national service and NHS managers operate in a national job market. Local pay would increase regional inequalities by tempting high-skilled staff away from deprived areas, damaging both NHS services and the local economy. Most NHS employers don't want local pay because it would be costly and complex to implement.

MiP POLICIES

- **Review bodies should be properly independent** with the needs of the NHS at the heart of their remit. Review body recommendations and contractual obligations (including increment payments under Agenda for Change) should be honoured in full – no ifs, no buts.
- **Pay systems for managers** must be designed to recruit, retain and motivate managers and other senior staff, and not manipulated for political ends. Pay systems should be transparent and based on equal opportunity principles.
- **No cap on redundancy payments** for any NHS staff. The government should honour contractual entitlements like any other employer.
- **Pay in the NHS must keep up with the rest of the economy** so the NHS can recruit and retain talented and committed staff and avoid expensive bills for agency staff.
- **End poverty pay in the NHS** by paying all staff at least the Living Wage.
- **All NHS staff should have consistent national terms and conditions** across the UK and the same protection and employment rights.

5. Reforming the NHS

Almost everyone agrees that integrating health and social care services, and hospital and community services, is essential to long-term future of the NHS. Our key message is that reforms will only work if politicians talk to the managers who will have to implement them and make them work on the ground, and don't try to force change by diktat from Whitehall.

MiP does not have a national policy on how integration should be done, but experience has shown time and time again that successful integration projects take years of planning and hard work and can only be delivered by professional managers with many years of experience working in the NHS and social care.

The government's proposal to devolve integrated health and social care budgets to **a new authority in Greater Manchester** ("Devo Manc") raises lots of tricky questions about the balance between local management autonomy and political accountability, whether pooled budgets and integrated services should be mandatory, and how far we should tolerate a "postcode lottery" of different service models. Our message is that we expect politicians to answer these questions and not to get carried away with another destabilising reorganisation, or to try to impose the Manchester model on every NHS area in England.

NHS managers have to make the system work for patients whatever the funding situation or the organisational upheavals thrown at it by politicians. Managers are the people who organise and run the NHS at local level: they know how the system works, how to get patients and the public involved, how to challenge vested interests (and each other) and how to work with other public services to get the best results for local people.

KEY ISSUES

- All parties support further integration of health and social care services in principle. If re-elected, the Conservatives are likely to extend the Devo Manc initiative to other areas, particularly London. Other parties, while not opposing Devo Manc outright, remain wary of the costs and complexity of another major reorganisation.
- Proposals from all parties (including Devo Manc) have failed so far to resolve the tension between local autonomy and democratic accountability in the NHS, and explain adequately how an organisation funded from national taxation can be accountable locally.
- Successful initiatives to integrate health and social care (e.g. Torbay), hospital and community care (e.g. Brighton and Hove), and other public services (e.g. Sure Start) show that substantial long-term investment and huge management effort is required. It doesn't happen overnight and won't save as much money as politicians think, especially in the early years, when additional pump-priming investment will often be needed.
- There are major funding barriers to integrating health and social care in England because NHS care is free at the point of use while local authority social care is means-tested.

- The response to Devo-Manc shows that there is substantial support across the political spectrum for the local government becoming much more involved in the way the NHS is run in their local areas. Despite insistence to the contrary in the Memorandum of Understanding, the Devo Manc proposals are widely portrayed in the media as a "takeover" of the NHS by local government.
- The Lansley reforms will remain a live issue during the election, with Devo Manc sharpening the argument that they were a waste of time and money. The King's Fund says the reforms were a "strategic error" which distracted management attention, "wasted" three years on organisational changes and contributed to the NHS missing patient care targets.[1]
- Privatisation — used in its widest sense to cover contracting out and the extension of competition and market mechanisms — will be a major issue in the campaign. The King's Fund says the 2012 Health and Social Care Act has increased "marketisation" in the NHS but has not led to the acceleration of privatisation that many critics feared.
- The consensus about the NHS internal market is starting to break down, with Labour and the Lib-Dems (and some Conservatives) questioning whether the purchaser/provider split and competition is the right model to deliver more personalised and integrated services.[2]

1. King's Fund, The NHS under the Coalition Government, Feb 2014.

2. Andy Burnham has talked about "reducing" the internal market and questioned FT status; the Lib-Dems are proposing to allow some commissioners and providers to merge; Jeremy Hunt has admitted that competition and choice cannot deliver integrated services on their own.

