issue 65 | autumn 2025

healthcare manager

Community trust chief Angela Hillery

"It's up to us to push and challenge for what we need—we've got to do this locally"

SPECIAL REPORT: England's Ten-Year Plan

Seven experts on what it means, what's missing and what's next

Exit strategies

What are your options as the NHS job cuts start to bite?

Working in the grey

How to manage and lead when the future's uncertain

mip managers in partnership

The union for senior health & care managers

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For the first time in my lifetime, there's a very real chance that the next Westminster government will be hostile to very idea of the NHS. Reform UK is well ahead in the polls and, in our winner-takes-all democracy, could get a majority with less than 30% support. That's why, despite its many faults (*see page 14*), we have to find a way to make the Ten-Year Plan work. We could be drinking in the Last Chance Arms.

Even if Reform, as many expect, waters down its hardly-thought-out-at-all proposal for an insurance-based system, the NHS isn't going to have many friends around the cabinet table of a Farage-led government. It will have fewer still among the army of little-known activists who would make up Reform's parliamentary majority—many Reform members make no secret of despising the NHS and everything it stands for.

We don't know much about Reform's health policies or how they would try to run the NHS, but it's unlikely to be pretty. My hunch is they won't be very interested in the triple shift, better workplaces or integrating services.

If the Ten-Year Plan is succeeding—and seen to be succeeding—around the halfway point, it will be much harder for a Reform government to take a chainsaw to the NHS or to even think about doing away with it altogether.

The Labour government has made its admirable ambitions for the NHS much harder to achieve than it needed to. It has foisted half-baked proposals on health service leaders, given too little thought to implementation, alienated staff and is now hacking away at the very management talent it needs to deliver its plans.

We need a miracle. But managers, working hand-in-glove with clinicians, delivered miracles during the pandemic and are doing so again now, by keeping already-overstretched services running while simultaneously re-organising themselves in the dark. If anyone can do it, you can. //

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

MiP reps

Calling all MiP reps: join us in Birmingham for our Reps' Day

MiP's annual gathering of workplace representatives returns to Birmingham on 25-26 November. MiP's Reps' Day is an opportunity for reps from across the country to meet for a day of learning and networking, and to support MiP's policy and campaign development.

The event begins with dinner and an evening drinks reception on 25 November to thank reps for their incredible work during one of the most turbulent years the NHS has faced in recent memory. The next day features a programme of workshops, interactive sessions and briefings designed to help reps in their workplace role. A full agenda will be sent to attendees before the event.

All travel and expenses are fully covered by MiP. For more information and to book your place, contact Rebecca Hall, MiP's National Organiser, at R.Hall@miphealth.org.uk.

Space is limited, so don't delay and book your slot today!

noticeboard

15-16 October 2025

NICON 25

La Mon Hotel & Country Club, Belfast

Annual get-together for the NHS Confederation in Northern Ireland. Speakers include first minister Michelle O'Neill, former UK health secretary Alan Milburn and Mike Farrar, head of the Northern Ireland Department of Health.

mip.social/nicon25

25-27 October 2025

UNISON Disabled Members Conference

ACC Liverpool

unison.org.uk/events/2025-ndmc/

5-6 November 2025

King's Fund Annual Conference

Central London

Annual conference of the venerable healthcare think tank, naturally focusing on England's Ten-Year Plan and the "tough and courageous decisions" it impliesneeded to implement it. NHS England chief Sir Jim Mackey is down to speak.

kingsfund.org.uk/events/annual-conference

6 November 2025

WelshConfed25

Cardiff City Stadium

With lengthening waiting lists, a new chief executive and a change of government possible in 2026, there'll be plenty to talk about at the annual gathering of Welsh health and care leaders. Reception and dinner down the road at the Cardiff Hilton.

nhsconfed.org/WelshConfed25

21-23 November 2025

UNISON National LGBT+ Conference

Edinburgh International Conference Centre

unison.org.uk/events/2025-lgbt-plus-conference/

25-26 November 2025

MiP Reps' Day

Birmingham

See above for details.

mip.social/repsday25

3 December 2025

Women in Health and Care Conference 2025

Horizon Leeds

Annual conference run by the NHS Confed's Health and Care Women Leaders Network. This year's theme is 'Thriving Not Surviving'. Usually sells out fast, so book your place now.

nh https://mip.social/whcc25

KEEP THE DATE

12-14 February 2026: UNISON National Women's Conference, Liverpool (unison.org.uk/events/2026-nwc/)

19 March 2026: King's Fund annual Leadership and workforce summit, central London (kingsfund.org.uk/events/annual-leadership-workforce-summit)

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

NHS Confederation

Confed chief steps down as merger decision looms

Matthew Taylor, chief executive of the NHS Confederation is to step down next year ahead of a likely merger between the organisation and the trust membership body, NHS Providers.

Taylor announced that he would leave in April after "five fantastic years" in charge of the the Confed, which represents both trusts and ICBs, and hosts the management-side negotiating body, NHS Employers. He gave no reasons for his departure.

"During this time, we have reasserted the role of the NHS Confederation as a constructive and influential voice in shaping health policy and practice on behalf of our members, while also empowering local health and care organisations to innovate and collaborate for the benefit of their local communities," Taylor said.

Taylor has been an influential figure in public policy for more than twenty years, serving in Downing Street as an advisor on political strategy to Tony Blair and later taking charge of centre-left think tank the Institute of Public Policy Research. In 2016, he led a review of modern employment practices for the then Conservative government.

Matthew Taylor: going after "five fantastic years" at NHS Confed

MARK BICKERDIKE PHOTOGRAPHY

The Confed and NHS Providers announced in June that talks were underway on bringing the two organisations closer together, and a decision on a possible merger is expected in October.

MiP staff

Helen Carr retires, Jamie Briers steps up and Rosie Kirk joins MiP

Helen Carr's retirement as MiP's head of operations at the end of September marks the end of a long and distinguished career in the trade union movement and public service, *writes Jon Restell*.

Helen joined MiP just before the pandemic, which she ably helped us navigate as a team and a union. Her managerial skills found a fitting home in an organisation for managers. She has the ability to make things happen and to make things work better—a defining purpose which our members, as NHS managers, will recognise at once.

Under Helen's stewardship, the team and our organisation changed for the better. She introduced our triage service for members with employment problems, developed our Reps' Day event (*see page opposite*) and the work of our national committee. She led on MiP's equalities priorities, most recently working on sexual safety in the workplace. We owe Helen a great debt of gratitude and wish her a long, enjoyable retirement.

Helen Carr retires after five years as MiP's head of operations

Jamie Briers takes over in October.

TOM CAMPBELL

Helen's successor, Jamie Briers, has an impressive legacy on which to build as our new head of operations. He brings a wealth of first-hand experience in representing and organising NHS managers, most recently as MiP's national officer for North West England and Northern Ireland. Jamie understands what makes our members tick and will help lead our efforts to change the culture of the NHS and tackle the many challenges managers face.

Rosie Kirk has joined us as assistant national organiser. Rosie is an experienced union organiser who has hit the ground running. Her job is vital to supporting and developing the reps who represent members in local workplaces. She will also help our new Black Members Forum become a force for good.

Ministers insist new league tables will "drive improvement" despite doubts over accuracy and fairness

Health secretary Wes Streeting has insisted controversial new league tables for NHS trusts in England will "take the best of the NHS to the rest of the NHS", despite warnings from critics that they were misleading and could prove counterproductive.

Streeting said the tables, published on 9 September, would "identify where urgent support is needed and allow high-performing areas to share best practices with others", as well as bringing "an end to the postcode lottery" in NHS services. "Patients have to know how their local NHS services are doing compared to the rest of the country," he added.

The government published three separate league tables—for acute, non-acute and ambulance trusts—grouping organisations into four 'segments' based on new performance metrics devised by NHS England. The rankings were adjusted to take account of financial performance, with trusts in deficit confined to the two bottom tiers. Trusts in the top two tiers can join the first wave of 'new foundation trusts' next year, while those in fourth tier could face 'targeted intervention' depending on the outcome of 'capability assessments' to be carried out this autumn.

Specialist trusts, led by Moorfields Eye Hospital, dominated the league table for acute trusts, holding the top eight places. Mental health trusts fared particularly badly, with more than a third falling into lowest tier and half being downgraded since NHS England's last assessment earlier this year.

Wes Streeting claimed league tables will bring "an end to the postcode lottery" in the NHS.

PA IMAGES / ALAMY STOCK PHOTO

Trust managers who spoke to *Healthcare Manager* were highly critical of the new tables, which some claimed were "biased" towards "big-name" specialist trusts that do not have to provide urgent and emergency care. Others said the tables did not measure care quality fairly, pointing out that some organisations—such as the Cumberland, Northumberland and Tyne and Wear mental health trust—were relegated to the lowest tier despite an 'outstanding' rating from the Care Quality Commission.

Some managers also criticised the league tables as "meaningless" and a "publicity stunt". One said: "There are only two tiers really. It doesn't really make much difference if you're ranked 1, 2 or 3. And some trusts in tier 4 are actually good performers."

NHS Providers, which represents trusts, said "there was more work to do" before the public could "have confidence" in the tables. They would only boost performance if "they measure the right things", are "based on accurate, clear and objective data" and "avoid measuring what isn't in individual providers' gift to improve," said chief executive Daniel Elkeles.

NHS Providers' Daniel Elkeles: "more work to do" before the public can trust league tables.

"Anything less could lead to unintended consequences," he warned, "potentially damaging patient confidence in local health services, demoralising hardworking NHS staff and skewing priorities."

Jim Mackey: "still too much unwarranted local variation" in trust performance.

PETER CRIPPS

Matthew Taylor, chief executive of the NHS Confederation, said league tables "can be a valuable tool for fostering healthy competition and enhancing local accountability", but warned "they must not become instruments of blame." He added: "We must guard against the risk of perverse incentives and ensure that the metrics used are transparent, relevant, and presented clearly."

