issue 64 | summer 2025

health mana

‘We’ve given management a home’

Jon Restell looks back on MiP’s first 20 years and forward to the battles ahead

Cut first, plan later

Geoff Underwood, Rhys McKenzie and Craig Ryan try to make sense of the UK government’s chaotic NHS reforms

Put down the chainsaw!

We don’t need a DOGE: the economic case for doing the right thing

NHS pay 2025

What the latest pay round means for your salary

mip managers in partnership

The union for senior health & care managers

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Maybe you, out there in remote posterity, understand. Maybe for you, it all makes sense. Maybe you know the answer to the question that's still haunting us: Why are they doing this? Maybe you've now seen the government's ten year plan.

If so, you have the advantage on us. We waited and waited but in the end the presses had to roll. The summer break waits for no one.

I think it's fair to say this has been, so far, the most chaotic reorganisation of any public service I've seen in 30 years as a journalist writing about this stuff. As an object lesson for future generations in how to alienate staff, disrupt services and keep everybody in the dark, it's going to take some beating. So there's a lot riding on the plan that's supposed to make sense of it all.

In this issue, we set out the state of play in different parts of the English NHS (a moving target, we know) and the damage the chaos and uncertainty is already doing to staff morale and services. We also pose some of the big questions the ten year plan needs to answer. We'll be back in the autumn with a full analysis, assuming the bloody thing has finally seen the light of day by then.

This momentous summer also sees MiP's own 20th birthday. As Jon Restell has been there since the start, we asked him to reflect on the past, present and future of our union, and you can read his full and fairly frank conversation with me on page 11.

I've also been involved with MiP throughout those two decades. It's been a pleasure and a huge privilege to work and spend time with such a dedicated, resourceful and, yes, kind, bunch of public servants. Whatever rubbish gets slung at you by people who should know better, you play your full part in making the NHS the most cherished institution in our country. //

Craig Ryan, Editor
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headsup

analysis & opinion

features

regulars

healthcare manager

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headsup

News you may have missed
plus what to look out for

Government spending review & the NHS—pages 4-5

NHS pay awards—pages 6-7

noticeboard

15 July 2025

King's Fund Digital Health and Care Conference

King's Fund, London

The think tank's annual get-together for tech-inclined managers and leaders, this year focusing on how to deliver the ten year plan's "vision of a digitally enabled and transformed NHS".

kingsfund.org.uk/events/digital-health-and-care-conference

16 July 2025

NHS Providers Mental Health Leaders Network

Online, 2-4pm

Regular meet-up for managers in mental health, with presentations, learning opportunities and "open and honest discussions" about mental health services.

nhsproviders.org/training-and-events/mental-health-leaders-network-july-2025

18-20 July 2025

Tolpuddle Martyrs Festival

Dorset

Annual "family-friendly" festival, organised by the TUC, commemorating the founding of the British trade union movement by six agricultural workers in Dorset in the 1830s. Speakers, bands and DJs, comedy, theatre and trade union activities. (Camping optional—hotels nearby).

tuc.org.uk/events/south-west/tolpuddle-martyrs-festival-2025

23 July 2025

Quantifying the economic and social impact of the NHS

NHS Confed Webinar, 2pm

Discussion on how we can demostrate the economic and social value generated by NHS trusts. Led by the Confed's head of health economic partnerships, Michael Wood.

nhsconfed.org/events/quantifying-economic-and-social-impact-nhs

7-10 September 2025

TUC Congress

Brighton

157th annual TUC Congress, with delegates from all UK unions, including MiP, UNISON and the FDA. Visitor passes available.

tuc.org.uk/events/tuc-congress-2025

9 September 2025

King's Fund: 10 Year Health Plan conference

King's Fund, London

One-day conference offering a deep dive into the (hopefully by then published) ten year plan and implementing the 'triple shift'. Speakers include Greater Manchester mayor and former health secretary Andy Burnham, and Dame Maria Gabriel, chair of North East London ICB.

kingsfund.org.uk/events/ten-year-health-plan

KEEP THE DATE

15-16 October 2025: NICON 2025: NHS Confed Northern Ireland, Belfast (nhsconfed.org/events/nicon-2025)

25-27 October 2025: UNISON Disabled Members Conference, Liverpool (unison.org.uk/events/2025-ndmc)

5-6 November 2025: King's Fund annual conference, London (kingsfund.org.uk/events/annual-conference)

6 November 2025: WelshConfed25: Welsh NHS Confederation Annual Conference, Cardiff (nhsconfed.org/WelshConfed25)

11 November 2025: NHS Providers Annual Conference, Manchester (nhsproviders.org/training-and-events/annual-conference-and-exhibition-2025)

Got an event that MiP members should know about? Send details to the editor: c.ryan@miphealth.org.uk

Skills

Managers need re-skilling, says NHS England chief

Some NHS managers have become "deskilled" since the pandemic and need to be "re-educated" to better manage waiting lists, patient flow and emergency departments, NHS England chief executive Jim Mackey has said.

Speaking to the Medical Journalists Association in May, Mackey acknowledged that most managers "really care about what they do" and often worked in very difficult situations, but said he shared concerns that some managers had been "deskilled at some things" because of how the NHS has worked since the pandemic.

"We're having to re-skill, train people again in things like waiting list management, stuff on flow and ED management," he said. "So, [those skills] are being rebuilt, and people are being re-coached and re-educated."

Earlier in May, a report from the National Guardian's Office said NHS managers need more "cultural intelligence training" when managing staff recruited from overseas.

IAN DAVIDSON/ALAMY STOCK PHOTO

NHS England chief executive Jim Mackey: "post-pandemic some managers need to re-skill"

The NGO's study, which found that international recruits felt more inhibited than other staff in speaking up about service failures, and said managers needed more training so they could "understand and adapt to the experiences and perspectives of overseas-trained workers".

Outsourcing

Private health firm Totally collapses

More than 100 jobs have been lost and 600 staff transferred after private health firm Totally plc collapsed and sold its business providing services to the NHS to rival firm PHL Group.

Derby-based Totally, which provided urgent care services to several NHS organisations, including London's King's College Hospital, was placed in administration on 9 June. The firm had been in financial difficulty for several months after losing its NHS 111 support contract in February, and revealing in April that it was facing an "eight-figure" claim for medical negligence.

According to administrators Ernst & Young, staff working on Totally's NHS contracts were immediately transferred to PHL, a larger firm that already provides a wide range of NHS urgent and primary care services. "We're are pleased to have agreed the sale of Totally plc, which safeguards critical frontline NHS services and includes the retention of over 600 jobs," Ernst and Young's Tim Vance told the BBC.

Employers

Merger of Confed and NHS Providers moves closer

The NHS Confederation and NHS Providers have opened talks about closer collaboration with full merger a possibility, according to Confed chief executive Matthew Taylor.

"We're now committed to bringing our organisations closer together," Taylor told delegates at NHS ConfedExpo in June. "Our members are saying to us, 'There's no justification for duplication, there's no justification for asking us for more money than we can afford.' And we're absolutely hearing that."

He refused to rule out a full merger, but combining the two organisations would be "complex" Taylor said. "We don't want to announce something really big and then have to work out how to do it. You'll have to be patient."

The NHS Confederation ('Confed'), founded in 1990, represents all types of NHS organisation, as well as hosting NHS Employers, the management side in national negotiations with unions. NHS Providers, which represents trusts, was formed from the Foundation Trust Network, which split from the Confed in 2011.

Job cuts

"Big, risky" reforms challenged by NHS England directors

Two NHS England directors have publicly questioned the planned cuts to ICB and trusts' running costs, with its deputy chair saying 50% "may well not be" the right number and could be "too much".

The comments, made during an NHSE board meeting on 29 May, were the first signs of internal disquiet over the cuts programme—described by chief executive Sir Jim Mackey as "big, risky and complicated"—which has forced many ICBs into merger plans and are expected to lead to thousands of managerial and administrative jobs being lost.

Deputy chair Sir Andrew Morris told the meeting: "My challenge is, if someone had said to me 18 months ago that we'd be taking 50% out of ICBs costs, plus 50% out of [trust] corporate costs, I'd have thought that was a bit too much, if I'm absolutely honest."

He questioned whether NHSE was "chasing 50% for the sake of doing it" and asked to see how the figure had been worked out. "It would be good to... convince ourselves that the 50% is the right number, because it may well not be," he added.

Sir Andrew Morris: "are we chasing 50% just for the sake of it?"

At the same meeting, non-executive director Sir Mark Walport questioned the decision to impose the cuts before the new roles and responsibilities of NHS bodies had been decided. While it was necessary to cut ICB costs "very substantially", he said, "it's quite difficult to do that if you haven't got a target operating model that you're making your changes against. So the danger is you cut the wrong people by accident."

Sir Mark Walport: "the danger is you cut the wrong people"

Responding to the comments, Mackey said "there's no way of dressing this up, it's a really big, complicated, risky change", but corporate costs had grown across the NHS in recent years, he claimed, and "we've ended up with a really complicated operating model".

There was "a degree of anxiety" among ICB colleagues because "they want to see the whole picture [but] we're having to make informed guesses about how everything fits," he added.

Funding settlement a "good turn" says NHS England chief—but is it enough?

"The government has done us a really good turn," claimed NHS England chief executive Sir Jim Mackey after the chancellor, Rachel Reeves, unveiled what she called a "record cash investment" in the NHS in England as part of the government's spending review. The settlement will see NHS spending rise by around 3% above inflation during the five years of this parliament.

Mackey told delegates at NHS Confed Expo, shortly after Reeves's statement on 11 June, that the NHS now had "all the money the country can afford to give us".

"It's a huge amount of money by any, any standards,' he said. 'The government's done us a really good turn compared to other parts of the public service. But it's not going to allow us all to just take our feet off the pedal and just run loose... we've still got an awful lot of difficult things to do."

Under Reeves's plans, NHS spending will rise to £226 billion by 2028-29, an increase of £29 billion over the course of this parliament and £11 billion higher than this year's budget.

The projected growth in NHS spending is well above the rates seen over the last 15 years, but below the long-term average before the pandemic of 3.7%, and less than the 3.8% growth seen over the last two years.

Redundancy costs from the government's job cuts across NHS England, ICBs and trusts must be met within these budgets, and Reeves also confirmed the NHS would be expected to make 2% productivity savings each year for the rest of the parliament.

UNISON general secretary Christina McAnea welcomed the funding boost but warned "the reality on the ground now is very different". NHS organisations across England were "making damaging cuts to jobs and services under ministers' orders to balance this year's budgets," she said.