CAMPAIGN MESSAGES

Key messages

Experienced managers deliver

Integrating health and social care demands skilful management from experienced professionals on both sides. It cannot be done on the cheap, or by armies of outside consultants who have no experience of running services for vulnerable people. After the unnecessary changes of the last five years, neither the NHS nor social care services can afford to lose any more of the experienced managers on whom the success of integration will depend.

Get out of management

The Lansley reforms show what happens when ministers try to reform the NHS without talking to the people who organise and run it. Billions of pounds have been wasted on reforms which are already being torn up by the same government that introduced them. Just as importantly, three years have been spent upending commissioning structures that could have been spent developing new and better services. Politicians should learn the lesson and get out of managing the NHS altogether.

No ideology

Ideology does the NHS no favours. Co-operation, partnership and integration come about through hard work and skilled management, not the magic of the market. Market mechanisms may sometimes be useful but local NHS leaders working with patients and councils can figure out for themselves what works best.

Manchester – many important questions need answering
The Manchester devolution proposals have attracted support on the ground, but support for the principle of integrated services and local autonomy is tempered by the many questions and concerns about the detail which remain unanswered, particularly given the speed with which the deal between local and national politicians was concluded. Those outstanding questions include:

- Who will be accountable for the £6bn spent in Greater Manchester?
- How much freedom will local leaders have? Will there be a balanced power relationship between local government leaders and NHS commissioners?
- How will all this be delivered without another massive upheaval to NHS and local government structures which could disrupt local services?
- What extra resources will be available to local managers who have to implement the reforms at the same time as the day job of running services?
- What happens if the money runs out? How will free access to care and treatment at the point of need be protected?
- Is there a workforce strategy to support successful implementation of the devolution proposals? If so, has this been developed in consultation with the trade unions?
- How have local people and staff been consulted? Will be they be involved from the earliest stages in future restructuring projects?
- How will genuine democratic control and accountability be assured?

We expect politicians to answer these questions and not get carried away by their usual enthusiasm for NHS re-organisation.

One size suits no one
What works in Manchester may not work elsewhere. The worst thing the government could do would be to rush to impose the Manchester model on everyone. We have learned the hard way that that "one-size-fits-all" solutions actually end up suiting no one.

Political interference
We need to be careful not to end up swapping one form of political interference for another. The last thing the NHS needs is another group of politicians rolling up their sleeves and reorganising the NHS to suit their own political ends.

Local solutions for local people
It's not for ministers or NHS England to decide how care should be integrated at local level. NHS managers, clinicians and their local government colleagues need the autonomy to develop their own arrangements for local people.

Removing obstacles
We need to examine whether the NHS competition rules and the strict separation of purchasers and providers is obstructing the integration of services. Managers on the ground need to work with local partners to commission and develop services, but the competition rules in the 2012 Act had a chilling effect on such partnership working.

Beware hidden cuts
Local government has borne the brunt of austerity and the cracks are beginning to show in children's services, adult social care and cuts to public health budgets. Integrating services must not be allowed to hide further cuts to services that keep people well in their own homes.

Passing the buck
There simply isn't enough money being spent on social care to maintain service levels and invest in integration. There are huge workforce problems that politicians haven't even begun to think about – not least that social care staff are very poorly paid even compared to NHS colleagues. A single budget won't solve any of that. Devolution must not become a way for ministers pass the buck for underfunding both services onto local politicians.