But NHS England chief executive Jim Mackey said there was still "too much unwarranted local variation in performance" and insisted the league tables "would help to drive improvement even faster" by "putting more power in [patients'] hands to make informed decisions on their choice of provider".

The full league tables for NHS trusts are available on the Department of Health and Social Care website at mip.social/leagues.

Confusion and lack of cash delays ICB job cuts

At least a dozen Integrated Care Boards have paused or postponed redundancy programmes because of a lack of funding and continuing confusion over transferring staff to other NHS organisations under government reform plans. The delays come despite an end of December deadline for ICBs to reduce their operating costs by 50%.

With the Treasury yet to agree funding for a national voluntary redundancy scheme, ICBs are understood to be facing unbudgeted bills of up £50 million each for redundancy payments and other severance costs. Several ICBs have warned they cannot fund the redundancies in this financial year while meeting the requirement to balance their budgets.

Among the ICBs pausing their job cutting programmes are North East and North Cumbria and all three ICBs in Yorkshire, as well as South West London, Frimley, and Buckinghamshire, Oxfordshire and Berkshire West.

Five ICBs in the East Midlands—Lincolnshire, Derbyshire, Nottingham, Leicestershire and Northamptonshire—are planning to postpone all redundancies below executive level until 2026, with Kent and Medway considering following suit.

Sarah Walter: reforms could be delayed

The delays make it unlikely that ICBs will meet the 31 December deadline set by NHS England. Most programmes require a consultation period of 30 to 45 days as well as time to respond to feedback and run a selection process for remaining posts.

In September, NHS England finance director Glen Burley admitted to the Commons health social care committee that the funding issue "will effect the timing of [the cuts] and we'll have to be flexible on that."

ICBs managers who have spoken to *Healthcare Manager* said the funding delays were being exacerbated by continuing uncertainty over the future role of ICBs and a lack of detail in government plans for new regional offices, which will take over some ICB functions. The 'model region blueprint', promised by NHS England earlier this summer, had yet to appear at the time of going to press.

One manager said it was still unclear which ICB staff could be made redundant and when. "The model ICB blueprint has a long list of roles that will be transferring to region or trusts 'over time'. No one knows what that means," he said. In some cases, he added, it wasn't clear which posts the model ICB blueprint was referring to.

Sarah Walter, director of the NHS Confed's ICS Network, warned the lack of funding for redundancies could delay the government's reform plans.

"It is clear that if [ICBs] cannot get redundancy schemes underway soon then they will not be able to make the savings planned for this financial year," she said. "The knock-on effect of this will be that the NHS cannot balance its books and the government's ambitious reforms will be delayed. It's vital that funding for patient-facing services is not impacted by redundancy programmes."

'The Ten-Year Plan: what does it mean, what's missing and what's next?' — page 14.

Healthcare leaders demand talks on latest NHS workforce plan

A coalition of 74 healthcare organisations, including unions, employers' bodies, royal colleges and think tanks, have called for a wide-ranging consultation process on the government's ten-year workforce plan for the NHS, expected by the end of the year.

The NHS Ten-Year Plan, published in July, promised ministers would produce a new workforce plan for the NHS this autumn to replace the Conservative government's 2023 plan, which it dismissed as "fiction". It said there would be fewer staff than previously projected, with more flexible working and changes to some clinical roles, but gave no further details.

The letter, signed by UNISON, the NHS Confederation and the Royal College of Physicians among many others, calls for "a regularly refreshed, credible national workforce plan for the NHS with independently verified modelling", and funding "attached to any priorities that the plan sets".

It urged ministers to publish a timetable for a "robust stakeholder engagement process" and to learn lessons from the 2023 plan, widely criticised for its lack of consultation and questionable modelling assumptions. A review of the 2023 plan by the National Audit Office recommended that future workforce planning "assumptions should be generated in transparent and systematic consultation with external stakeholders".

Professor Mumtaz Patel, president of the Royal College of Physicians, and one of the signatories to the letter, said the workforce plan was "fundamental" to the success of the NHS, "so it's important we get this right."

She added: "This coalition,

Profesor Mumtaz Patel

representing hundreds of thousands of NHS staff and patients, is urging the government to engage with us, ensure that the assumptions behind the plan are robust, the detail is properly thought through, and a clear implementation plan is set out."

NHS job cuts

NHS England consults unions on voluntary redundancies

NHS England is in consultation with trade unions, including MiP, on a voluntary redundancy scheme as the government presses ahead with plans to abolish the arms-length body and transfer its functions to the Department of Health and Social Security by October 2026.

Around half of the 17,000 staff working for the two organisations are expected to lose their jobs in the shake-up, with the bulk of the cuts expected to fall on NHS England as the larger body.

Progress on agreeing a voluntary redundancy scheme has been slowed by delays to the design of the combined organisation, to which some NHS England staff will transfer, and in securing Treasury funding for the redundancy programme. NHS England has proposed following the national model voluntary redundancy scheme on the assumption that Treasury funding will be forthcoming, leading to concerns that the consultation could be invalid if a lack of cash forces changes to the scheme's terms and conditions.

Consultations on the scheme opened in late July and the original closure date of 12 September has been postponed indefinitely. Corrado Valle, MiP's national officer for NHS England, said MiP would submit a joint response with other NHS unions based on concerns raised at members meetings and in MiP's own survey results.

Members main concerns were "on the clawback provisions, selection and prioritisation criteria, and the impact on partially retired employees and those who are not on Agenda for Change contracts," he said.

TOM CAMPBELL

Corrado Valle: no obligation for staff to apply for or accept a redundancy offer.

NHS England has yet to confirm the timetable for the scheme, but once consultations are complete, decisions and offers are expected this autumn with the first staff set to leave early in the new year.

"As with all voluntary schemes there is no obligation for staff to apply or accept an offer," explained Valle. "Members should consider their personal circumstances very carefully before applying for voluntary redundancy." He advised members to take independent financial advice from either MiP's financial partner, Quilter, or their own FCA regulated financial adviser.

Staff who are offered an settlement agreement should also take independent legal advice before signing, Valle said. MiP members are entitled to advice from the union's legal partners Thompsons Solicitors.

"The settlement agreement only becomes binding once legal advice has been obtained and the agreement has been signed by both parties," he explained. "You can withdraw from the voluntary redundancy process right up until signing the agreement."

MiP will keep members in NHS England updated as the redundancy process develops. Please check your emails from MiP and our website (miphealth.org.uk) for the latest information.

Government unveils barring scheme for exec-level managers

Senior NHS managers in England could be banned from NHS jobs for serious misconduct under a proposed new barring scheme unveiled by ministers in August.

In its official response to the public consultation on regulating NHS managers, which closed in February, the government confirmed that the barring scheme will apply only to board-level managers and staff who report directly to them. This is likely to include all very senior managers (VSMs) working for trusts and ICBs in England. Executive managers working for NHS England will not be covered due to the body's impending abolition.

The government said it is considering extending the scheme to some Agenda for Change grades, specifically Band 9, but only after a "thorough review of the regulatory system once embedded".

The scheme will be run by the Health and Care Professions Council (HCPC), which will be given new powers under legislation expected to be introduced during this parliament. The government said it would set out further details on the regulatory process before legislation is introduced, with a further public consultation expected on the draft bill.

"We're pleased that the government has listened to our views on management regulation," said MiP chief executive Jon Restell. "It's sensible to limit regulation to the most senior posts, at least to begin with. And we argued strongly for an independent regulator."

But he warned "there is lot of work to do" before the scheme can begin. "The government will need to clearly define standards, design a fair regulatory process and answer several technical questions such as what happens to managers already covered by a regulator," he said. "MiP is ready to work with the government on these issues."

Statutory regulation is "a small piece of jigsaw", he added. The "culture change, greater accountability and higher professional standards," MiP members wanted to see "requires a much bigger effort".

"This means trusting managers to get on with the job, freeing them up and letting go of micro-regulation from Whitehall," he said. "And it also means having enough managers working in stable organisations. The hard truth for patients and staff is that the government's swingeing job cuts and risky system upheaval are the biggest threats to good management in the NHS."

Agenda for Change

NHS staff willing to strike over pay

STEPHEN BELL / ALAMY STOCK PHOTO

Many UNISON and MiP members have signalled they would be willing to take industrial action to challenge this year's NHS pay award.

Most NHS staff were awarded a pay rise of 3.6% for 2025-26, following a recommendation from the NHS pay review body. The award was only marginally above the rate of inflation and lower than other public sector workers such as teachers and doctors received.

In an online consultation, 70% of UNISON members who responded said they would be willing to take strike action to challenge the award. Turnout was 26%.

Helga Pile, UNISON's head of health said the result "must act as a wake up call for government" and renewed the union's call for the government to abandon the pay review body process in favour of direct talks with NHS unions.

"Staff know plans to transform the NHS won't come to anything without them. But the realisation that the government intends to continue using the discredited pay review body system has made them very cross. This is because the pay review body process repeatedly awards some health workers lower rises than other groups."

She added: "Ministers must show they value the workforce by starting grown-up talks with unions now."

MiP's chief executive Jon Restell said ministers should not underestimate the "strength of feeling" among members and called for modernisation for the Agenda for Change framework to tackle long-standing structural problems with NHS pay.

"NHS staff never want to go on strike, but this result shows the strength of feeling among health workers," he added. "Set against the backdrop of a chaotic top-down restructuring and significant cuts to staffing numbers, this pay award was simply not good enough."

He said talks through the NHS Staff Council on issues such as pay compression between bands and incorrect grading, "must start now to convince staff that ministers are taking this seriously".