For the Conservatives, shadow health secretary Edward Argar said the NHS budget was "now roughly the equivalent of the entire GDP of Portugal" and criticised ministers for lacking detailed plans on how the money would be spent. "The Labour party has failed to come up with a plan for the NHS, with the exception of the abolition of NHS England, which will not happen for years and appears to be delayed and in chaos," he said.

Health and care experts welcomed the settlement but most warned it would still not be enough to meet all the government's promises on the NHS.

"We know there are already trade-offs happening in the NHS due to tight finances, said Sarah Woolnough, chief executive of the King's Fund. "It's hard to see how all the things [the chancellor] mentions—faster ambulance times, more GP appointments and adequate mental health services and more—can be met on this settlement alone. Particularly when large parts of this additional funding will be absorbed by existing rising costs, such as the higher cost of medicines... and covering staff pay deals."

Social care settlement "insufficient" to fund fair pay

Day-to-day health and care spending outside the NHS—which includes social care and public health—is set to fall by £500 million in cash terms over the next three years, as the Department of Health and Social Care squeezes other budgets to fund higher NHS spending.

In her spending review, the chancellor did announce a £4 billion increase in spending on adult social care over the next three years, through increased allocations to councils and a bigger contribution from the NHS through the Better Care Fund. But the funding increase—just 2.6% in real terms—will also have to cover the cost of the government's Fair Pay Agreement for social care staff, details of which have yet to be announced.

Health Foundation chief executive Jennifer Dixon said, "with one in five residential care staff living in poverty", the government's commitment to a fair pay agreement was "welcome",

Nuffield Trust's Sally Gainsbury: "difficult to invest"

Siva Anandaciva, King's Fund: private finance "not a quick fix"

Jennifer Dixon, Health Foundation: productivity target is "a huge ask"

IMAGEPLOTTER / ALAMY STOCK PHOTO

Flatlining NHS investment poses productivity threat, experts say

A standstill in NHS capital spending over the next three years, announced in the spending review, could undermine the government's efforts to modernise the health service and boost productivity, expert commentators have warned.

After sharp increases in the last two years, capital spending will stay flat for the rest of this parliament, at just under £15 billion a year. As well as the maintenance backlog, the capital budget must cover spending on 25 projects in the remodelled New Hospitals Programme, refurbishing seven hospitals affected by unsafe RAAC concrete and any new facilities required to deliver the ten year plan.

The £10 billion investment in new technology projects, also announced by the chancellor, will also come from the same capital budget. These include developing the NHS app into a "digital front door" for NHS services and delivery of the long-awaited single patient record, which will offer patients a "unified view of their medical history" and enable "two-way communication and active management of their healthcare", the spending review says.

Health Foundation chief executive Jennifer Dixon said the constraints on investment would make the government's target of annual 2% productivity improvements "a huge ask", while the Nuffield Trust's Sally Gainsbury warned: "With capital funding staying flat in real terms for the rest of the spending review period, it will be difficult for the NHS to invest in the technology and facility upgrades it needs to meet the government's ambitious productivity targets."

The government may be looking to private finance to plug the gap. In June, NHS England chief executive Jim Mackey said he was exploring a new "off-balance sheet capital investment mechanism"—a scheme similar to the private finance initiative, introduced in the 1990s, which led to an influx of private capital into the NHS but left many organisations with steep annual bills they struggled to fund. But the Treasury is understood to be highly sceptical and the initiative was not mentioned in the spending review.

"Flatlining public capital investment... could make more sense if private finance is intended to pick up the slack," said the King's Fund's Siva Anandaciva. "But even the more recent models of private investment took some years to get going. So private finance may prove to be both contentious and necessary, but it might not be a quick fix."

but warned the overall increase in social care funding "is only enough to prevent a further deterioration in services and will not be sufficient to fund increases in pay or improve access to or quality of care".

Shadow health and care secretary Edward Argar accused ministers of neglecting social care in the spending review. "There were just two sentences about it in a four-page statement. Social care deserves better. The [government] knows very well that we cannot improve the NHS without social care working well," he told the Commons.

Shadow health secretary Edward Argar: "We cannot improve the NHS without social care working well"

Argar called on the government to speed up social care reform by bringing forward Louise Casey's forthcoming review of the sector—not due to report until 2028—and providing a "seat at the table" for private-sector social care providers. "They want to have their voices heard in decision making on funding", he said.

IAN DAVIDSON / ALAMY STOCK PHOTO

England, Wales & NI

Managers paying the price for 3.6% pay rise, MiP says

UNISON head of health, Helga Pile: "The absurd pay review body process has led to two different awards. The NHS is one team and should be treated that way."

Most NHS staff in England and Wales are set for a 3.6% pay rise after the UK and Welsh governments accepted the recommendations of the NHS Pay Review Body (PRB). A similar award for staff in Northern Ireland is awaiting approval by Stormont ministers.

The award, marginally higher than the April inflation rate of 3.5%, will be backdated to April 2025 and paid in August pay packets. All Agenda for Change pay bands will also be increased by 3.6%

In its evidence to the PRB, the UK government had previously claimed a 2.8% rise was the most it could afford, and health secretary Wes Streeting claimed he had been forced to make "difficult decisions on other areas of spend" to pay the higher award.

MiP chief executive Jon Restell said that, while most MiP members' pay would keep pace with inflation, higher awards of 4% for doctors and lower rises of 3.25% for the most senior managers "will not feel fair".

He added: "Big job losses among managers will partly pay for these pay rises, throwing a deep shadow over what some might see as a better-than-expected outcome. The NHS needs managers, and I fear the result will be lower productivity, a poorer experience for staff and patients, and unsustainable workloads."

The award, which was not negotiated with unions, "will be imposed regardless", he said. Encouraging all members to vote in the unions' consultation, he said "members will decide whether MiP and UNISON seek to challenge and improve this award."

Commenting on the award, UNISON head of health Helga Pile said: "The pay rise is more than ministers said they could afford, but it barely matches inflation. The money will also be landing in pay packets four months late.

"And not everyone in the NHS is getting the same," she added. "The absurd pay review body process has led to two different awards for employees. But the NHS is one team and should be treated that way."

The UK and Welsh governments also accepted the PRB's recommendation to give the NHS Staff Council a "funded mandate" to negotiate solutions to long-standing structural problems with the Agenda for Change pay framework, but the UK government has delayed work until 2026-27.

In a statement, Streeting said that the government would "carefully consider" funding for the mandate but has not yet given any indication of the money available.

Stormont health minister Mike Nesbitt announced in May that he had begun the process of securing funding to implement the 3.6% pay award for NHS staff in Northern Ireland. But he suggested the award would need final approval from the finance minister and possibly the full Executive before it could be implemented.

Members in England and Wales can take part in MiP and UNISON's consultation on the pay award by using the voting link sent by email or voting online at unison.org.uk/nhspay. The consultation closes on 30 July.

Scotland

NHS staff accept "inflation-proof" two-year pay deal

JULIE BROADFOOT

"No room for complacency": Matt McLaughlin, UNISON Scotland's head of health

NHS staff have accepted the Scottish government's two-year pay offer, worth 4.25% this year and 3.75% in 2026-27. UNISON and MiP members in Scotland voted overwhelmingly (86%) in favour of accepting the deal in a consultation that closed in May.

The offer also includes a guarantee that pay rises will be at least 1% above the CPI rate of inflation in both years.

Unlike the rest of the UK, the Scottish government holds pay talks directly with staff and their unions. Since abandoning the pay review body process in 2023, Scotland has seen NHS pay rates overtake those in other parts of the UK, with this deal widening that differential still further.

"The approach taken in Scotland shows that direct pay talks deliver, not only better rates of pay, but more timely payment of awards," said MiP chief executive Jon Restell. "It's time for the other UK governments to learn from this approach and ditch the outdated pay review body process or their staff risk falling further behind."

UNISON also welcomed the deal but warned it wouldn't be enough to resolve significant workforce shortages in Scotland. "NHS workers have accepted the deal. Now ministers must get the wage rise into their pay packets as soon as possible," said the union's head of health in Scotland, Matt McLaughlin.

"However, there's no room for complacency," he added. "Waiting lists are the worst since devolution. The NHS in Scotland must address staff shortages if it's to turn the service's fortunes around."

Very senior managers

Board-level managers given lower pay rise as new pay system kicks in

PA IMAGES / ALAMY STOCK PHOTO

Health secretary Wes Streeting visiting St Thomas's Hospital with the chancellor in June.

MiP has warned the government to "get senior staff on board" after executive-level NHS managers in England were given a lower pay rise than other health service staff.

The UK government accepted the 3.25% pay award recommended by the Senior Salaries Review Body (SSRB) for very senior managers (VSMs) in providers and ICBs, and executive senior managers (ESMs) in arm's length bodies. The award is below those given to colleagues on Agenda for Change (3.6%) and to doctors and dentists (4%).

MiP chief executive Jon Restell warned the lower award, following years in which executive managers were sometimes given no pay rise at all, would exacerbate existing pay overlap issues – where some executives are paid less than Agenda for Change staff they manage.

"There has to be a long term solution to this or it will continue to get worse. If the government is serious about its NHS reform agenda then it must get senior managers on board," he said.

The SSRB again recommended using an extra 0.5% of each employer's pay bill to tackle these pay overlap issues, but the proposal was rejected by health secretary Wes Streeting, who said the additional money "has not seen widespread use by employers" in previous years. He promised to report back on the review body's recommendation to withdraw the ESM framework once the winding up of NHS England—where three-quarters of ESMs work—is complete.

Restell said MiP "understood the government's reluctance" to commit extra money but the pay overlap issue still needed to be resolved. "In MiP's own conversations with senior manager members we found no evidence this pot of money was ever being used. This doesn't mean the government is off the hook—it's up to them to explore other avenues to deal with this problem," he said.

The new pay framework for very senior managers, published in May, attempts to link executive pay to performance. Annual pay rises will be withheld from executives in trusts which fail to meet performance targets, while remuneration committees will be able to award VSMs one-off bonus payments of up to 10% of basic pay in "recognition of exceptional contribution".

To encourage VSMs to take on struggling organisations, the new framework also allows employers to pay managers an additional 15% of their base pay while working at an organisation deemed as "challenging".

"MiP is not convinced that linking senior manager pay to performance, especially while organisations are making significant cuts to running costs and staff numbers, is the right approach," said Restell. "It will likely prove counterproductive to the health secretary's admirable aim of getting the best leaders to take on struggling trusts."

Forget Musk's slash and burn– is what real change looks like

How the NHS can do better without more money is the big question the ten year plan needs to answer. Health economist Andi Orlowski argues for making change with consensus rather than a chainsaw—and explains why 'allocative efficiency' is our best bet for real reform.