Cherry picking
Private sector providers have a role to play in delivering NHS services. But that does not extend to destabilising NHS providers who have a duty to provide less profitable services. That isn't competition, it's cherry-picking.

Accountable to whom?
NHS managers want to be accountable to patients and the public. But all the lines of authority go upwards, to regulators and Whitehall. It's not surprising the public can't see how local NHS services are supposed accountable to them.

MiP POLICIES

- **No top-down reorganisation** of NHS structures during the next parliament.
- **Integrated care initiatives to be introduced through existing structures** wherever possible, following negotiations at local level between CCGs and local authorities.
- **Further devolution proposals for health and social care to be negotiated** between all interested parties, including CCGs and local NHS providers, and subject to widespread public consultation.
- **Address the workforce implications and impact on staff wellbeing** (and hence patient care) before implementing any major changes in services or organisations at national or local level.
- **Restore the Secretary of State's duty to provide a universal and comprehensive healthcare service** in England, free at the point of use, and clarify how national responsibility for the NHS fits with local autonomy over the way services are provided, and the devolution of functions and budgets to regional level.

6. Our NHS

This is where we get to speak positively about the NHS and MiP members' hand in its success. Our message is that the difficult problems the NHS faces (funding, ageing population, integration etc.) are not abstract questions of policy to NHS managers, they are the very real management problems they have to grapple with every day. NHS managers are not bureaucratic outriders from Whitehall, "agents of privatisation", or even a "necessary evil" – they are part of the NHS's DNA.

NHS managers work across four different health systems in England, Scotland, Wales and Northern Ireland without apparent difficulty, and have made a decent job of making each of them work despite a very hostile political and financial climate.

KEY ISSUES

- There's no evidence of any significant difference between the performance of the UK's four NHS systems. The Nuffield Trust[1] found "little sign that one country is moving ahead of the others consistently across the available indicators of performance".
- In 2014, patient satisfaction[2] with the NHS was near to record levels and dissatisfaction at an all time low.
- The NHS performs well in international comparisons, including the 2014 Commonwealth Fund[3] study, which found it was the most efficient healthcare system in the world, and ranked the NHS top overall.

CAMPAIGN MESSAGES

Key messages

It's not about structures

In the end it's not about structures or how much you use the market. It's about compassionate management and dedicated professional staff providing the best quality care possible. It's not always easy but however tight money is, managers just get on with the job and make the system work the best they can.

Part of the DNA

NHS managers see themselves as the custodians of NHS values and culture. They're not an alien species, they're part of the NHS's DNA. Simon Stevens is right to say the NHS is a social movement as much as a healthcare service,[4] and our members are proud to be part of that movement.

As good as ever

Of course the NHS is a sustainable model of healthcare. Despite everything that's been thrown at it, it's still here after 67 years and surveys show it's almost as good as it's ever been.

1. The four health systems of the UK: how do they compare?, Apr 2014

2. The 2014 King's Fund/BSA survey found that patient satisfaction rose to 65%, the second highest level since the survey began in 1983. Dissatisfaction fell to its lowest ever level — just 15%.

3. Mirror, Mirror on the Wall: How the US Health Care System Compares Internationally, June 2014.

4. The Guardian, 24 Oct 2014.

Resilience
Our ageing population is a great success story but it's also a challenge for all healthcare systems, however they're run or funded. The NHS has proved a very resilient way to provide universal healthcare. With stable funding and massive public support, there's every reason why it should cope just as well, if not better, than other systems.

Stability
Above all, the NHS just needs stability to flourish. The government needs to promise no more top-down re-organisation and a programme of stable funding for the years ahead. We need to end the cycle of crisis and reorganisation which has dogged the NHS for a generation.

Consensus
To really thrive, health and social care services need to be able to plan for more than four or five years ahead. We'd like to see the political parties try to establish some sort of consensus about stable funding and the future development of services, beginning with adult social care.