New shadow health secretary calls for ban on doctors' strikes

Former minister Stewart Andrew was appointed as shadow health secretary as part of Conservative leader Kemi Badenoch's shadow cabinet reshuffle in July. Andrew replaced Edward Argar, who quit the front bench for health reasons.

Andrew, 53, is the MP for Daventry in Northamptonshire, having represented Pudsey in Yorkshire from 2010 until the constituency was abolished in 2024. He served in a succession of junior ministerial posts during the last Conservative government, including sport, equalities and prisons, and as a government whip.

Stewart Andrew MP

PJRNEWS / ALAMY STOCK PHOTO

Before entering parliament, Andrew worked as a fundraising manager for the British Heart Foundation and several hospice charities. In 1998, when a councillor in Wrexham, he briefly defected to the Labour party before returning to the Conservatives two years later. He is openly gay and a patron of the Conservatives LGBT+ group.

Since taking up the health brief, Andrew has proposed a legislative ban on strikes by doctors, and called on the General Medical Council "to make striking incompatible with Good Medical Practice" as an interim measure.

Commenting on X (formerly Twitter), Andrew said: "Labour faces a clear choice: back our plan or keep bowing to union pressure that puts self-interest before patients. If this Labour government truly wants an NHS that works for those who need it, there's only one answer."

Andrew has also attacked as "baseless" and "disgraceful" claims made at the Reform UK party conference in September that the Covid vaccine may have led to the King and the Princess of Wales contracting cancer. "Public health should never be undermined by conspiracies. Nigel Farage must apologise and take responsibility for promoting such dangerous disinformation," he said.

Professional regulation: more questions than answers

Government plans for regulating and supporting NHS managers have become a little clearer, but many key questions remain unanswered. Rhys McKenzie **reports.**

On the surface, the NHS Ten-Year Plan for England doesn't say much NHS managers that they haven't heard before. It would be easy to dismiss the Plan as just another big-picture strategy document with limited immediate policy implications. But buried within its 168 pages are some proposals that could have a significant impact on managers.

These include a new statutory barring scheme for senior managers found guilty of serious misconduct, a commitment to accelerate the reforms recommended by Sir Gordon Messenger's 2022 review and a new range of powers and penalties for very senior managers in trusts and ICBs. While further detail and legislation are still to come, let's look at how these measures may affect managers in the years ahead.

Statutory barring

Regulation of NHS managers was already Labour policy before the party came to power last year. Shortly after the election, the government opened a public consultation to explore the options for regulating managers. MiP's response was covered in a previous issue of *Healthcare Manager* (mip.social/hcm63-regulation). A few weeks after the consultation closed in February, the government set out its vast programme of cuts to management throughout the NHS in England.

Thankfully, the Ten-Year Plan acknowledged that introducing full scale regulation would be a monumental waste of resources, particularly when managers are already grappling with major organisational upheaval. MiP agrees with the government's decision to go with a more limited barring system instead.

A statutory barring list will be easier to implement. Rather than maintaining a list of all registered managers who hold a formal qualification or have otherwise demonstrated they meet the requirements to practise, a barring system only requires a list of senior managers who have been found unfit to practise. Omission from the barred list will be evidence of being fit to practise, saving unnecessary bureaucracy for the system and the individual.

In its response to the consultation, the government confirmed that the disbarring scheme will cover very senior managers (VSMs) at NHS trusts, foundation trusts and ICBs, subject to legislation. It will not apply to managers currently working in NHS England due to the organisation's abolition and transfer of functions to the DHSC.

Ministers will consider extending the scope beyond VSMs, to Agenda for Change band 9, but only following a review period after legislation is enacted.

The scheme will be run by the Health and Care Professions Council (HCPC). HCPC will be known to most managers; it's an existing statutory regulator which covers 15 health and care professions, including paramedics, physiotherapists and occupational therapists.

While the details of how the HCPC will run the barring-system alongside their existing regulatory duties remain unknown, it will be given further powers through legislation during this parliamentary term.

Double jeopardy and adjudication

The government acknowledged in its consultation response that there are potential issues with dual registration. Many NHS leaders, such as clinicians and finance directors, will already have a separate regulator. Concerns were raised in the consultation about double jeopardy, additional fees and overlapping processes.

The government is considering how to address this. One option, they suggested, would be to only apply the statutory barring system to non-clinical managers, with clinical regulators adopting "common management standards" to assess clinical management practices against. Another option is for HCPC to investigate all cases involving senior managers and refer to other regulators when appropriate—with cases mainly involving managerial situations being dealt with primarily by HCPC.

The government is aware of complications with both options. These will be considered, and ministers will consult further with stakeholders, including MiP, before legislation is drafted.

The government is also considering options for the adjudication process. As the right "to pursue a chosen livelihood" under the European Convention on Human Rights would apply to a barring mechanism, the government has confirmed that there will be a legal appeal mechanism, likely through the High Court.

Ministers have not yet decided if the regulator will have powers to implement

Rhys McKenzie is MiP's communications officer.

sanctions short of permanent barring, or if it will be able to implement interim measures in the public interest while an investigation is ongoing. The government has said that this will also be under consideration while legislation is developed.

A clear definition of what would lead to disbarment is also needed to ensure the system is objective. Safeguards must be in place to prevent the barring system being used to deal with issues normally handled through performance management, appraisals or an employment contract.

MiP will be meeting with HCPC and the Department of Health and Social Care to ensure these issues are addressed as the statutory barring mechanism takes shape.

Professional support and development

To be effective, regulation of any kind must come with support and development. The government says it agrees, and we've now heard some of the ways it plans to offer that support. The Ten-Year Plan says the government is committed to

> **"Full scale regulation would be a monumental waste of resources, particularly when managers are grappling with major upheaval. MiP agrees with the government's decision to go with a limited barring scheme instead.**

"accelerating" the delivery of Sir Gordon Messenger's recommendations on management set out in his 2022 review. Chief among them are:

- Establishing "national and regional talent management systems" in the NHS by April 2026, to identify and support "leaders with the greatest potential" into future leadership positions
- Publish a new "Management and Leadership Framework" this autumn, which will include "a code of practice, standards and competencies from first-line manager to board level"
- Establish a "national development curriculum" for NHS managers
- Establish a new "College of Executive and Clinical Leadership" which will sit "outside of government"

MiP supported Messenger's recommendations when they were published and accepted by the previous government in 2022. And we still support them now. But set against the backdrop of the most significant cuts to NHS management since Lansley, is it really enough?

Time will tell what impact these measures will have. MiP has had assurances from the DHSC that Messenger's recommendations are a priority and that there is a commitment to make them work well for managers. That's a start.

Carrots and sticks

Wes Streeting has promised more freedom to the best performing VSMs, but also to dock the pay of those deemed to be failing. It's another example of the health secretary's self-proclaimed "carrot and stick approach"—reward for success, penalty for failure.

These much-trailed reforms to the VSM pay framework are now in force. VSMs at organisations in the lowest segment of the NHS Oversight Framework, or any VSM who does not meet individual appraisal objectives, will not receive annual pay uplifts. High performers will continue to receive pay awards, gain more flexibility over budgets, be eligible for bonus payments and be given the "power to act decisively when they identify underperformance" in their organisations. Other 'freedoms' are promised but not yet outlined. Just like its approach to regulating managers, the government's approach to supporting them clearly remains a work in progress.

As Streeting's 'carrot and stick' approach comes fully into effect, MiP will continue to push for more incentives, better support and greater development opportunities for managers at all levels. The true test of the Ten-Year Plan, statutory regulation and pay reforms will not be the impact of the new penalties they introduce, but whether they create the conditions for managers to thrive and lead the NHS through the challenges ahead. //

This isn't the way to deliver the Ten-Year Plan

People often ask me what MiP thinks of the Ten-Year Plan and if our members support it. I struggle to give a glass-half-full answer because of the circumstances in which the Plan has been launched. The government's brutal financial reset and (unpromised) system change is bearing down hard on managers, their jobs, wellbeing and effectiveness. Throw in the imperative to cut hospital waiting lists and you have the real NHS strategic plan, now and for the foreseeable future.

To add insult to injury, this is framed as cutting useless bureaucracy and freeing up resources for the frontline, with the maddening request for managers not to take it personally. Guess what? Dedicated public servants, who know their work matters to the public, even if the public don't yet, *do* take it personally. They worry about what's happening to safety and the ability of the NHS to get back on its feet. They worry—managers are human beings—about their livelihoods and careers. And they worry about what will happen if the NHS fails at a time when its political haters on the right are running rampant.

This is the hard context of the Ten-Year Plan for our members.

Then there is the Plan itself, expertly dissected in this issue (*see page 14*). More vision than plan, its inconsistencies and uncertainties inevitably create more questions that need answers. For me the challenge—identified by the original planners—was not what to put in plan itself, but to work out why earlier attempts to achieve the same shifts have failed. Why do we so often set a course only to row in the opposite direction? Have we answered that? Probably not.

But—deep breath—the Ten-Year Plan is the only plan in town. As a union we will try to influence and shape what happens next, paying attention to four interlocking areas.

First, keep making the case that good management is vital for the Plan's success and improving public satisfaction with the NHS. Our slogan is 'good management eradicates bureaucracy'. Steve Black, who makes this case every week in the *Health Service Journal*, draws an arresting, if dated, analogy with the Battle of Britain: it took 15 people working in different functions to put one pilot in the air. If we had focussed just on getting more pilots, as many argued at the time, we'd have lost.

> *The biggest challenge for the Ten-Year Plan was to work out why previous attempts to achieve these shifts have failed: why do we often set a course only to row in the opposite direction? Have we answered that? Probably not.*

Last November, Wes Streeting said he was ready to make the unpopular argument for NHS management. We can help him. We support getting on with implementing the Messenger recommendations, and an acid test for us is getting the right attention for the non-clinical workforce in the forthcoming ten-year workforce plan.