With the new ten year plan on the horizon (at least at the time of writing), the NHS in England is once again promising transformation: digital-first care, prevention at scale, integrated models, local autonomy. But all of this is set against a backdrop of real crisis.

There's no blank cheque coming. Funding is flatlining. Inflation and demand are outpacing capacity. Cuts are already happening, some quietly, others with brute force. We're seeing services reduced, teams disbanded, programmes defunded. Not through strategic choices, but through necessity. "Cut now, think later" has become a defining feature of this reform cycle.

It doesn't have to be this way. If we want a better NHS, one that survives, improves and becomes more equitable, we need to spend better, not just spend less. That means understanding what really works and what doesn't. And it means having the courage to stop doing things that no longer add value.

There's a saying in healthcare that gets wheeled out whenever times are tight: "We'll just have to do more with less."

It sounds noble, even defiant. But in reality, it usually means doing the same things, stretched thinner, with greater risk and less margin for error. It leads to longer waits, thinner services, exhausted staff and worse outcomes.

So here's a better idea: let's do better with what we already have. Let's move away from across-the-board squeezes and start looking at how we're using our resources now. What's working? What isn't? What adds value and what simply adds cost? That's where what economists call 'allocative efficiency' comes in. It's not about cutting corners; it's about making deliberate, evidence-based choices.

Let's talk about cuts

The world has been watching Elon Musk wield a chainsaw through the US government with his Department of Government Efficiency (DOGE)—a chaotic, ham-fisted attempt to cut costs by dismantling institutions, laying off staff, and centralising control. It's high drama, low planning. It's not transformation, it's theatre—scorched earth dressed up as reform.

We don't need a DOGE. And we don't need a Musk. What the NHS needs is something more rigorous, robust and quite frankly beautiful: system stewardship.

This is where health economists and analysts can really help. Often, when NHS managers hear the word 'economist', their hearts sink as they imagine anonymous suits sat in Whitehall, red-stamping 'no' across budget requests. However, the NHS actually has a strong cohort of friendly health economists who, using techniques like allocative efficiency, can help managers not to just do everything more cheaply, but to do the right things with the resources we've got.

JIM WEST / ALAMY STOCK PHOTO

Fortunately, the tools we need are hiding in plain sight. Using Programme Budgeting and Marginal Analysis (PBMA) and the Socio-Technical Allocation of Resources (STAR) approach, economists can help the NHS make smarter, braver decisions transparently and fairly.

Tools that save lives, not just money

PBMA is designed for reallocating resources. It maps current spending, identifies marginal gains, and supports decisions that generate the most health benefit per pound. It's ideal when you have decent cost and activity data and need to optimise within existing budgets.

STAR, on the other hand, is better suited when the data isn't perfect or the outcomes are more complex. It explicitly

—this

Andi Orlowski is director of the NHS Health Economics Unit, and a senior adviser to NHS England on population health management.

combines technical evidence with stakeholder values, involving clinicians, patients, finance leads and system partners in building a shared view of what should be invested in, and what can be stopped.

Both methods confront the reality of opportunity cost: that spending on one thing means not spending on something else. But they do so in a way that builds consensus, accountability and trust, not fear. Unlike the Musk model of dramatic and traumatic disruption for its own sake, these frameworks invite people in. They build consensus. They hold the system to account. They ask not just "what's the cheapest option?" but also "what's the right thing to do, and how can we do it well?"

Take chronic obstructive pulmonary disease (COPD). Five Integrated Care Systems used STAR to review their COPD care pathways. Over 100 professionals and 500 patients came together to weigh up what's currently delivered against what could be done with the same money. The result? Investment shifted upstream—into group consultations, education, virtual wards, and housing interventions—while some less effective or duplicative services were scaled back.

Or consider 'boilers on prescription'—a headline-worthy intervention that turned out to be both cost-effective and morally sound. By insulating the cold homes of patients with respiratory illness, some areas saved £4,000 per patient on emergency admissions. That's not just good economics. That's smart, human, joined-up care.

None of this was done with a chainsaw or with spreadsheets in back rooms. It was done through deliberation, modelling, and inclusive design. That's what real system change looks like.

Courage to decommission

If we're serious about doing better without more money, we must face up to one truth: some services need to stop. Not all services are equally effective. Not all interventions remain relevant. And not everything we fund is helping the people it's meant to.

Decommissioning isn't failure. It's a mark of maturity. Every system evolves, and what worked ten years ago may no longer be right today. Holding onto every intervention out of habit or fear just drains the oxygen from innovation.

But these decisions must be defensible. They must be made transparently, using evidence, and with input from people affected. Tools like PBMA and STAR give leaders the confidence and cover to do this well. They make sure the rationale is clear. They document trade-offs and create accountability. They ensure that value, not volume, is what drives the system forward.

Giving the system confidence

In times of upheaval, allocative efficiency does something that Musk-style slash and burn cuts never will: it inspires confidence.

Confidence in the numbers, yes—but more importantly, in the process. In a system under intense public and political scrutiny, being able to show your workings is a game changer. It helps the public, staff and politicians to see why certain things are funded and others aren't. It brings the public into the logic of the system, rather than leaving them guessing about decisions made behind closed doors.

If the ten year plan is to succeed, it must embed robust prioritisation and allocative thinking into its DNA from the start. Otherwise, it risks being more of the same: ambitions on paper, business as usual on the ground.

This time, we need something different. Something honest. Something rigorous.

We need the plan to acknowledge that there's no blank cheque coming and then show us how we'll still move forward by choosing better, spending smarter, and working together to shape a more equitable system.

That means bringing economists and analysts out of the shadows and putting them at the heart of reform. Not as naysayers, but as enablers. Not with chainsaws, but with maths, a conscience and insight.

There's no Elon Musk in the NHS. And thank goodness for that. We don't need iconoclasts with flamethrowers. We need methodical, evidence-based, human-centred planning. We need brave decisions, made well, not fast. Because we don't need to do more. We need to do better. And we already have the tools to begin. //

We're proud of what MiP has done—managers need it more than ever

Twenty years ago, UNISON and the FDA created Managers in Partnership (MiP). It remains a unique joint venture among Britain's trade unions. In our view, MiP has done what we hoped for in 2005—bringing thousands of NHS senior managers into a trade union that represents and speaks up for them with governments and in the media.

Why create a separate organisation for NHS managers in the first place? In the early 2000s, both unions had problems organising NHS managers into their membership. For the FDA, predominantly a civil service union, senior NHS managers did not have an obvious home in its structure and their employment needs were appreciably different from other members. They required more personal representation, especially during continual re-organisations of the NHS, which sadly still feature as much today as then. For UNISON, with its leading presence in the NHS, the needs of a tiny number of senior managers would always get lost in the campaigning work of a union representing the entire workforce.

Unions facing these problems traditionally had three options: compete, merge or withdraw. The decision to collaborate on a solution, drawing on the strengths of both organisations, was one of those eureka moments and greatly to the credit of both unions' leaders at the time.

Also groundbreaking, was the wide-ranging research into what NHS managers wanted from a union. The result was a unique organisation. While remaining part of the partner unions—its members belong to both UNISON and the FDA—MiP was given significant autonomy over how it represented members, individually and collectively with employers, and in public discourse. MiP would have its own identity, staff, budget and policies. It would be a specialist home for senior managers in the NHS and allied sectors.

How we did it was just as important as what we did. It took us a long time to build the trust needed to risk something so new and different. While both are rooted in our country's public services, the two unions are very different in size and culture. That early investment in building trust has paid off. We have worked in quietly effective partnership ever since, never needing to fall back on hard agreements and proceeding by consensus. We have a shared strategic interest in MiP's success, and have developed the understanding and relationships to deliver on that.

// MiP's membership has trebled, it now has 150 workplace reps, and a public reputation and influence out of proportion to its size. This success is built on the hard work and enthusiasm of MiP staff and member activists, supported by the partner unions. //

That mindset flowed into the DNA of MiP: its reputation and influence are built on the thousands of relationships it has created through its partnership approach to representing its members and campaigning for the best possible management of our NHS and the wider care system.

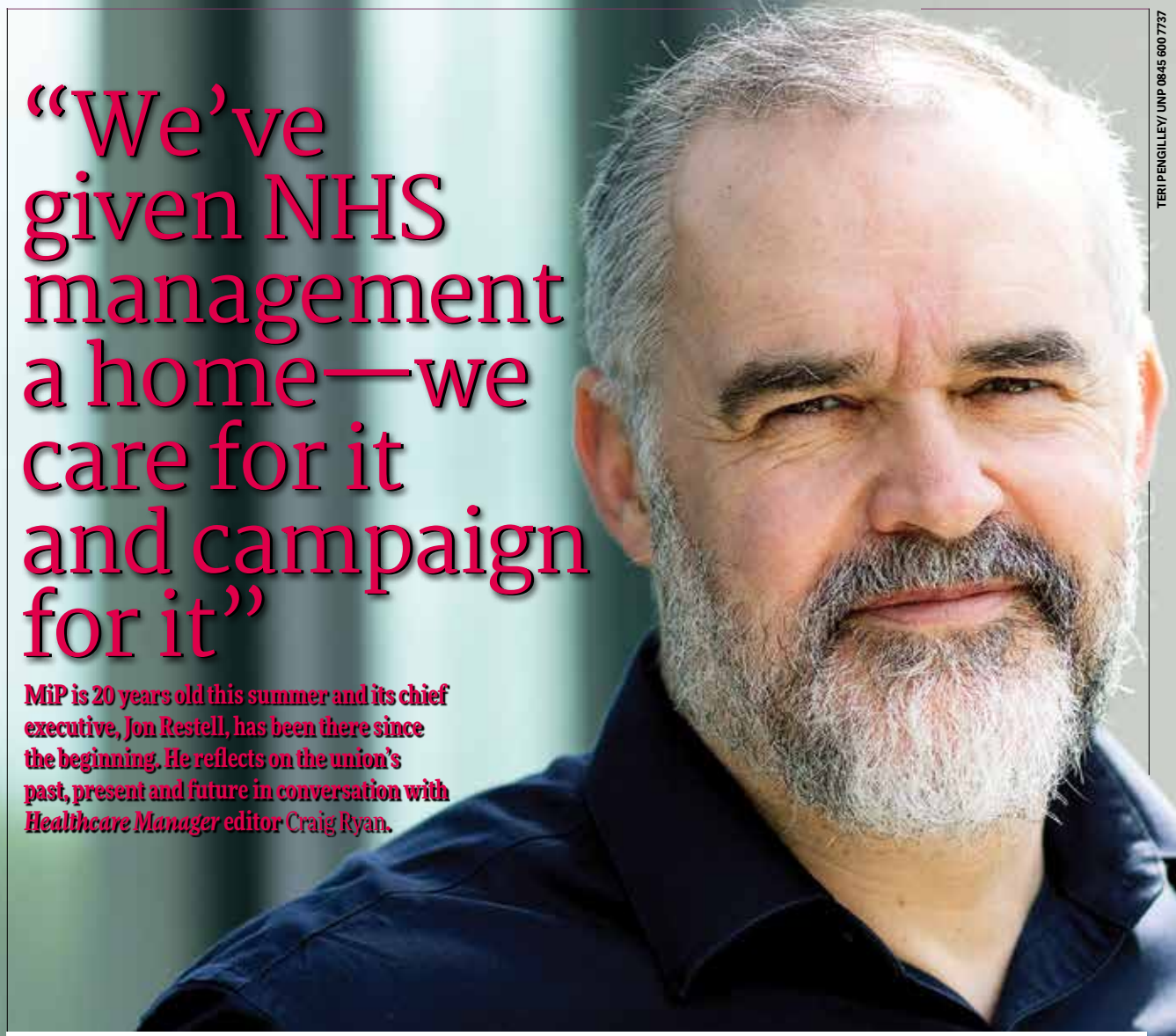
We are proud of what MiP has done. At over 9,000, membership has trebled since the union's formation. MiP now has more than 150 workplace representatives in NHS organisations across the UK. It has seats on both national and employer partnership forums. It has a public reputation and influence out of proportion to its size. It also campaigns for good management standards, fair treatment for members and respect and understanding for the critical role of managers in the whole health and care system. This success is down to evolution, rather than following a blueprint from another age. It is built on the hard work and enthusiasm of MiP staff and member activists, supported by the partner unions.

As the present leader of UNISON, I re-affirm our commitment to the MiP model. Managers need it now more than ever, as the NHS in England grapples with another seismic, chaotic and completely avoidable upheaval. Managers need a union voice speaking up for them against lazy stereotypes and ill-informed hostility about their role and value. The *Daily Mail* never takes a day off!

We also pay tribute to the work of MiP members. If this country is to get the NHS and the public services it needs, it will need the skill and dedication of managers and to invest in management capacity and capability. MiP is your union home, and it will stand by you, speak for you and campaign for better management and culture. By belonging to MiP you are already playing your part. Thank you for joining MiP and for making your voice as a manager heard. //

"We've given NHS management a home—we care for it and campaign for it"

MiP is 20 years old this summer and its chief executive, Jon Restell, has been there since the beginning. He reflects on the union's past, present and future in conversation with *Healthcare Manager* editor Craig Ryan.



TERI PENGILLEY/ UNP 0845 600 7737

"I love this job." Jon Restell is staring out the window of a UNISON media room in the beautifully refurbished building that used to be the Elizabeth Garrett Anderson Hospital. It's twenty years almost to the day since MiP started operating out of the FDA's stuffy old offices next to St James's Park tube, and while almost everything about the union has changed—its size, reach and influence, its staff and head office (three times), not least this magazine—one thing hasn't: Jon Restell is still here. Why?

He talks about being "deeply loyal to MiP because I set it up" and how he "really likes NHS managers as people". The way they're treated and spoken about "is just unfair", he says. Despite their seniority, managers are "a bit of an underdog and, if you find unfairness difficult, as I do, then you're naturally attracted to an underdog."

But most of all, he just loves the job. All of it. "As an omnivore, terrified since school of specialising in one narrow field of life, I'm as interested in our email system as the ten year plan," he explains. The work keeps changing, "so I feel like I've had three or four different jobs with MiP," he adds. "If I ever felt it was just more of the same old thing, I'd go and do something else. But when I look at this job or that job, it never feels like it's going to be quite as rewarding or fulfilling."

The organisation Restell was midwife to is the offspring of two unions, the FDA and UNISON, which both had NHS managers as members but didn't feel they could fully support them. MiP has long since grown up, but the 'partner unions' still play a big role, he says.

Broadly speaking, the FDA provides "organisational infrastructure", things like information management, finance, subscription collection and HR, while UNISON brings its industrial

heft and bargaining strength within the NHS. A partnership board, with representatives from both unions, provides "leadership and management capital", he adds, "because otherwise it would be quite lonely and difficult doing all these governance functions on our own".

"MiP has become more like a traditional trade union over time, but we were a bit behind the members because of how we were set up," Restell says. "We thought managers wanted more of a professional body than a trade union, and wouldn't be interested in other forms of activism." That was quickly disproved: within a week MiP had its first request to become a rep and within two years it was negotiating on organisational change and running conferences.

The driving force behind this shift, he says, was MiP's elected National Committee, led by former chair David Amos. "You need members who are leaders, who can shape the future of the organisation, because their views will be very different to what a bunch of [professional] trade unionists think managers want from a union," he says.

By quickly establishing its own identity, MiP overcame initial scepticism, both from managers who feared it was "a front for UNISON"—memories of the union's vociferous campaign against NHS trusts "was still quite raw for people", Restell says—and from some UNISON branches, who saw MiP as a "bosses union... whose reps were "management spies reporting back after each meeting".

Now, most UNISON branches "are proud that many of their senior staff are in MiP", he says, "and I think we've given many UNISON activists some insight into how difficult health service management is."

But it's MiP's rapidly growing reps network that "has transformed our profile, reach, and influence" in the last five years, Restell says. With almost 200 members representing colleagues and negotiating with employers, "a lot more people are talking about us now."

Workplace reps can "reach into places" that MiP's full-time national officers can't, he explains. "Many are managers of some influence in their own right; they can nip problems in the bud, coach people and have informal conversations with the employer."

But with this comes a step change in members' needs and expectations. "People don't become reps just because they love casework or banging the table in negotiations—they want to be part of a campaign for change", he says. "They want to be involved in policy and have a voice in the leadership. I think that's the biggest single thing that has made us sharper as an organisation."

The reps network, alongside regular email bulletins, surveys, consultations, this magazine and the website, have helped MiP to boost its member participation massively since the early days. And the union is still small enough for its leadership to be responsive to individual members. "We often get email suggestions and think, that's a great idea, let's work with that," says Restell. At conferences, he prefers talking to people on the MiP stand "because I get more from that than being in the room listening to a speech or trying to get onto the stage."

MiP's regionally-based national officers are the other key ingredient to MiP's success and resilience, he says. As well as "doing amazing casework, often representing people in very difficult situations", they have "nurtured relationships with employers and other unions", and "some are becoming real players in their local health systems", he adds. And without national officers "spotting talent and supporting people to become established in the workplace," there would be no reps network.

I ask what MiP has achieved for managers in 20 years. I'm expecting a long list of boring bullet points, but Restell's answer is simple and direct, though entirely unrehearsed: "We've given NHS management a home, and an organisation that cares for it and campaigns for it."

This was MiP's defining purpose from the start, he points out: "the best way to organise workers is to find an occupational group, because their professional identity is what they share in common." Managers, few in number, are "often quite isolated even within their own organisations. And frankly, they're singled out, and that creates a powerful sense of group identity," he says.

He senses the "mood music" may have changed in recent years, with some politicians and journalists prepared to think—and even talk—positively about management. But the public discourse remains overwhelmingly hostile—all the more so since Wes Streeting decided the NHS was 'over-managed' after all. In any walk of life, "the bosses" are rarely popular, but the intensity of public antagonism towards NHS managers is peculiar, and not easy to explain.

At bottom, public understanding of the NHS is limited to "the clinical experience", Restell says. "There's a sort of 'Carry On' view of the health service, as just matron, the consultant and the hospital ward. And we've never had a political or NHS leadership that has seriously tried to challenge that."

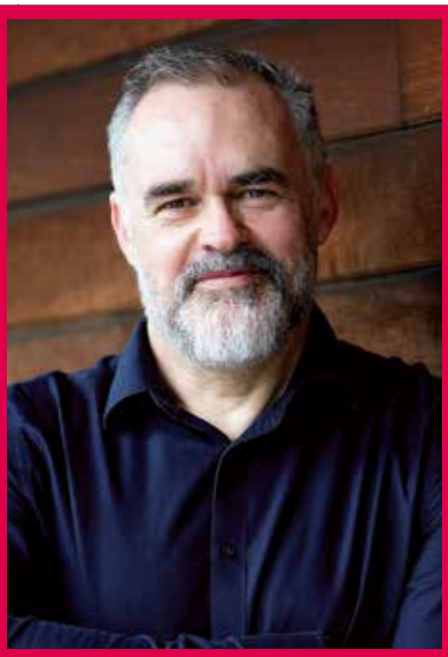
This means the optimum 'amount' of management will always be the minimum, and the answer to any problem is always to move resources to the 'frontline'. "It's become a political and media habit to describe NHS management as a cost or, at best, a necessary evil," Restell says. "It's very rare to hear a management role described as an investment in healthcare, improvement or productivity."

It also leaves managers as a very convenient "lightening rod" when things go wrong, he adds: "Perhaps politicians need an explanation that preserves the public's core belief in the NHS, doesn't blame nurses and doctors but keeps them relatively clean from responsibility."

Restell describes two damaging caricatures of managers that he says MiP wants to knock down: the "mill-owner", a hard-hearted bean counter who doesn't care about patients; and the "magician", someone who's expected to solve problems and turn around services through sheer force of personality.

"Our message is that managers are neither—they're just workers with the

"We've always been determined to be a UK-wide union"



"We've always been conscious of the size of England relative to other parts of the UK," says Jon Restell, explaining why Scotland, Wales and Northern Ireland have reserved seats (almost a third of the total) on MiP's National Committee. "We wanted to make sure they always had a voice. We've always been determined to be a UK-wide union."

MiP membership is growing fast in the devolved nations—particularly Wales and Northern Ireland— reflecting the shared interests and concerns of managers in all four nations. "I think everyone's concerned about professionalism, reputation and effective management, Restell says. "I can give the same talk about the need to invest in managers and value their role to the public in any of the four countries."

In contrast to the high drama of the NHS in England, with constant cuts and reorganisation, the devolved nations may seem calm, even "benign", he says, but managers face all the same day-to-day pressures: bullying, excessive workloads, underfunding, staff shortages and discrimination. "And some of the political pressure can actually feel more acute in the devolved nations where politicians have a far more direct relationship with managers than in England," he explains.