Second—and how's this for an unpopular argument?—argue for investment away from the frontline. With money as tight as ever, this means difficult decisions, managerially and politically. For example: you won't make HR a digital-first experience, as the Plan promises, unless you invest in systems and specialist staff, and you won't accelerate digital adoption by clinical colleagues if you cut specialist digital teams (which we're doing).

Third, demand cultural change. Our members want managers and their teams to have the autonomy and tools to get on with the job and to be held accountable for outcomes, not micro-managed on inputs. We agree the NHS should be the best employer and will help to create the promised Staff Standards—which must cover organisational change and diversity in new, meaningful ways.

Fourth, urge the government to focus on 'how' as much as 'what'. Without effective organisation design, delivery becomes an exercise in wishful thinking. The Treasury-enforced pause in system changes (*see page 5*) is a chance to take stock and think again about how we actually deliver the Plan. If we don't take this opportunity we risk another round of top-down re-organisation in a few years' time and minuscule progress on the three shifts.

These four areas need fresh thinking and a willingness to act differently. It's hard, bucking all the trends, but that's what's needed for the Ten-Year Plan to succeed.

TIM GEORGE/UNP

"Nobody can do this on their own"

Angela Hillery, chief executive of community trusts in Northamptonshire and Leicestershire, is one of England most influential NHS leaders and a pioneer of collaborative working. She talks to Craig Ryan **about why integrating services offers the best chance of overcoming a hostile environment and turning the NHS around.**

"I didn't have a plan to be a chief executive. I think people saw something in me that perhaps I didn't see in myself," says Angela Hillery. After starting her career as a speech and language therapist, she was encouraged "to dip a toe" into management. "It was then I realised that it was leadership that I loved."

Running two community and mental health trusts—Northamptonshire Healthcare and next-door Leicestershire Partnership—Hillery is now seen as one of England's most influential trust leaders and a pioneer of collaborative working. Twice named top NHS chief executive by the Health Service Journal, she was runner up in 2025.

We're meeting at Berrywood Hospital, a modern psychiatric unit in a leafy suburb of Northampton. It's one of 14 hospitals, as well as several health centres and other community facilities, which Hillery oversees as group chief executive.

Joining Northamptonshire in 2013, she led the then struggling trust to an 'outstanding' rating within five years. She was brought in to run Leicestershire in 2019, after the CQC found the trust's leadership 'inadequate'. Its ratings have improved since, but overall Leicestershire is still rated as 'requires improvement'.

Culture change takes time, so stable leadership is important, she says. "You can't do quick fixes or quick turnarounds. You've got to be prepared to live and breathe it, and when it doesn't work out... you've got to be prepared to pick that up as well."

The trusts have worked together—on staff programmes, quality improvement and strategy, for example—in a group arrangement since 2021, and Hillery has talked herself hoarse insisting they have no plans to merge. "It can be very distracting, very costly and you can create what you need without it", she says.

Instead, she says, the glue holding the partnership together is a shared culture, which boils down to a common understanding "that people matter". It's culture that "drives the change... so we put a lot of energy into it," she explains. Staff will only "go above and beyond" to deliver change if they feel "part of something they want to be part of. And that's what we create."

The benefits of working together have become "increasingly obvious", she explains, and with the Leicestershire and Northamptonshire ICBs clustering—and possibly merging—it felt "natural" for the trusts to have a joint strategy.

The five-year plan, *Together We Thrive*, adopted this spring, sets out the group's priorities, with heavy emphasis on tech, population health and inclusiveness. All fine and dandy, but what difference will it make on the ground? "I think you'll see more integrated working," Hillery says, with the trusts' digital services "working more closely together to make sure we can share, learn and maximise efficiency," as well as the group having "a bigger voice as a community mental health cohort."

The strategy itself reads like it was written in response to the Ten-Year Plan, rather than three months earlier. That's "probably fortuitous", Hillery says. With its strong record on collaboration and working with local populations to improve outcomes, she claims the group is ideally-placed to get involved in integrating neighbourhood teams and the planned multiple contracts for neighbourhood services. West Leicestershire has since been selected to join the first wave of 43 'places' rolling-out new neighbourhood health services.

The Ten-Year Plan itself "is clearly ambitious, there's a lot of intent there, but we have to remember it's for ten years," she says. Yes, the shift from hospitals to community services has been promised many times before—while money has actually moved in the opposite direction—but Hillery sees good reason to believe it might be different this time.

"This is the first time I've seen the policy direction supported by a range of workstreams to [achieve it]," she says. Work is in hand on new models of care, contract types and incentivisation systems, she understands. "All of those are necessary. In the past there's been ambition, but the detail hasn't come."

She urges trusts and ICBs to "push and challenge for what we need to make it happen" rather than expect a national blueprint from NHS England. "We've got to do it locally," she says. "It's not one approach; it's got to be a multitude of approaches and why can't we pioneer some of those new elements and contractual forms?"

She's enthusiastic, too, about promised new freedoms for foundation trusts. Foundation-status Northamptonshire and non-foundation Leicestershire "are dealt with pretty much the same from a regulatory point of view," she says. She wants trusts—but only those "with firm foundations"—to take more responsibility for population health, while having freedom "to innovate, scale-up and deliver in partnership".

The option for the "very best" foundation trusts to become 'integrated care organisations', holding the whole health budget for a defined population, clearly interests her, but "big questions" remain about how IHOs will work with other parts of the NHS system. Comparisons with American commercially-orientated 'accountable care organisations' are wide of the mark, she says. "It's a completely different concept. My sense is it's about taking responsibility for delegating resources, being a convenor or facilitator. It's not about leading everything, it's about improving outcomes in a cohesive and collective way."

She sees a possible prototype for IHOs in the collaboratives the group has already set up, which have "created the conditions for people to want to work together," she says. "It's led us to do commissioning in the voluntary and community sector, to change crisis pathways and improve outcomes for people with learning disabilities and autism."

The benefits of collaboration are visible, she says, in the transformation of CAMHS 'Tier 4' services—those for young people with the most complex mental health needs—where Northamptonshire leads for the East Midlands alliance of mental health trusts. By introducing a common waiting list and shared approach to prioritising need, a single clinical leadership and investing in community resources, the alliance has cut the number of beds needed across the region by more than half.

Northampton has also been successful in cutting waiting times for CAMHS referrals—a real bottleneck for many community trusts—from two years to 48 weeks, in a matter of months. "There's no magic bullet," says Hillery. Increasing access for specific population groups "has helped significantly", as have partnerships with the voluntary sector and new models of care developed with local ICBs. In the long term, more mental health investment in schools will be "vital", she says, "so those referrals coming through to [CAMHS] are the right ones. It's that partnership thing again... nobody can do this on their own."

But the challenge of delivering such transformational change, while making eye-watering cuts to organisations already running hot, still looks daunting. Northamptonshire has 33,000 people on its mental health waiting list—4% of the county's entire population—yet must cut costs by another 6.5% this year. A recent board meeting welcomed savings of £1 million in the first month of this financial year—before one director noted wryly that the target was double that.

"Yes, it's a big ask," says Hillery. Both trusts take a 'value-based' approach to efficiency, she explains, trying to concentrate resources on activity that produces the best outcomes for patients rather than cutting costs across the board. "That may be through integrating services, through transforming care, or around procurement."

But Northampton's board still identifies

"People still want to be managers—that's important"

TIM GEORGE/UNP

"Absolutely, I see healthcare management as a profession", says Angela Hillery. "There will inevitably be regulation but equally it comes back to development and understanding the competencies you [need]." She's open-minded about sketchy government proposals for a new management and leadership framework. "Something that develops individuals and gives some consistency to access to support and resources... can only be a good thing," she says.

She "hears the view" that uncompetitive pay, heavier workloads and threats of redundancy are making NHS management careers increasingly unattractive, but isn't convinced. "Certainly, in my experience people still want to be managers... and that's important," she says. But "we can't expect people to just manage. What are we doing to support these managers? How are we cross-fertilising?"

A multi-trust group like hers "can bring people together across complex organisations, and the more you bring [managers] together, the more chance you've got of keeping people wanting to do it," she adds.

She's also big fan of mentorships and shadowing and is "actively supporting quite a few people at the moment". When first stepping into a leadership job it's important "to have a support structure so you're not in an isolated position," she says. A leader's job is "to create opportunities", she adds. "That's one of the key roles of a chief executive—not only to do it personally, but to create conditions where [organisations] can do that, through secondments and different system leadership opportunities."

the threat to care quality and safety posed by the efficiency programme as the biggest risk facing the trust. Mitigating that means being "clear about what we're commissioned to deliver", says Hillery. "Inevitably... you can get some drift on those things. We're prepared to innovate, but you have to balance it with safety... to ensure we're not introducing more risk."

Job losses are inevitable, Hillery admits, despite significant savings on agency spending. "Above all else, we've got to reduce the workforce—that's the same for everybody," she warns. She won't say whether compulsory redundancies are on the cards—suggesting it depends on the outcome of the trusts' efficiency drive—but in the absence of a nationally agreed and funded voluntary redundancy scheme, both trusts are introducing mutually agreed resignation schemes (see page 20).

The probably permanent increase in demand for some mental health services— particularly ADHD and autism, "which we're more likely now to be aware of", Hillery says—means the NHS will eventually have to get used to spending a bigger share of its budget on mental health (it's now 9% and falling).

"We haven't got parity. The mental health investment standard has been helpful but it's still limited," she says. More investment needs to come from outside the NHS too, she adds: "We need to push for more resources in schools and in local [communities] around mental health, and not assume everything needs to escalate into CAMHS or into a mental health organisation."

In such a hostile environment, what levers can chief executives like Hillery pull to improve services rather than just fight fires? "I firmly believe integrated care is the answer to that," she replies. Outcomes won't improve "if organisations stay separate", she warns, and while there are good examples of integrated services, we need more "partnerships at scale", as well as "a [clear] sense of what good outcomes look like" and much more use of population health data in planning services.