He expects managers in Scotland, Wales and Northern Ireland to come under similar pressure to cut management costs as colleagues in England. "There are the same perceptions of too many organisations and too much bureaucracy, so that agenda will play out everywhere," he warns. "One thing we need to do across the healthcare industry as a whole is learn and share more about what's going on. And MiP has a big role in doing that."

skills and experience to organise and support care," he says. "I've rarely sat down with a manager and not been able to explain afterwards the value of what they do. We want to help managers tell their own story in a way that has absolute human impact."

It's a message the government really needs to hear as it embarks on another major reform of the English NHS by again targeting managers as the problem not the solution. Restell says he's "disappointed" by the government's "crazy, chaotic announcements", but that feels like understatement. They carry the force of a betrayal.

"I think they wanted a big symbolic act to show they were taking on the state, that they knew how to reform, how to be tough," he says. "At the end of the day, this is a financial reset of the NHS. That's the driving force behind everything."

The "fair amount of goodwill" among managers towards the new government "has evaporated in the last couple of months, and it's going to be quite a job to restore confidence," he warns. The management cuts in NHS England, ICBs and trusts "are taking out huge swathes of the very workforce ministers will need to deliver both their long-terms plans and the financial reset", he says.

Ministers know full well that "what people want is better administration, better digitisation, and better management of resources and care," he adds. "That's all work for people who aren't clinicians." Is there any hope? "If they're sensible" the government will slowly start to adjust their plans", he says wryly.

If nothing else, the ten year plan, which now has to be retrofitted to the drastic cuts already announced, needs to make "a brutally honest assessment of what can be done and by when", he says. With the financial reset and fallout from the cuts likely to consume most management energy for the next two years, "it won't be until year three or four that we can really start investing in transformation," he warns.

Ironically, he says, this "grim scenario" around the ten year plan will place "quite a premium on excellent management and management investment", he says – so we can expect MiP to be far more engaged in "campaigning for and promoting management", not just externally, but within the NHS.

In the early days, MiP supported a manager from Kent caught up in a local care scandal. She was new in the job and, like so many others, was trying to turn round the very difficult situation she'd walked into. "She was a convenient scapegoat for the higher ups and the politicians. A campaign group had been formed and they were gunning for her too," Restell recalls.

In a "pretty hostile" media interview, Restell set out MiP's defence: she hadn't been responsible, she'd tried to make changes to stop it happening, it was a complex situation and it wasn't in the public interest to heap all the blame on her. "People started ringing up, saying things like, 'My mum heard that and thought that woman had been really unfairly treated'," he says. "We got a lot of feedback that just putting out an alternative viewpoint is enough to make people think there's more to it than these lazy tropes about managers."

It's still an uphill struggle but twenty-odd years later Restell is still convinced there's an audience for MiP's message about the value of management and why we need to invest in NHS managers.

"We've got to be on the park playing the ball, or trying to play it," he says. Much of the commentary is so irrational and unfair, "managers feel bullied out of the limelight", and unable to defend themselves through fear or embarrassment. "I've met reps who always describe themselves as a 'senior nurse', if they've got that background, rather than say they're an NHS manager. We can't go on like that. One thing MiP can do is be there and make sure there's an alternative story. And I think that can have a big impact." //

TERI PENGILLEY/ UNP 0845 600 7737

We get knocked down. We get up again

Chirp! Buzz!

I'm distracted from something I should be doing by a notification on my phone: "Here's a memory from 2012!" It's my photos app, surfacing a video from what feels like a long time ago. Of course I watch it immediately.

INT. A SITTING ROOM – DAYTIME

In the foreground, an adult hand starts to build a tower with toy blocks on the floor. At the back of the room a happy toddler spies the tower and locks on. Shambling across the carpet, they smash the tower with glee and wobble away delighted. The adult starts to rebuild the tower and makes some progress before the toddler notices and smashes it down again. And again. And again.

FADE TO BLACK

Here's another memory from 2012. In March, Andrew Lansley's Health And Social Care Act received royal assent. Remember that one? It's the one where the coalition government, having said they would "stop the top-down reorganisations of the NHS that get in the way of patient care", kicked off the biggest top-down reorganisation of all time.

I'm about to start a sentence with words I thought I would never put together in my mind, let alone in print.

To be fair to Andrew Lansley (relax brow, unclench jaw), it's easy to forget that the changes that were formalised in 2012 followed almost two years of consultation and planning. There was the *Liberating The NHS* white paper in July 2010, the first Health and Social Care Bill in January 2011, the "pause for listening" in April after a serious backlash, and a revised bill with more than a thousand amendments in September, before, ultimately, the bill became the act in March 2012. There's so much to criticise about those reforms, but you can argue that form followed function. They had a plan.

Out of nowhere

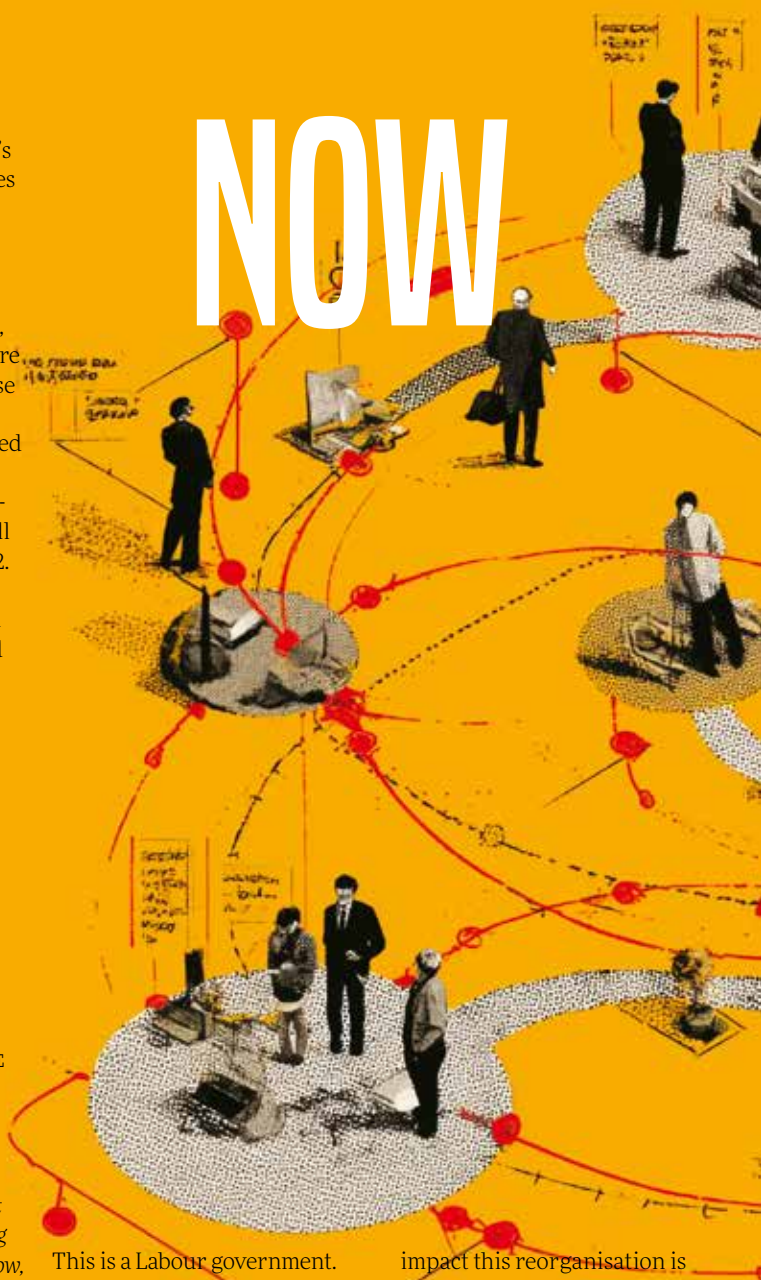
Chirp! Ping!

It's March 2025 and I'm distracted from something I should be doing by a message on my laptop. It's from a fellow MiP rep: "Have you seen this??!", with a link to a video. Of course I watch it immediately.

INT. ATRIUM OF A LIFE SCIENCES COMPANY HQ – DAYTIME

In the foreground, the prime minister wanders to and fro, sleeves rolled up, talking about democratic control and cutting bureaucracy. (Looking back now, I wonder if his team suggested brandishing a chainsaw.) After a long preamble he finally gets across the carpet to the tower of blocks. Out of nowhere, without consultation and, as is becoming more and more apparent, without much thought, he knocks them over: NHS England will be abolished, he announces, and over 13,000 public servants in "the world's biggest quango" (™ Wes Streeting) will be tossed casually under the bus, on top of swingeing cuts to ICBs and trusts.

FADE TO BLACK



This is a Labour government. The prime minister is Sir Keir Starmer, a man knighted for his work leading thousands of public servants at the Crown Prosecution Service. When he made that announcement on live television, he would have known, not only how union members would react, but the impact it would have on the motivation and morale of thousands of public servants. I'm not just disappointed, I'm angry.

Doing damage now

I've been hearing from managers across the NHS about the impact this reorganisation is already having, when—and, in large part, because—months later we're not much clearer on what any of this means.

But the impact on individuals—now—is real.

This from an ICB manager in the north of England: "We're tired. We're really, really mentally drained. We're still doing our best, but I'll be honest, it's absolutely dire."

And from a head of Workforce programmes: "I'm absolutely physically and mentally exhausted. I'm not sleeping. I have a mortgage and bills to

WHAT?

The future shape of the NHS in England remains a mystery, but the UK government is already moving fast and breaking things. It will be up to managers to fix them again, writes *Geoff Underwood* (left), while *Rhys McKenzie* (overleaf) sets out the state of play and how MiP will support members through the chaos.

pay on my own. I have a roof to keep over my head and no real indication of where I'll be in six months."

The impact on health service delivery and productivity—now—is real too.

A lead for business intelligence at a south-west ICB told me: "Me and my team haven't touched our day jobs in the last week. We haven't had time, we've just been responding to all of this."

And the head of medicines optimisation for an ICB said, "We're losing members of our teams. I have a small team and one has handed their notice in already, citing the changes as the only reason for wishing to leave. It's making a hard job even harder."

Chaos & distraction

In May, a friend of mine broke her knee while running in a field. She waited in the field, in agony and unable to move, for five hours before a paramedic in a fast response vehicle recommended hauling her into her own car so her husband could drive her to hospital. No stretcher, no two-person crew to lift her safely, just plenty of gas and air to deal with the pain. She needed surgery but the lack of trauma theatre capacity—at a Major Trauma Centre!—meant her operation was listed and cancelled twice. She had to wait three days in pain for urgent treatment.