Hillery has long championed the 'community asset' model, which aims to build on a community's existing strengths, relationships and resources to improve health outcomes. She sees the government's ambitions for neighbourhood health centres as an endorsement of this approach, but admits "it needs more to bring it to life".

She points to Leicestershire's 'neighbourhood cafés'—drop-in centres where locals can chat with staff trained "to listen and provide practical support"—as an example of this approach bearing fruit. "That develops a community asset because you're sustaining the voluntary and community sector. You're also reaching far more people, and your trust through those communities is massively [increased]," she explains. NHS organisations need to do more than just deliver services, she says. "It's about what you're adding to the community to build these assets."

This means fully embracing 'co-production', says Hillery. "I think people [in the NHS] can say 'co-production' without really meaning it... It's a much more mature way of working. It's saying that we are genuinely equal in this." The group's collaboratives involve "people with lived experience" at every level, she explains. "It's not a tokenistic approach; it literally holds us to account." Co-production often works out cheaper in the long-run, she claims: "It's actually very cost effective because you're more likely to get the service meeting the need."

Meaningful co-production can't be done through a single group or advisory body, she says. The trust group has "people with lived experience delivering resources in our recovery centres", she explains, peer support workers and a variety of representative bodies including a People's Council and a Youth Advisory Board, as well as the trusts' own governing bodies. "You can't just have somebody who has lived experience and say that's the only way," she adds.

The fuzziness surrounding the Ten-Year Plan has left many NHS leaders scratching their heads about what to do next. But Hillery seems very clear-eyed and confident that her collaborative approach is the way forward, despite the daunting reality facing trusts like hers.

To get a "mandate" for change, we need "to change public perceptions of the NHS," she says. "That's a tall order, but we're up for it. I feel very privileged to be leading organisations wanting to do that. I have that hope and optimism because of the people I work with." //

2025 THE TEN YEAR PLAN 2035

The government's Ten-Year Plan for the NHS in England finally landed at the beginning of July, inspiring enthusiasm and exasperation in equal measure. We asked seven healthcare experts to reflect over the summer and give us their considered view on one aspect of the Plan that interests, excites or annoys them.

What does it mean, what's missing & what's next?

JESSICA MORLEY TECH | GEOFF UNDERWOOD STRATEGIC COMMISSIONING | NIGEL EDWARDS NEIGHBOURHOODS | DR ANDY BROOKS GPs | SIVA ANANDACIVA TRUSTS | ANDI ORLOWSKI VALUE | LUCINA ROLEWICZ WORKFORCE

The NHS's AI revolution: promise or peril?

TECH: JESSICA MORLEY
Associate research scientist at the Digital Ethics Center, Yale University.

Technology was always going to feature strongly in the Ten-Year Plan. Back in September 2024, Wes Streeting outlined three big shifts as solutions to the NHS crisis: from hospital to community, from analogue to digital, and from sickness to prevention. While the digital shift was the most overtly tech-centric, it was clear that all three would rely heavily on digital, data and artificial intelligence (AI) and, unsurprisingly, the published plan uses these three terms 102, 106, and 79 times respectively.

According to the Plan, the NHS will be the most AI-enabled health system globally by 2035. AI will automate triage, act as a trusted assistant embedded in care pathways, liberate staff from bureaucracy, support radiology reporting, assess patients remotely, predict hospital flow, discover medicines, and act as companion, coach, and GP via the NHS app. This will, ministers claim, give joy back to clinical staff, automate over a million administrative requests, and save 90 seconds per GP appointment—additional capacity equivalent to over 2,000 full-time GPs.

While investing in life-saving technology is laudable, expectations are so high that the NHS risks putting far too many eggs in a relatively flimsy basket.

First, the plan perpetuates myths about NHS having "the best population health data in the world". In reality, NHS data assets are often siloed and rarely AI-ready, requiring standardised curation and careful interpretation by specialists. The 5.6% opt-out rate also undermines completeness and risks bias.

Second, prediction doesn't equal prevention. The Plan's faith in genomics and predictive analytics ignores substantial evidence of their limitations. The predictive power of genomics is often modest; relying too heavily on predictions based on polygenic risk scores can be counterproductive, and widen rather than narrow

health inequalities. And population risk stratification tools rarely produce benefits—in fact, they can make care worse, especially for marginalised patient groups.

Third, evidence for effective AI-enabled hospital care is currently weak. The Plan cherry-picks examples while ignoring systematic evidence that AI's real-world performance is often poor. Multiple systematic reviews demonstrate weak evidence of effectiveness, small effect sizes, non-transparent reporting and significant implementation challenges.

Fourth, ambient AI scribes pose safety concerns and should not be blindly trusted. These systems are stochastic inference machines making active 'decisions' about clinical relevance based on biased and incomplete data. They can generate different results each time, potentially even for identical consultations with the same patient. And we have limited control over data flows and background processing, raising significant privacy concerns.

Fifth, over-reliance on AI risks widening inequalities. The Plan promises to help those "who have not previously been able to access healthcare on their own terms," but AI systems are likely to perform worst for populations with the greatest health needs. This reflects systematic biases throughout the development pipeline, from dataset composition to algorithm design. Those who generate high-quality data about themselves (the 'worried well') benefit most, while those with greatest health needs are left behind.

Finally, the plan underestimates implementation complexity. Brief nods to reviewing regulations feel like afterthoughts. Successful AI implementation requires robust infrastructure spanning technical, social, ethical, and regulatory domains, privacy-preserving mechanisms, curated datasets, interoperability standards, and designs that support clinical expertise.

The NHS has repeatedly failed to deliver similar digital promises. Without addressing fundamental challenges, the Plan risks repeating historical mistakes with newer technology.

STRATEGIC COMMISSIONING: GEOFF UNDERWOOD
Chair of MiP and programme director at South Central and West Commissioning Support Unit.

Are ICBs being set up to fail?

After considerable time spent, coffee consumed and steps counted around the fields of north Somerset, while thinking about what the Ten-Year Plan says about strategic commissioning, here's my view: the plan is a mess and it's setting ICBs up to fail.

First, the mess, also known as Chapter 5 on the new operating model. It says ICBs will "draw on a deep understanding of population need," and "deep engagement with patients and the public". Health and Wellbeing Boards will produce neighbourhood health plans for ICBs to bring together "into a population health improvement plan for their footprint". ICBs will then "be responsible for commissioning the best, most appropriate neighbourhood providers". When something goes wrong, ICBs "will take decisive action to decommission services or terminate contracts where a provider consistently delivers very poor-quality care."

But ICBs aren't in sole charge. Regions will performance manage the providers commissioned by ICBs using "a rules-based process to determine where intervention and support to address poor-performance is needed... backed by a new failure regime". (I think "failure regime" is a practically and morally wrong way to frame an improvement intervention in healthcare, but that's an argument for another day). The plan continues: "Where we identify problems, we will then help solve them" by supporting reconfiguration of services, replacing leadership teams or placing failing providers into administration. I think "we" in this context means the Department.

To further muddy the waters, ICBs won't be the only commissioners. The "very best" foundation trusts will become 'integrated health organisations'. IHOs will, "hold the whole health budget for a local population" and "will be free to contract with other service providers, within and outside the NHS."

It seems the ultimate goal for ICBs is to make themselves redundant by strategically commissioning local providers who regions and the Department approve of so much they become local commissioning providers who strategically commission other local providers locally.

But ICBs won't be able to do that because I think they're being set up to fail. They will "need to evolve new capabilities to be successful" but with half their previous resources. Most ICBs will cover much larger populations than now—the largest will serve over 3.2 million people, roughly the population of Uruguay. Full disclosure: I haven't been there. But there must be a lot of neighbourhoods in Uruguay.

ICBs will not have the resources to analyse or engage with neighbourhoods in any "deep" way. I understand the emerging intention is that ICB staff who lead on neighbourhood development won't follow their colleagues through the 50% grinder to the new ICBs, but transfer out to providers. So ICBs may not even employ the people whose job it is to have the deep understanding of neighbourhoods that ICBs are supposed to have.

This won't be the end of the turmoil for ICBs. The plan encourages them to "adjust their boundaries" to be coterminous with strategic local authorities. As one ICB executive said to me recently, "It's bonkers, we'll be doing all this again in two years." ICBs may not even have time to fail before they get reorganised again.

We had 42 commissioning organisations with detailed integrated care strategies and joint forward plans ready to go. We didn't need to do this.

NEIGHBOURHOODS: NIGEL EDWARDS
Senior advisor with public sector consultancy PPL and former chief executive of the Nuffield Trust.

Impatience is one of the biggest risks facing the Plan

Perhaps the most significant idea in the Ten-Year Plan's long list of proposals is the development of the neighbourhood health concept. This builds on work already underway following Dr Clare Fuller's 2022 'stocktake' on integrating primary care (mip.social/fuller).

There will be a national development programme in which 42 'places' will be supported to push the idea forward. However, other places will not want to wait—and nor should they, as developing this type of model takes time and some aspects of the process cannot be easily leap-frogged. The Plan says little about how change will be made but previous experience suggests that policy-makers underestimate the time and effort required to achieve it.

A lot of work is needed to develop the systems that will underpin these models. Some community staff will need to be re-aligned to work in neighbourhoods. Work on getting information systems aligned and talking to each other will need to be accelerated. I'm concerned that that GP practices are not as central as evidence suggests they should be—ensuring that general practice is strong, resilient, and able to adopt new pathways and work more collectively will be very important. While there are advantages to a scaled-up approach to primary care, relational continuity will still be important for a significant proportion of patients. Finding ways to get the best of both will be a challenge, but methods do exist, such as 'microteams' with their own patient list working as part of larger practices.

Acute trusts need to think about how referral systems work and develop new ways for specialists to support GPs. Models to do this are already in place in some areas; they involve replacing some referrals with advice and guidance, having util-disciplinary review meetings between neighbourhood teams and consultants, and streamlining communication to reduce the number of tasks hospitals hand to GPs. This will mean creating new job plans and pathways to support these new approaches. This work will also help to realise the Plan's goals for reducing use of outpatients and, experience suggests, reduce admissions for chronic conditions.

Experience also suggests this sort of integration needs to be organised and co-ordinated. There will be difficult decisions about resource allocation because, as teams are formed, we will find that the inverse care law—that the availability of good medical care varies inversely with the need for it—is still very much in force. The development of an 'integrator' function alongside a new model of commissioning will be important to drive change locally. The NHS has tended to ask commissioners to specify far too much detail about what is provided, and the model will need adapt to a more outcome-based approach as systems become more integrated.

There is an important lesson that the Plan does not seem to have learned from previous experience: the development of integrated services and teams cannot be mandated. While systems and processes can be put in place, success depends as much on relationships and staff aligning to a different set of objectives and success criteria. This takes time, effort and resources. Impatience about this is one of the biggest risks facing the Plan—and only local leaders can manage it.

WORKFORCE: LUCINA ROLEWICZ
Researcher with the Nuffield Trust, specialising in the NHS workforce.

Investing in NHS staff will be crucial

The 2023 NHS Workforce Plan was the first large-scale, long-term workforce modelling exercise for the NHS. It was criticised for having unrealistic expectations of workforce growth and questionable modelling assumptions. The Ten-Year Plan rejected the 2023 plan as "a fiction", but there is hope that a new workforce plan due this autumn will remedy its failures.

The Ten-Year Plan's vision for three big shifts in care—from hospital to community, analogue to digital, and sickness to prevention—will have big implications for where and how staff train and work.

The main workforce ambitions in the Plan are:

» **Growing a sustainable, domestic supply of NHS staff.** Reducing reliance on international recruitment developing more talent from local communities is no small challenge. The latest available data show more than two-thirds of new doctors and almost half of new nurses were trained overseas.

» **Making the NHS an employer of choice.** This means tackling structural issues and smaller, everyday frustrations. Small wins will include an NHS staff app to make HR processes more accessible and reforming mandatory training requirements. Better support for staff returning from long-term sickness absence is also crucial, as such staff are more likely to leave their jobs.

» **Equipping staff for a digitally enabled NHS.** Lack of career progression

GPs: DR ANDY BROOKS
GP and chair elect of the National Association of Primary Care.

It's hard to be optimistic with misty optics

How has the Ten-Year Plan landed with you? Are you eager for change or thinking, here we go again? How we view the Plan may depend on what lens we're looking through—our experience and position always colour and sometimes cloud our perspective. There are some optimists chomping at the bit to get started, and some who can't even find a glass, never mind whether it's half-full or half-empty.

While there isn't much detail, general practice is at the heart of plans for neighbourhood health services. The vision is for a fundamental shift away from a hospital-dominated system, delivering more care in the community by focusing on long-term relational care, increasing capacity in primary care and investing in estates, digital and workforce. Surely, all this is good news for general practice?

However, reaction in the world of general practice has been mixed. Some say "don't touch it with a bargepole" while others advocate jumping in and shaping the plans—through the recently launched neighbourhood health implementation programme, for example. Why are some in general practice optimistic while others seem to have misty optics?

One of the big concerns is the proposal for two new contracts: one for neighbourhoods with populations of 50,000 and one for multi-neighbourhood providers serving populations of 250,000. Immediately, questions arise about what they mean for standard GP contracts, primary care network (PCN) contracts, GP federations, and what some see as the threat from trusts becoming integrated health organisations (IHOs).

These are significant concerns, especially when combined with current underspends in primary care budgets, including those for transformation, enhanced services and workforce. History tells us that investment tends to shift right, not left. Many NHS providers and commissioners are in deficit, but the one sector that isn't is general practice. It simply can't be: deficits become a personal financial loss for GPs as business owners.

No wonder so many in general practice are looking at the Plan through misty lenses. Their concerns must be acknowledged—simply suggesting that they need new specs isn't going to help.

I'm at heart an optimist who likes to embrace challenge and change. I've found that getting involved and being part of the conversation leads to better general practice, better system working and better outcomes for the public. But I've also learned that there are often nuggets to be found by listening to those with a different perspective, those who are cautious, point out risks and understand the complexities of care. Taking time to understand and mitigate concerns without losing sight of the vision or the necessary momentum is a skill of competent leadership.

Ultimately, whether our optics are clear or clouded, the challenge before us is the same: to move from vision to reality in a way that strengthens general practice and builds healthier neighbourhoods. Optimism alone will not deliver change, nor will caution prevent it—what matters is how we balance both, working together with honesty about the risks and determination about the opportunities. If we can find that balance, the aspirational words in the Ten-Year Plan may become a lived experience of better, more connected care for the communities we serve.

is a longstanding factor in NHS staff turnover. The plan's proposed "skills escalators" aim to give staff personalised career development and clear advancement routes—including training in using digital and AI tools, which are expected to play a big role in reducing administrative burdens.

To create a domestic training pipeline fit for the future, clinical careers must be attractive, and universities and employers need to reduce attrition during training and encourage participation in healthcare careers. The Nuffield Trust has previously recommended student loan forgiveness or similar policies to incentivise students to choose NHS careers and reduce early-career leavers.

The recent announcement of job guarantees for new nursing and midwifery graduates is encouraging, but some of the practicalities remain unclear—including how trusts and universities will determine where staff are most needed, and how this squares with the wider aim of shifting care—and therefore jobs—into the community. Retaining higher apprenticeship funding for key community roles (such as district nurses) is welcome too, as these jobs are essential to the shift.

But these recruitment efforts will fall flat if the NHS can't retain staff for the long term. The NHS needs better information on why staff leave and where they go next, and to identify staff who are most likely to leave and target interventions accordingly.

Digital and AI skills will be important, but the NHS needs to be able to walk before it can run. Prioritising upgrades to basic IT systems, introducing fully integrated digital patient records, and establishing adequate data infrastructures are essential to integrate existing processes with new digital solutions.

If the NHS can nurture more homegrown talent, retain staff and equip them for a digital-first service, it will take important steps towards its long-term ambitions. But our studies of other countries, like Denmark and Ireland, have demonstrated that additional investment, contractual changes, and financial incentives are needed to make some of these big changes a reality.

THE TEN YEAR PLAN 2025 2035

TRUSTS: SIVA ANANDACIVA
Director of policy, events and partnerships at the King's Fund.

Foundation trusts were the future, once

There are some old ideas in the government's new Ten-Year Plan. One of the oldest (and most technocratic) is the promise of a "reinvigorated" foundation trust model.

Foundation trusts (FTs) were legally different from their NHS trust predecessors. FTs were meant to be quasi-autonomous NHS organisations, freer from central oversight and regulation, and more accountable to local communities.

Some things did feel different. I saw CEOs of first-wave FTs who no longer had to wait for Whitehall's approval for strategic decisions, and FTs using their commercial freedoms to set up subsidiary companies or—rarely—deviate from national frameworks like Agenda for Change.

But there were limits. Most FTs still relied on government revenue and had to meet the same performance standards as everyone else. Having two types of trust was a real headache for national NHS leaders, who had to withhold investment from NHS trusts in case FTs decided to spend their reserves and blow the overall NHS budget.

And it was never clear that FTs were 'better' than trusts. They didn't perform significantly better on finances, patient satisfaction or waiting times. Which led some government advisors to privately muse, "Well what's the [bleeping] point of them then?"

That hasn't stopped ministers resurrecting the idea. The Plan says the first 'new' FTs will be authorised in 2026, with every provider becoming one by 2035. And the 'very best' FTs will be eligible to hold population-wide budgets and become proto-integrated health organisations (IHOs) by 2027. Without a detailed implementation plan, it's impossible to know how IHOs will work with existing providers or ICBs, or why FT freedoms are essential to being an IHO. But we do know that FT status is now a necessary first step towards becoming a nationally-recognised IHO.

The FT resurrection poses interesting policy questions. The new model jettisons some elements of local accountability, like the need for governors, without an obvious replacement. And it's still unclear how FTs can use their commercial freedoms when every spending decision will score against the government's balance sheet.

Perhaps most interesting is what this says about the beliefs of national policymakers. Much of the DHSC and NHS England senior leadership were either architects of the foundation trust policy more than 20 years ago, or have run foundation trusts. They found you could do more, and do it faster, to improve patient care if high-performing organisations were unleashed, with less bureaucracy holding them back.

That may be the biggest problem in some parts of the NHS, but it's surely not the case across the board. So, there's a real danger that this policy is about letting the best parts of the NHS race away, rather than letting the most challenged parts catch-up.

I was in the Department when FTs were all the rage, I've worked for the Foundation Trust Network and I've been an FT governor. I genuinely believe the FT 'movement' worked in some ways, and that the entire NHS cannot be run directly from Whitehall. But I'm still sceptical that FT status is the answer to the problems the NHS faces. As my neon socks demonstrate, if you wait long enough, everything comes back into fashion. But as those socks also show, sometimes you should think twice before bringing things back from the past.

VALUE: ANDI ORLOWSKI
Director of the NHS Health Economics Unit.

Back to school for the NHS

Picture this. You're getting Timmy ready for school. New pencil case, shiny shoes and creaseless shirt. But meanwhile the school has been preparing for months. Timetables set. Staff lined up. Classrooms ready. Day one works because preparation is real, practical and focused.

The NHS Ten-Year Plan is that same preparation for our health service. It's the curriculum, the timetable and the room plan, all organised around 'value'. The NHS won't deliver better outcomes for every pound without deliberate choices about what to stop, start and scale.