That's just one story showing how the NHS needs to improve. I know there is complex work going to improve ambulance services, patient flow in hospitals and the capacity of trauma services. I know there's improvement work going on at that hospital. And I know that much of that work will be delayed because of the chaotic way the government is reorganising the staff the NHS relies on to make change happen.

NHS staff will be distracted and demotivated for at least as long as the formal reorganisation takes, which will likely stretch well into 2027. But the damage to could go on much longer than that.

Commitment & hope

Two of the big shifts we expect in the Ten Year Plan are 'from illness to prevention' and 'from hospital to community'. To succeed with this nationally, change will have to be hyper-local. Supporting prevention and providing more care locally means something very different in the commuter village where I live to what it means in a London borough or an isolated hamlet on the Cornish coast. Change will necessarily involve the NHS and local authorities working with a broad range of neighbourhood-level stakeholders like parish councillors, teachers, police officers, volunteer drivers, art therapists or sports coaches, to reach people of all ages in all our communities.

Newsflash: Integrated Care Systems are already doing this! As a lead for prevention in the South West told me, "We've set the direction, we've built the vehicle, now we just need to get there". But as they also reminded me, change like this happens at the speed of trust. If reorganisation means trust with local people is broken, that funding streams become unreliable and that new people in new posts have to start building trust again from scratch, it could take years just to get back to where we are today.

The way the government is managing these cuts is unnecessary and damaging, but there's hope. The demoralised, tired managers I've spoken to are furious with the government and have had it with reorganisation, but they've lost none of their commitment to the teams they're part of or the people they serve.

I'll leave you with these words from an ICB manager who got in touch: "I will continue supporting colleagues and adding value to whatever work I'm given to do, even if there is no job for me at the end of it. I'll never give up because I do believe what I do makes a difference and I'll continue to lead, manage, and communicate with compassion and care."

They are knocking the blocks down again, but we will be able to rebuild.

Geoff Underwood is chair of MiP National Committee and programme director at NHS South Central and West Commissioning Support Unit.

Picking up the pieces

In December 2023, when he was still shadow health secretary, Wes Streeting told the *Sunday Times* that he had "absolutely no intention" of following in the footsteps of Andrew Lansley by "wasting time with a big, costly reorganisation" of the NHS.

Yet just over a year later, he found himself on the same path he had warned against going down while in opposition. In March 2025, he ordered tens of thousands of NHS job losses, primarily targeting NHS managers and corporate staff, and started a big, costly reorganisation of the health service and the people who devote their working lives to it.

Since then, the English NHS has been in chaos. Here, we run through what's known, what's not and what MiP is doing to support members through the turmoil.

NHS England

NHS England, still reeling from a previous restructure that saw it absorb NHS Digital and Health Education England, was told to cut its headcount by further 15% in January. It was another blow for staff, but even the most pessimistic observer could not have expected what came six weeks later.

By early March, the 15% cut had become 50%. Three days later the government announced it was abolishing NHS England altogether. Job losses totalling 50% of the combined workforce of NHS England and the Department of Health and Social Care (DHSC) were confirmed, with remaining NHSE staff merging into the department.

The number of job losses at each organisation is still unknown, but as NHS England has 15,000 staff compared to DHSC's 3,600, the bulk are set to come from the former NHS body. All vacancies at NHS England have been frozen since March, other than in 'exceptional circumstances'.

Wes Streeting suggested that abolishing NHS England would improve NHS productivity by reducing waste and avoiding duplication. But writing in June, we still have no idea what the newly designed 'centre' will look like. All we know is that the 'change process' must be completed by October 2026.

Integrated Care Boards

In the same week as the abolition of NHS England was announced, the government confirmed that ICBs in England must cut their running costs by 50%—putting up to 12,500 jobs at risk.

Less than three years since ICBs opened for business, a swathe of functions and responsibilities will now be transferred out, with ICBs told to concentrate on 'strategic commissioning' rather than performance management. In May, a model ICB blueprint was published, giving a barebones overview of which functions they will retain, and which will be transferred to providers or reconfigured regional set-ups.

The blueprint also says ICBs should reduce spending to an average of £18.76 per head of population. To facilitate the 50% cut in running costs, many ICB are merging or 'clustering', and the number of ICBs looks set to drop from 42 to 27. NHS England expects ICBs to complete mergers by April 2026—or April 2027 at the very latest.

Whether they merge or not, ICBs must still cut costs in half by December 2025—an unprecedented pace for cuts on this scale. With so much about the future structure of the NHS still a mystery, and so little known about the revamped 'regional tier', ICBs and their staff have been left in limbo.

Providers

NHS trusts have been told to reduce the growth in 'corporate costs' over pre-pandemic levels by 50% by the end of 2025 and deliver efficiency savings of 4%. This is likely to result in thousands of job losses at England's 215 trusts.

Trusts are expected to target cuts on non-clinical functions such as HR, communications, estates and finance, with many already undertaking wide-ranging organisational change and proposing job losses to deliver savings this year.

With providers now set to take on a range of functions from ICBs, employers are left with the difficult task of trying to remove posts in line with NHS England's timetable without the

information they need to plan their workforce needs once the transfer of ICB functions has taken place.

Other parts of the NHS

Commissioning Support Units (CSUs) have been reviewing their future operating model for over a year. The government and NHS England have so far said little about how the reforms will affect CSUs, despite obvious risks to their income from the cuts at NHS England and ICBs. Under pressure to cut costs, some ICBs have ended, or are considering ending, their contracts with CSUs, putting the units' funding model at risk.

Penny Dash, now chair of NHS England, has led a review into the DHSC's health and care regulatory bodies, looking at closing or merging organisations, or bringing their functions back into the department. As the review was still unpublished at the time of writing, the future of many NHS's arms-length-bodies remained uncertain.

National voluntary redundancy scheme

To cope with job losses at this scale and speed, NHS England promised to set up a national model voluntary redundancy (VR) scheme. This would set the terms nationally for voluntary redundancies, be centrally funded and would be open for all NHS employers to use if they wished.

A national model scheme should speed up the process, allowing staff to voluntarily leave in return for financial compensation based on years of service and other factors. A VR scheme reduces the risk of compulsory redundancies further down the line.

MiP and other NHS unions were invited to comment on the model VR scheme, and secured some concessions and changes to the terms, but it is not a formal negotiated agreement and is not without its flaws.

The model scheme has been with the Treasury for months and has yet to be signed off at the time of writing, leaving employers having to make staff cuts in a matter of months without any agreed mechanism to make them.

Due to the Treasury delays, some employers, including NHS England, have opened 'expressions of interest' schemes for VR—an approach which MiP and other NHS unions strongly oppose. Others have tried to use mutually agreed resignation schemes (MARS), the terms of which are generally around half as good as redundancy. MiP's position is that employers must not offer lower-value MARS terms to staff at likely risk of redundancy and that, for such staff, MARS schemes should be withdrawn once the VR scheme becomes available.

MiP wants to save as many NHS jobs as possible by reducing the number of redundancies, but we would still prefer to see the model national VR scheme to rolled out so staff can make informed decisions about their future. We continue to push for an update.

As employers launch their VR schemes, MiP will arrange briefings so members can make sense of their options and understand the risks and potential benefits of voluntary redundancy. But MiP is clear that government and employers must consult staff before launching redundancy schemes. For staff to be consulted adequately, the design of the new organisation, whether it's being merged or just reduced in size, must be clear. Three months on from the initial announcements, too much is still unknown for any meaningful consultation to take place.

MiP believes that the decision to announce cuts without knowing what the new structure will look like or which staff will be needed will result in the biggest loss of skills and talent in the NHS since the Lansley reforms 13 years ago. Wes Streeting warned about it himself, but failure to heed his own advice has severely hampered his reform agenda before it has even got off the ground.

As this is a fast moving situation, please make sure you are subscribed to MiP's regular emails and check our website (miphealth.org.uk) regularly for the latest information.

METHOD TO THE MADNESS? SIX QUESTIONS THE TEN YEAR PLAN MUST ANSWER

The NHS system in England has been blown up and thousands of managers are set to lose their jobs without knowing why, writes *Craig Ryan*. The upcoming ten year plan has a lot of questions to answer. Here are six of the biggest.

1 How do we do this?

Let's take this first because it mustn't be an afterthought. We don't need another 'compelling vision' for the triple shift (to prevention, to community and to digital—in case you need reminding). We get it. We need to know how it's going to happen.

Almost everyone I speak to, whether manager, clinician or system leader, is privately extremely sceptical that the triple shift—particularly out of hospitals—will happen. That's not a good start. However good the vision is, it won't get off the ground without a clear, credible plan for achieving it. What we've seen so far, in the blizzard of announcements, hints and deathbed edicts from NHS England, is as clear as mud.

The plan "cannot simply describe policy changes; it must give an indication of how delivering this change will be possible", says Sarah Walter, director of the NHS Confed's ICS network. "Each part of the system needs to be clear on its purpose, what it is accountable for, and to whom, something that does not currently exist. Instead, historic structures are layered on top of one another like a coral reef."

2 What are the trade offs?

The plan needs to include a brutally honest assessment of what can be done and when. Promising more of everything while hiding behind glib mantras like "we have to do more with less" isn't good enough. We've been doing that for years.

The government has made the trade offs even harder by cutting NHS management off at the knees before it even starts. These are not small 'administrative' cuts, trimming off waste and duplication, they're a step (down) change in the NHS's capacity to reform itself.

The June spending review included a decent financial settlement for the NHS, but it won't avoid the need for those 'difficult choices' that politicians like to talk about in theory but often duck in practice. If the 18-week elective care target is the key priority, what weight do we give to A&E waits, cancer standards, ambulance response times or mental health waiting lists?

"They must know that it's not enough to achieve all the ambitions in their manifesto," warns the King's Fund's policy director, Siva Anandaciva. "It's only when we see the rest of the reform plans... that we will know what in our health and care service will be fixed, what can be patched, and what might—unfortunately for us all—stay broken."

3 Is collaboration still the thing?

"Is collaboration out of fashion already?" asked the Health Foundation's Phoebe Dunn in a recent blog: ICBs have been stripped of their role as "system convenors", while regulators seem to be refocusing on individual organisations rather than systems. "There's talk of new league tables," she added, and a new performance framework that "judges providers solely on their own merits".

Ministers are facing both ways on this. Health secretary Wes Streeting and his colleagues still talk about collaboration, particularly in the context of the

"neighbourhood NHS" and public health. But the mood music and the government's reforms so far point in a different direction. Maybe all this recycled Alan Milburn stuff can be reconciled with collaborative working—it will be interesting to find out how.

If not, this will be a serious upsetting of the apple cart—and one that flies in the face of the evidence. As the King's Fund's Chris Naylor points out, the best performing systems have invested the most time and money into collaboration between health, care and other public services. "The challenges demand a systemic response," he says. "Going backwards on the commitment to system working simply isn't a viable option."

4 How do we integrate?

Collaborative working is still counter-cultural in the NHS. It won't happen just because Whitehall wants it or the 'logic of the system' seems to point that way. Maybe "the conditions were never right for ICBs to perform their role as system convenors", says Naylor, but somebody still has to do it.

That could be beefed-up integrated care partnerships, like the one being modelled by Suffolk and North East Essex, or, as advocated by MiP chief executive Jon Restell, new statutory regional bodies "big enough to carry heft and consolidate resources, but small enough to take on locally sensitive functions".

Another option is providers themselves. Trusts are already set to take over several strategic functions from ICBs, including local workforce planning, infrastructure and primary care reform. Recent comments by Streeting that he wants to see an end to distinctions between different types of trust ('acutes', 'community' and so on) may indicate the direction of the government's thinking. Or not.

There are problems with this—not least that there's a lot more to place-based working than providing treatment services—but it couldn't be worse than trying to do it from the centre. "The government machine's evident operational inadequacy over the last few months should put paid to any idea of managing the NHS from Whitehall, directly or via regional outposts," warns Restell.

5 What will drive improvement and productivity?

Stalled productivity in the NHS over recent years is perhaps the biggest headache for politicians and system leaders alike. The ten year plan needs credible proposals to drive improvement, upskill staff and quickly roll out effective new technologies.

But the implication of the government's reforms to date is that the main problem is too many managers and not enough 'frontline' clinical staff. That flies in the face of all evidence. Productivity has fallen despite big increases in clinical numbers since 2019 and research shows that organisations with more managers tend to perform better.

Any new performance regime needs to free managers to innovate and collaborate locally—just replacing the dead hand of NHS England with the blunt instrument of league tables won't do. If ministers want to "reinvent" the foundation trust model with "even more freedoms"—as Streeting has suggested—they need to explain how such organisations will be motivated to co-operate rather than just look after themselves.

Setting clearer priorities and reforming targets, payment systems and regulation "will make limited difference without also supporting the NHS's capacity to improve", says Health Foundation innovation expert Penny Pereira.

The government needs to embrace evidence-based 'improvement approaches' so local leaders can "shape implementation and effectively engage staff," Pereira explains. "The government's health mission needs thousands of teams in hundreds of organisations to have the licence and means to do things differently."

6 How will the NHS win back staff?

It's not just the public who've lost faith in the NHS—it's staff too. The NHS staff survey shows little improvement in morale and motivation since the pandemic, a loss of faith in team working and almost a third of staff feeling burnt out all the time. The infamous 'loss of discretionary effort' since 2020 may become permanent.

"The findings demonstrate that working in the health service continues to look like an unattractive career, with many NHS staff feeling undervalued and overstretched," warned King's Fund director of leadership, Suzie Bailey.

Worse still, it's the very staff who must deliver its reforms that the government has pissed off the most. The 'social contract' of NHS employment—basically, that we accept modest pay and difficult work in return for secure jobs, a career path and decent conditions—has been broken, especially for managers.

Repairing it needs to be at the heart of the ten year plan, not outsourced to another workforce plan, maybe, later this year. Maybe we do need a compelling vision after all—for why people should work for the NHS, particularly if they could offer their skills elsewhere. We can't just rely on goodwill—because it's more or less run out. //

SubCos

Flexible friend or cheap date?

SubCos are back in vogue as trusts scramble to meet stiff cost-cutting targets set by NHS England. But can spinning off non-clinical services to subsidiary companies really save money and improve services—and will staff end up paying the price? Alison Moore reports.

NHS trusts have run subsidiary companies ('SubCos') for decades but their numbers are set to swell over the next few years, with new NHS England chief executive Sir James Mackey pushing for trusts to hive off many non-clinical functions as part of the government's cost-cutting agenda.

But there is one crucial difference between the model already adopted by many trusts and what Mackey is proposing: he wants the new generation of subcos to continue to employ staff on nationally-agreed Agenda for Change (AfC) pay and conditions, something most existing subsidiaries have failed to do. Will this be enough to head off union opposition and soothe managers' qualms?

The centre of the NHS in England has blown cold and hot on subsidiaries in recent years, as one manager familiar with them points out. Mackey was keen on them when he ran NHS Improvement but interest waned when it merged with NHS England, and many managers are wondering whether this revival of interest is a permanent shift or a passing fad—particularly as NHS England itself is set to be abolished next year.

Union opposition

Any trust seeking to form a SubCo—usually to run facilities management, although some provide other services—is likely to face stiff opposition from unions. "If you're going to set one up you're going to struggle in the teeth of quite a firm campaign," says MiP chief executive Jon Restell.

HELGA PILE

UNISON's head of health Helga Pile wrote to all trusts following Mackey's announcement, highlighting that there was already a wealth of guidance on establishing SubCos and a process trusts should follow. The union is aware of two new attempts to set up SubCos (although these have been underway since before Mackey's appointment) at trusts in Dorset and at Newcastle—the latter run by Mackey before his secondment to NHS England earlier this year.

Guy Collis, UNISON policy officer for health, questions the evidence base for SubCos, pointing out that hopes they would be more entrepreneurial and attract other clients has not really borne fruit. Business cases frequently lack even the most basic evidence to support such claims, he adds.

Mackey was chief executive of Northumbria Healthcare Foundation Trust when it set up a successful SubCo (see above). But Restell says it's far from clear that the conditions there can be replicated in very different labour markets elsewhere.

Northumbria: a model for the future?


SIR JIM MACKEY

Northumbria Healthcare Facilities Management Ltd, a SubCo set up by Sir Jim Mackey's former trust, Northumbria Healthcare, is one of the few to have retained Agenda for Change (AfC) terms and conditions—including access to the NHS pension scheme—for all staff.


DAMON LEE KENT

In doing so, it may have lost some money-saving opportunities, but managing director Damon Kent insists the company has found other ways to deliver better quality and more cost-effective services.

The SubCo—one of several at the trust—was set up in 2012 to provide estates and facilities management services and has delivered several large capital projects for the trust. It has a turnover of around £220m and employs 1,050 staff.

"From a corporate structure and governance point of view, it's a separate business with its own board of directors and its own accounts but we are very much part of the Northumbria group," says Kent, who is also director of estates and facilities at the trust. "We don't have a different set of values to the trust, we follow the trust's."

The SubCo was set up with the intention that it should not disadvantage staff, Kent adds, particularly as many staff are in the lower AfC grades. It follows the trust's policies in areas such as HR and uses many of the trust's services. But having its own board means it can bring in greater estates expertise among its non-executive directors. Kent says the company is able to have a "laser sharp" focus on its services and not get distracted by other priorities.

SubCos can give managers more flexibility and agility in making decisions and delivering services, which "helps us become more innovative and more forward thinking," Kent says. This has allowed the company to reduce risks for the trust and insource some services, such as a manufacturing hub for textiles.

Kent insists the SubCo is not "fixated" on the VAT advantages. Like the trust itself, it has a cost improvement plan to deliver but its managers are also focused on key workforce metrics such as turnover, and patient-facing ones such as patient-led assessments of the care environment.

His advice for managers thinking about setting up a SubCo is "you need to make sure there is equity for all staff and you need to make sure there is a governance process, that there is a golden thread [of accountability] running through the subsidiary and the parent trust all the time."

Uncertain backdrop

The Northumbria SubCo is one of a handful to maintain AfC pay and conditions for all staff. Many others offer lower unsocial hours payments than AfC and often make far lower pension contributions. This can save them money, as can exploiting a loophole that allows trusts to reclaim VAT on purchases when using a SubCo.

But an ongoing review of public sector VAT rules by the Treasury could result in this benefit disappearing soon. "If this is taken away, what does that mean for existing SubCos?" asks Restell. "It feels to me quite an uncertain backdrop when taking decisions."

Even if trusts continue to employ staff on AfC contracts, UNISON would still oppose the setting up of SubCos, Collis warns. The union remains concerned that any commitments made while a subsidiary is being set up might not be kept in the future.

But some managers do see advantages in more flexible pay and pensions, allowing trusts to respond to local labour shortages, especially for specialist staff. For example, a trust located near major construction projects may find it hard to recruit people skilled in building trades at AfC pay rates, something that may become an even bigger problem as the government tries to meet its ambitious housebuilding goals.

As existing staff usually have the right retain their AfC contractual terms when transferred, SubCo managers often have to deal with groups of staff doing similar jobs but on different pay and conditions—something which seems to strike at the heart of the "one team" ethos of the NHS, says Collis, and which may also have a negative impact on morale, recruitment and retention.

Restell also points out that many of the jobs which have been moved into SubCos are disproportionately done by women and people from an ethnic minority background, resulting in still greater inequality when terms and conditions are reduced.

Supplier or partner?

The sense of disconnect between SubCos and the trust can also be important, Restell adds. With their own governance systems and a contract with their 'owner', subcos could be pushed into a purely transactional 'customer and supplier' relationship with the NHS. This could become more marked if SubCos are set up covering several trusts—legal firm Hill Dickinson say they are currently advising "numerous" trusts on single and multi-trust models—or if SubCos pursue more contracts away from their 'parent' trust.

Restell points out that while some managers say that setting up a SubCo gives them more freedom and autonomy to run the organisation, they may need to work through their own feelings of being "out of the flow" and adapt to a new relationship where they will feel more like a contractor than part of the team.

"Where's the driver here? Is it to improve services or is it just to cut costs?" asks one manager with long experience in estates and facilities. "There's governance complexity around this", he warns, and also questions about workforce morale and motivation: "Do they feel they are in or out of the trust?" //

Jo Seery is a senior employment rights solicitor at Thompsons Solicitors, MiP's legal advisers. For more information visit: www.thompsonstradeunion.law.

Employment transfers: a brief guide to the law

With the NHS transfer window wide open again, **Jo Seery** from Thompsons Solicitors explains your rights if you have to move to a new employer.

Government announcements on the abolition of NHS England and a broader restructuring of the NHS in England will leave many managers with questions about their rights if they transfer within the NHS, to other public sector employers like the civil service, or to the private sector. Structural reform can be unsettling, so it helps to know where the law stands.

What is TUPE?

In principle, the Transfer of Undertakings (Protection of Employment) Regulations 2006, commonly known as 'TUPE', apply where a transfer results in a change of employer. The regulations aim to protect the terms and conditions of employees who transfer. Under TUPE, an employee's contract of employment and the liabilities for employment rights (except pensions) transfer to the new employer, with continuity of employment preserved.