Here's the curriculum—what the Plan says about value:

- **Finance built around value:** Move away from paying for volume. Use best practice prices, test Year of Care payments and reward high quality and patient experience. Over time, providers are rewarded for improving outcomes, not just activity.
- **Shift spending to where it works:** Reduce the share of spending in hospitals and invest more in primary and community services, aligned to need and delivered through neighbourhood teams.
- **Productivity and discipline:** Better health for the same staff time, theatres and kit, with outcomes and patient experience protected. If quality slips, productivity falls.
- **Transparency and low-value care:** Publish outcomes and access by place, increase use of patient outcome and experience measures, and decommission low-value activity. Strengthen NICE to identify what adds little benefit.
- **Capital and estates to enable the shift:** Progress Neighbourhood Health Centres and consider partnership models to move services closer to home.
- Earned autonomy and clear roles: High performers gain more freedom to innovate, alongside a tougher improvement regime where quality lags. ICBs focus on strategy and outcomes, with providers more accountable for population health delivery.

Delivering the curriculum demands analytics, clinical leadership and honest public conversation.

1. **Set your value syllabus.** Pick three conditions and two cross-cutting aims. For each, agree the outcomes that matter, including equity and experience. Map the payment lever you will use: best practice price, blended payment or a Year of Care bundle?
2. **Work on allocative efficiency.** Bring clinicians, finance, analysts and public voice into one room. Score options against outcomes, equity, affordability and feasibility. Decide what to stop, start and scale. Publish the criteria, weights and rationale. (Use STAR or PBMA — they're free!).
3. **Pilot Year of Care.** Start with long-term conditions where integrated teams already exist. Write one simple bundled-payment spec, one outcome dashboard, and one gain-share rule with providers. Build in patient feedback and case-mix adjusters.
4. **Create a reinvestment pipeline.** Commit to removing at least one line of low-value activity this year. Move that money to an evidence-based community offer. Track both the pounds and the benefits.
5. **Wire up the analytics. Build a clean, reproducible pipeline for activity, cost and outcomes.** Give boards a single page showing outcomes, experience, equity and spend, and use tools like Model Health System and GIRFT to reduce unwarranted variation. Professionalise the analyst workforce so decision-grade work is the norm.
6. **Make transparency about improvement, not blame.** Talk about published place-based results with staff and communities. Celebrate outliers who improve outcomes, and support teams that need to catch up.

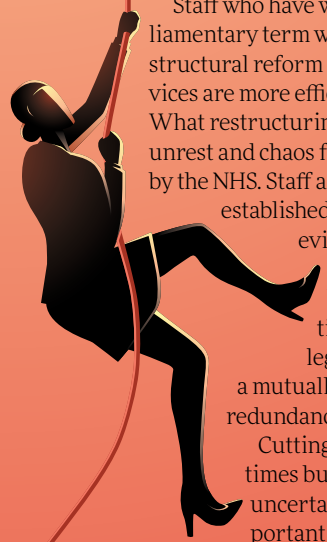
Back to school energy matters. If we choose well, measure what matters, move resources and support teams, patients will feel the difference. Better outcomes. Better experience. Better equity. That is the job... and no sausages thrown in the canteen!

NHS JOB CUTS: what could they mean for you?

When politicians start reforming the NHS, there is only one certainty: some people will lose their jobs. But what options might be on the table and how does redundancy work? MiP national officer Corrado Valle explains.

Change is a fact of life in the NHS. As politicians wouldn't dare change the model of healthcare in this country, they will often resort to more publicly palatable methods of tinkering with the NHS: top-down restructures.

Staff who have worked in the NHS long enough to see out a parliamentary term will have seen this movie before. They know that structural reform rarely leads to the promised land where services are more efficient, more productive and better for the public. What restructuring undoubtedly does deliver is uncertainty, unrest and chaos for the more than one million people employed by the NHS. Staff are shifted around different parts of the system, established organisations make way for new ones and, inevitably, many staff lose their jobs.



Employers can cut jobs. But the process must be fair and lawful. When embarking on job cutting programmes, NHS employers have a few legal options they can use. Most notably, these are a mutually agreed resignation scheme (MARS), voluntary redundancy (VR) or compulsory redundancy (CR).

Cutting through the jargon is difficult at the best of times but it's even harder when you're dealing with the uncertainty that organisational change brings. It's important to understand how these methods differ in order to make informed decisions about your future.

Mutually agreed resignation schemes (MARS)

A mutually agreed resignation scheme is a voluntary resignation arrangement, distinct from redundancy, under which staff agree to voluntarily resign their position in return for a severance payment.

A MARS is designed to give employers greater flexibility during organisational change by creating vacancies that can be filled by redeploying staff from other roles. It can also help mitigate potential redundancies by providing an alternative option for staff who are at risk.

Staff with at least twelve months of continuous NHS service would generally be eligible to apply under a MARS. These schemes should not be used to address poor performance or disciplinary matters; in many schemes staff are ineligible if they are involved in a formal performance management or disciplinary process.

In the NHS, MARS usually offers severance pay equal to half a month's salary for every year of reckonable service, capped at twelve months' salary with an absolute ceiling of £80,000.

Staff who leave under MARS but find another NHS job within a certain timeframe may be required to pay back some of their severance payment. The timeframe varies between schemes, but it's generally six months. This repayment, known as 'clawback', is a mechanism used by the Treasury to recover money from public sector exit payments.

There is no obligation on anyone to apply under a MARS. It's a voluntary scheme. There is also no guarantee that a MARS application will be successful—your resignation would need to be agreed with your employer, and would be conditional until a binding settlement agreement has been signed by both parties.

A MARS shouldn't be used as replacement for redundancy. There could be legal implications for employers who agree a resignation with someone only to make their post redundant later. MiP and most other trade unions urge members to be cautious about pursuing a MARS application.

How redundancy works

Although they may seem similar in practice, redundancy is legally different from resignation. Staff who are made redundant are not resigning their position. Employers can only dismiss employees through redundancy if they deem the role as surplus to requirements, not the person.

Employers must consult with staff and/or their trade unions during a redundancy process to ensure that it is lawful. They must outline what jobs are in scope and demonstrate why they would be no longer needed in the future structure. Staff at risk of redundancy should also be offered suitable alternative employment, where possible, to mitigate overall job losses. Staff must be kept informed throughout the process.

While MARS is generally offered during a redundancy process, there is no legal obligation to consult staff on a MARS. Eligibility and selection will also vary.

The exit payment under redundancy, either compulsory or voluntary, is also different. In the NHS, staff are only eligible for redundancy pay if they have worked at least two years continuously at one or more NHS employers. Any break in employment of more than one week means the time worked at a previous employer will not be counted (annual leave and sick leave do not constitute breaks in employment).

Redundancy pay in the NHS is generally calculated at one months' pay for each year of reckonable service. This is capped at 24 months' pay, again with a ceiling of £80,000. Depending on the situation, redundancy may be worth double what's on offer from a MARS—one reason why unions generally advise caution with MARS, especially when a redundancy situation is ongoing or yet to start.

Clawback still applies to redundancy payments, although it varies from scheme to scheme. Whether the redundancy was voluntary or compulsory will also likely affect the clawback period.

With all exit payments, it's important to consider the tax and pension implications which depend on your individual circumstances. Your should get professional advice on this before executing any agreement.

Compulsory vs voluntary

During any redundancy process, employers have a legal duty to try to limit the number of compulsory redundancies. A compulsory redundancy ultimately means that the member of staff has no other option. Voluntary redundancy, on the other hand, gives staff agency during organisational change. By volunteering, staff who are willing to leave can give colleagues who want to stay the opportunity to find a role in the new structure.

Voluntary redundancy schemes are preferred as they give staff dignity during change. It offers a structured exit option for staff who, for example, are nearing retirement age, have many years of service or who simply wish to leave their employer.

Is there a right way to cut jobs?

Trade unions are in the business of saving jobs, not helping employers cut them. Mitigating job losses will always be MiP's number one priority during organisational change in the NHS.

When job losses are unavoidable, we see voluntary redundancy schemes as an effective way to help limit the number of compulsory redundancies which may be needed later.

But not all schemes are created equal. MiP considers voluntary redundancy schemes individually before taking a position on each. One-to-one assistance for individual applications cannot be guaranteed as staff are under no obligation to apply or accept an offer—it's ultimately your decision.

While MARS may have its place in certain circumstances, it's generally best not to be rushed into an early decision during the change process. A resignation under MARS may affect your eligibility for unemployment benefits and mortgage protection payments, which is not usually the case when you're made redundant. You may also miss out on other options that become available later in the organisational change process as the shape of the new structures becomes clearer.

As always, it's important to take advice from your union and carefully consider all options when faced with a reorganisation. The reality of life in the NHS unfortunately means you are never too far from the next one. //

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

Know your new legal rights and duties at work

The government's employment bill has been styled as the biggest upgrade to workers' rights in a generation. **Jo Seery** explains what the new rights will mean in practice for MiP members.

The Employment Rights Bill (ERB) is in the final stages of its passage through parliament and is expected to become law this autumn. In this article, we summarise the proposed changes to unfair dismissal rights, employer's duties to consult over redundancy and protection from discrimination—as well as improvements to 'family friendly' rights.

Claiming unfair dismissal from day one

One of the ERB's key features is giving employees the right to claim unfair dismissal from day one of their employment. An employer must act 'reasonably' when dismissing someone for one of the five 'fair' reasons: conduct, capability, redundancy, breach of a statutory duty or 'some other substantial reason' (SOSR).

During the 'initial period of employment' (IPE), regulations—to be made once the bill is passed—will set out a 'light touch' procedure which employers must follow before dismissing an employee. The light touch approach will apply where the reason for dismissal is anything other than redundancy. The duration of the IPE will also be set in regulations, but is expected to be nine months.