However, TUPE does not apply when administrative functions are transferred between public authorities, such as within the NHS or between the NHS and other parts of the public sector—unless the functions are defined as an 'economic activity', such as providing goods and services where there is a market for them.

What if TUPE doesn't apply?

The secretary of state has the power to introduce similar protection to TUPE under section 38 of the Employment Relations Act 1999, and has exercised it in the past in relation to specific events. For example, regulations were introduced in 2013 covering the transfer of staff from various public bodies to Public Health England.

However, the Cabinet Office Statement of Practice (COSOP), which applies to government departments, agencies and the NHS, states that the TUPE principles should be applied to transfers within the public sector. All affected staff should be able to transfer on terms that are, overall, no less favourable than if TUPE applied. COSOP is only guidance, so while it's rare for employers not to apply it, it would be difficult to enforce legally.

What protection does TUPE offer?

One of the key TUPE obligations is to inform and consult the appropriate representatives of the affected employees, usually the union if it's recognised or has elected representatives. These are two distinct rights.

The information that must be provided—far enough in advance of the transfer to allow time for consultation—includes:

- the date of the transfer and the reasons for it
- the legal, economic and social implications of the transfer
- any measures which the transferor (existing employer) or the transferee (the proposed new employer) intends to take in relation to employees, such as redundancies or changes to terms and conditions
- details on the use of agency workers

The duty to consult only applies if the existing employer is proposing measures affecting staff in connection with the transfer. Usually, it will be the new employer who intends to take such measures after the transfer.

An individual employee can object to being transferred but will not be treated as having been dismissed, so cannot bring a claim for unfair dismissal.

Can the new employer change my contract?

Any changes to terms and conditions are void if the reason for them is purely the transfer—even if the employee agrees to them. An example would be changes made solely to harmonise terms and conditions of employment at the new employer.

Changes to the contract will be valid if there is an 'economic, technical or organisational' (ETO) reason, and the employer and employee agree to them. An ETO reason can be a change in the nature of the job, a change in headcount (typically a redundancy situation) or a change in the place of work. In addition, changes will not be void if the contract permits them or they are unconnected with the transfer.

What about my pension?

COSOP provides that there should be appropriate arrangements to protect occupational pensions of public sector staff. The Fair Deal Policy 2013 covers arrangements for staff who are compulsorily transferred outside the public sector. Under this policy, transferred staff can stay in the relevant public service pension scheme as long as they continue to provide the outsourced services or function.

Transfers can raise complex issues with your terms and conditions and can give rise to legal cases. So it's best to seek advice from your MiP representative as early as possible—especially as the time limits for lodging legal claims are very short. //

Legal Eye does not offer legal advice on individual cases. Members needing personal advice should contact MiP by emailing MemberAdvice@miphealth.org.uk.

How to deal with a toxic workplace

Siobhan O'Reilly offers her tips on how respond to toxic behaviour at work and protect your own health and wellbeing.

During my career as a civil servant and employment lawyer, I've often seen how the culture of a team or organisation can create a toxic environment. This is not only bad for the business, but it can also do enormous damage to the health and wellbeing of people working there.

It's a passion of mine to help equip individuals to recognise, deal with and avoid the harmful effects of toxicity. These are my top tips.

1. Recognising a toxic workplace

Many factors cause toxicity in a workplace: untrustworthy leaders, non-inclusivity, grade-ism, favouritism, poor leadership, and a lack of empathy and respect. Staff working in toxic workplaces typically describe experiences such as a lack of collaboration, keeping their heads down, normalised poor behaviour, feeling bullied and harassed and a climate of fear.

2. What a healthy workplace looks like

To be healthy and thrive within our workplace, we typically need to:

- feel valued and that we belong
- feel competent and effective
- be allowed to grow and develop
- have autonomy and control
- have consistent values and integrity

If you don't have those five, you could be in a toxic environment.

3. Your behaviour is not the problem

Unethical and poor behaviours drive toxicity and, left unchecked, lead to unhealthy working environments. You may spend hours agonising about what you've done or what you could do differently. Understanding that it's someone else's bad behaviour—driven by their own motives—that causes toxicity can save precious time ruminating and self-blaming.

4. Recognising a toxic personality

A good definition of a toxic personality is "anyone who demonstrates a pattern of counter-productive work behaviours that debilitate individuals and teams".

Toxic behaviour is not an 'off day'—we all have those. It's when there's a consistent pattern in someone's counter-productive behaviours which has a debilitating effect on people around them.

5. Understanding the impact

Workplace toxicity is harmful and pernicious. People are in a constant state of stress and anxiety; they become hyper-aware and direct their energies towards surviving the day. In turn, this stress loop affects attention, perception, short-term memory, learning and even the ability to find the right words. Like a phone in power saving mode, 'just surviving' degrades your abilities to multi-task and perform at your best.

6. Taking back control

Recognise and accept there's a problem. Keep a diary or log of what's happening and how it makes you feel. Find a friend, coach or mentor to help you seek clarity, challenge assumptions and give you validation. Make a plan—what steps can you take and what might hold you back?

7. Work through the problem

Who's behaviour is the problem? What effect is it having on you? When does this behaviour happen and what form does it take? Write it all down to give yourself clarity and help plan your next steps. Remember you need to deal with this to protect your health and wellbeing.

8. Making a plan

Decide whether and how to confront the behaviour. Prepare for a difficult conversation by planning what to say. Use open questions so you can explain, in a professional manner, what's happening, how it's making you feel and what change you want to see. Think about any steps you need to take to exit the situation safely if necessary. Ask you coach or mentor help you plan for anything that may distract or be a challenge for you.

9. Managing your resilience

Stress and anxiety will greatly reduce your resilience. But you can take steps to build it back up. Making plans to confront the situation can help by giving you back a semblance of control. Be your own best friend—set boundaries, and try not to ruminate or catastrophise.

10. Your self-care plan

Think about what will help you get through this. Exercise? A good book? A relaxing bath? But remember that, while positive initiatives like these can help you prepare for dealing with the situation, no amount of self-care will help if you stay in a toxic working environment. //

After retiring from the civil service, Siobhan O'Reilly now provides leadership training, coaching and consultancy services to public sector and charitable organisations.

Dealing with toxicity: resources

Sorted: mental health (previously *The Feel Good App*): a free mental health app widely used in the NHS (sortedmentalhealth.app)

Headspace: subscription-based app with meditations to help manage stress, anxiety and sleeplessness (headspace.com)

What's Up: an organisation-level app which uses CBT methods to help with anxiety, depression, anger and stress (thewhatsupapp.co.uk)

My Possible Self: an app offering strategies to help manage anxiety, stress and fear (mypossibleself.com)

TOXIC: A guide to rebuilding tolerance and respect in the workplace, by Clive Lewis, 2021 (mip.social/toxic)

meetyour**reps**:**Scott Diamond**

"Being a paramedic helps you connect with people"

TOM CAMPBELL

MiP's National Committee rep for Scotland and former paramedic, Scott Diamond, talks about resilience, collaboration and making a deep connection with people. Interview by **Craig Ryan**

"It's fantastic. It keeps your mind active and you can really work on your people skills, communication skills, attention to detail and teamwork," says Scott Diamond. That's not his day job at NHS Lanarkshire or representing MiP members he's talking about—it's refereeing football matches in Scotland's amateur and semi-professional leagues.

"I've always liked football but I was a terrible player, so I did a refereeing course years ago and absolutely loved it," Scott explains. Fierce local rivalries can "put the Old Firm to shame" and some games get "really tasty", he says. "You certainly develop plenty of resilience and awareness refereeing in those leagues!"

Scott's experiences as a Glasgow paramedic—he still works "the occasional shift"—led him to join the board of the Scottish violence reduction charity, Medics Against Violence (MAV). "We work with people who are escaping violent lifestyles or have drugs or domestic abuse issues," he explains. "Our staff are in emergency departments across Scotland day and night with these people, trying to make their lives better."

Scott became interested in management after working in quality improvement and studying for a "top-up" degree in healthcare management. Covid put him briefly back on the frontline, but he "just ended up progressing more and more into management".

Rather than leading a local ambulance station team, Scott took what he calls "more of a health board liaison route", working on improvement projects "rather than just heavy admin and teamwork".

This grounding in "collaboration for the greater good" led Scott to NHS Lanarkshire where, as a capacity and flow manager, he manages access to acute services, performance standards and patient safety, as part of a team of three providing round-the-clock coverage at the board's hospitals. He also works on projects aiming to improve patient flow and reduce hospital occupancy and delayed discharges—just as big a problem in Scotland as in England, he says.

"It's council-led and the councils are really, really strapped for cash," Scott explains. While Scotland's closely integrated health and social care partnerships "allow us to collaborate a lot better", he says, "the big thing it comes down to just now is a lack of money."

// It takes a lot to faze you when you've dealt with city centre riots. You just need to keep focusing on the job and looking after your staff to get through the day. //

Has being a working paramedic helped him as a manager? "Yes—firstly with the ability to talk to absolutely anybody about anything!" he says. "In Glasgow, you can go from someone in an incredibly affluent house to someone in almost slum conditions on the next call. Being able to connect deeply with both people and build trust has really helped me to develop leadership skills."

Ambulance work also builds resilience, he explains: "It takes a lot to faze you when you've dealt with city centre riots. You know the day will end—you just need to keep focusing on the job and looking after your staff to get through it."

Active in Unite as a paramedic, Scott found out about MiP "by Googling" after joining the health board. "It was an excellent find," he says, "because I'd been thinking we have a management tier that nobody fully represents". He subsequently trained as a rep and joined MiP's National Committee earlier this year.

The big concerns for members at NHS Lanarkshire are pay—the Scottish Government is "quite good", he says, because NHS staff are "massive voting bloc"—and proposals to reduce the working week from 37.5 to 35 hours. "It's fantastic that we can reduce people's hours and still pay them the same but it's a big management challenge to deliver safe services with that chunk of resource reducing," he explains.

Scott does see a "really difficult period ahead" for MiP, dealing with job losses from the English reforms and the possible merger of Scottish health boards after the 2026 Holyrood elections. "The priority for me is to increase our presence in Scotland. We can only strengthen through numbers and ideas... so we need to be really responsive to members' needs but also very proactive," he says.

"We need to treat management as a profession with its own development pathway," he adds. He sees MiP's role as "supporting members to be the best managers they can be... Professional regulation may be coming but we can strengthen that through union work as well." //

If you're interested in becoming a rep, contact MiP's national organiser, Rebecca Hall: r.hall@miphealth.org.uk.

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MANAGING our NHS