This effectively introduces a probationary period during which it may be easier employers to dismiss an employee except for redundancy. But staff with less than two years' service will not qualify for statutory redundancy pay. They may claim a basic award if they are dismissed unreasonably on grounds of redundancy during their IPE, but a lower level of compensation may apply, because the secretary of state has the power to specify a different level of compensation for employees dismissed during their IPE.

During the report stage, the House of Lords tabled an amendment to introduce a six-month qualifying period for unfair dismissal claims, but this is unlikely to be accepted when the bill returns to the Commons, as the 'day one' right is a Labour manifesto commitment.

According to the government's implementation roadmap (mip.social/erb-roadmap) the right to claim unfair dismissal from day one is not expected to come into force until 2027.

Collective redundancy

The ERB makes significant amendments to the duty on employers to consult the appropriate representatives (e.g. unions) if it proposes to dismiss 20 or more employees at one establishment within a 90-day period. Subsequent regulation will set a new threshold for employers proposing to dismiss employees across the business at different sites or workplaces—this could be a percentage of the workforce or a specified number higher than 20.

Under the ERB there would be no need for an employer to consult all employee representatives together, nor to reach the same agreement with all representatives. The bill also increases the level of a protective award—where the employer fails to comply with the consultation requirements—from 90 to 180 days' pay.

According to the roadmap, the changes to protective awards will take effect from April 2026, while the additional threshold for collective redundancies across different workplaces will come into force in 2027.

Discrimination protection and 'family friendly' rights

Under the bill, employers will be liable for harassment of an employee or job applicant by a third party—a patient for example—where it takes place during the course of employment and the employer failed to take all reasonable steps to prevent it. Regulations will specify what reasonable steps an employer should take to prevent both third party harassment—and sexual harassment in general—at work.

Any agreement, such as a settlement agreement or a contract of employment, which prevents a worker from making or disclosing an allegation of harassment or discrimination will be void.

The right to request flexible working will also be strengthened, by shifting the burden to the employer to explain why it is reasonable to refuse a request on one of the eight statutory grounds.

The bill also gives employees the right to paternity leave and unpaid parental leave from day one, and introduces a new right to take one week of unpaid bereavement leave, which will also apply to pregnancy loss earlier than the 24th week. //

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

Working in the grey: how to manage uncertainty

Leadership coach and former senior detective **Andy Cribbin** gives his tips for managers on making effective decisions with limited information, while navigating the uncertainties of rapid change.

Right now, NHS leaders are being asked to make long-term decisions when even the immediate working landscape is uncertain. To make informed choices and defensible decisions in this situation, leaders need to capture all the available data, identify gaps and work through the possible scenarios.

1. Stick to your values

Stay aligned with your core principles and those of your organisation. Your values should be at the heart of your decision making; using them as guiding beliefs will help you make better choices. When you get it wrong—as we all do sometimes—if your rationale shows that you were acting with honesty (no hidden agenda), integrity (no personal gain) and transparency (clear documented reasoning), it will be easier to defend your decision under scrutiny.

2. Focus on your goal

What's the objective? What's your end game? Keep your focus on what you want to achieve. There will always be compromises and changes to your plans, but these should not be to the detriment of the required outcome. Defining what success looks like will help you to filter out any distractions.

3. Assess what you know

How reliable is the information you're working with? Is it from a trustworthy source? If it's anonymous or untested, be clear about that and give it less weight than something that you know is true without reservation. Document what is fact, any constraints and your working assumptions.

4. Hypothesise

Using hypotheses allows you to make educated guesses to guide your decision-making. They serve as initial explanations based on your existing knowledge, helping you to predict outcomes and test assumptions. By narrowing possibilities and focusing your attention, hypotheses can reduce uncertainty, enabling quicker, more strategic choices. Well-formed hypotheses provide direction and can be refined or discarded as new data becomes available.

5. Find your experts

If you're unfamiliar with the area, which experts can help? They can't and won't make decisions for you, but they'll give you a strong foundation to work from, providing new possibilities or ruling out some of your initial hypotheses. Seeking a range of views and opinions will help you to see things from different perspectives.

6. Assess the urgency

Is the risk and threat posed by the problem so great that you need to make a decision now? If not, when do you need to make it? How much time have you got to think it through and gather more information? Some of my best decisions were made the following day; it's amazing how your mind works, even when sleeping, so that something that seemed complex can suddenly seem straightforward 24 hours later. But equally, a timely decision can be better than a seemingly perfect one taken too late.

7. Keep doing the basics

With challenging decisions, it can be tempting look for a different approach to your normal one. This may be necessary sometimes, but sticking to your tried and tested methods can help bring clarity and confidence to your decisions.

8. Own your decisions

A wrong decision can be justified based on the information known at the time and the reasonableness of your decision. Own it, don't try to pass the blame or make excuses. When you become aware of new information, review your original decision and don't be afraid to change it if necessary. Learn from results and adapt.

9. Evaluate risk

Consider worst-case and best-case scenarios. Ask yourself: "what's the cost of being wrong?" If the consequences are serious, test small and use the results to verify your choice or amend where appropriate. Is not responding a worse outcome than taking action?

10. Trust your experience

The more limited the information, the more challenging the decision, particularly when the outcome is important. There is always a risk of procrastination and imposter syndrome creeping in. Remember you're in the job on merit and because of your past successes—be confident in your ability. If it's 'gut instinct', write down what's forming your view; this will help you to rationalise your thought process and support your choices. //

Andy Cribbin retired in 2021 as a detective superintendent after 30 years with Lancashire Police. He now provides leadership training and coaching for private and public sector organisations.

meetyour**reps**:**Karin Jackson**

"I've never seen people work as hard as they do in the health service"

Karin Jackson, an NHS senior executive manager and engineer, is making a big impact as MiP's new National Committee rep for Northern Ireland. She talks to **Craig Ryan**.

"We may be small, but if you've got a $20 billion Ferrari and can't put fuel into it, you're not going anywhere," says Karin Jackson, chief executive of the Northern Ireland Blood Transfusion Service (NIBTS). "If we don't deliver then the whole system stops."

It's Karin's job to make sure that doesn't happen. The service put out an urgent appeal this summer when a critical shortage of O-negative blood threatened to bring the NHS to a standstill. "The public responded and now our stocks are really healthy," she says. But that can change in a matter of days. Only 3% of eligible people give blood, she explains, and the big challenge is encouraging younger people to donate. England "has really struggled with this too, she says. "It's a global phenomenon."

But her biggest headache remains the "massive hole" in Northern Ireland's healthcare budget. "There's so much demand—we're meeting it in blood tranfusion, but we're creaking at the seams," she explains. Small organisations like NIBTS can be "agile" but also "very fragile", she says. "If someone falls over, for any reason, delivering the service becomes very difficult."

Before joining the NHS, Karin was an engineer at Ford plants in South Wales and Belfast. She says engineering gave her an understanding of "systems, process and flow", and evidence-based practice, that transferred well to healthcare. "Medics and engineers have either tension or affinity depending on which university you went to," she explains, "but I think it helped having... a fresh set of ideas and thoughts."

When Karin told her usually mild-mannered father she was considering studying accountancy instead of engineering, "because I'm a girl", he became "quite annoyed", she recalls. "I never want to hear you say that ever again. That's not a reason not to do it," he said. A female engineer was still seen as unusual at Ford in the early '90s, she says. "I used to say, 'I'm an engineer first and just happen to be female. For me, this is normal. It's the men who are used to dealing with other men who find my presence unusual.'"

Karin joined the Royal Hospitals in Belfast in 2002, working in research governance and medical education, then operational management. "Coming from the private sector, the perception was that you didn't really know how this place works," she recalls. But operational management is "all about guiding and encouraging people, making life a bit easier for them... whether that's in manufacturing or healthcare," she says.

> *// Resistance to change isn't consistent, even within individuals." People often "flip over" between enthusiasm and opposition, "and that's what I want to explore. //*

Twenty-three years in the NHS have shown her that "it's very fast moving—there's a huge amount of innovation that people aren't aware of," she says. "And in the private sector, I never saw people working as hard as they do in the health service."

Karin is no exception to that. Alongside her management career, she has already accumulated three masters' degrees in different fields. She ascribes her passion for lifelong learning to either "a deep psychological flaw—constantly wanting to catch up" or "a genetic predisposition" inherited from her father. "Every time I finish one, I say, 'never again'," she says. Inevitably, she's now embarked on a four-year doctorate in business administration at the University of Liverpool, with plans to research why people resist organisational change.

This isn't an abstract question for Karin; as director of the Pathology Blueprint Programme, she's working to bring all Northern Ireland's pathology services—including NIBTS—into a single organisation. What leads people to resist change is complicated: "resistance isn't consistent, even within individuals", she explains. People often "flip over" between enthusiasm and opposition, "and that's what I want to explore".

Karin is already having a big impact as MiP's new National Committee rep for Northern Ireland. Earlier this year, she was instrumental in breaking the long-running impasse that has left NHS senior executives in Northern Ireland earning significantly less than counterparts in the rest of the UK.

Karin worked with other unions, ministers and fellow NHS leaders to broker a "politically palatable" agreement, which saw many senior executives get substantial pay rises this year, narrowing the gap with England, Wales and Scotland. "Patience was running out. We'd been told for 20 years that this was going to be sorted out," she says. Members were in the "uncomfortable position" of contemplating industrial action, but as a cohort of 74 staff in a 40,000-strong workforce,"you don't have much leverage," she explains.

The successful negotiation has raised MiP's profile in Northern Ireland, leading to an influx of new members. As a union member since her early days at Ford, Karin says the deal proves that "the collective voice is far stronger than the individual... It demonstrated what you can do with visible trade union support and engagement." //

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