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healthcare manag

Mr Brightside
Providers chief Daniel Elkeles sees green shoots as well as warning signs for England's NHS

Taking different roads
What's at stake for the NHS as Wales and Scotland go to the polls in 2026?

NHS job cuts
How your union supports you and how to support each other

Going-pro with co-pro
Does 'co-production' mean anything in the NHS?

The union for senior health & care managers

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healthcare manager

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The NHS in England has been given a lot of priorities: cutting waiting lists, delivering record productivity gains, setting up neighbourhood services, linking up IT systems, getting our heads round AI, improving outcomes, reducing health inequalities and—I almost forgot—implementing the unimplementable in the shape of the Ten-Year Plan.

But it turns out those weren't the priorities after all. Since launching its reforms in March, the government's priority, first, last and always, has been cutting costs and, particularly, management jobs.

But here's the rub: none of those things above—not a single one—can be done without managers. They all demand your know-how, your experience, your people skills, your capabilities in budgeting, planning, operations, data and tech—in short, your sheer nous for getting things done.

This government has a worrying habit of making life difficult for itself and this is the example *par excellence*: it is making a priority of making its priorities harder to achieve.

Ministers will realise this soon enough, but for now they're doubling down on their mistakes. The 'clawback' rules written into the national voluntary redundancy scheme *(see page 5)* will drive many skilled and experienced managers not just out of the NHS, but out of public service altogether.

No doubt the government wants to avoid nasty headlines about "payoffs" in the *Daily Mail*. Hard truth: it will get them anyway. The scheme will save peanuts and cost far more in the long-run as we shell out for expensive consultants to plug the skills gaps the NHS has opened up for itself.

To those of you choosing, probably reluctantly, to end your NHS careers this festive season, our warmest thanks for your support for MiP and all you've done for the NHS and our country. I wish all readers a very happy Christmas and a great new year—after all, it's hard to believe 2026 could be worse. //

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

Green light for job cuts—page 4

MPs slam NHS reforms—page 6

NHS pay latest—pages 6-7

Climate change

NHS on target to reach net zero by 2040

The NHS has reduced its carbon footprint by 68% since 1990 and is on target to reach net zero by 2040, according to the latest progress report from NHS England.

Emissions controlled directly by the NHS were down 14% in the last five years, the report found, meaning the service is also on track to meet its interim target of an 80% cut from 1990 levels by 2032. The targets were set in 2020, when the NHS became the first healthcare system in the world to commit to achieving net zero within a defined timeframe.

But the report found less progress on the target to reduce 'NHS Carbon Footprint Plus'—which includes emissions by NHS suppliers—to net zero by 2045, with no reduction recorded over the last five years. NHS England said this was due to increased activity during and immediately after the pandemic and that emissions per patient episode have continued to fall.

"Despite the challenges over recent years, NHS staff have demonstrated extraordinary dedication. They have embraced sustainability principles, implemented impactful solutions and driven change," the report said.

The report, Five years of a greener NHS: progress and forward look, *is available at: mip.social/nz-2025.*

noticeboard

15 January 2026

NHS Employers: AI & Recruitment webinar

Online, 1pm

Learn more about the impact of AI on recruitment and what it means for NHS people managers. Lead by actual humans: industry expert Matt Burney and NHS Employers director Caroline Waterfield.

nhsemployers.org/events/ai-and-recruitment-what-it-means-skills-people-team

12-14 February 2026

UNISON National Women's Conference

ACC Liverpool

unison.org.uk/events/2026-nwc/

24 February 2026

NHS Confederation 'Care Closer to Home' Conference

London

Bringing together NHS leaders to discuss practical solutions for delivering the government's ambition to move "care closer to home". Speakers include outgoing Confed chief Matthew Taylor and Dr Buki Adeyemo, chief exec of the North Staffs Combined Healthcare trust.

nhsconfed.org/events/care-closer-home-conference-2026

27 February 2026

NHS Providers Masterclass: Using AI to improve Productivity in the NHS

Newcastle upon Tyne

Another day, another AI conference. This one aims to boost board directors' understanding of AI and give them the tools to maximise its potential to improve quality and productivity in the NHS.

mip.social/nhsp-ai

5-6 March

Nuffield Trust Summit 2026

Windsor

The think-tank's annual flagship event, brining together leaders and policy makers (as well as—you have been warned—"disrupters") to discuss the state of health and care and how tackle future challenges.

nuffieldtrust.org.uk/summit/nuffield-trust-summit-2026

19 March 2026

King's Fund Annual Leadership and Workforce Summit 2026

Central London

Meet with health and social care leaders to explore what compassionate leadership means in practice and how to lead create "cultures where people thrive". Expect "honest conversations, practical tools and fresh thinking," says the King's Fund.

kingsfund.org.uk/events/annual-leadership-workforce-summit

20-22 March 2026

UNISON Black Members Conference

Brighton Centre

unison.org.uk/events/2026-nbmc/

KEEP THE DATE

13-15 April 2026: UNISON National Health Care Group Conference, Edinburgh (unison.org.uk/events/2026-health-care-sg-conference/)

15 April 2026: NHS Confed Mental Health and Learning Disabilities Annual Conference, Birmingham (nhsconfed.org/events/mental-health-annual-conference-and-exhibition-2026)

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

MiP members elect new National Committee

MiP members have elected a new National Committee to serve for two years from January 2026, following two rounds of elections this autumn.

The National Committee oversees MiP's strategy, management and operations, supports the union's campaigning work and helps to shape member events across the UK. The committee is made up of workplace reps elected to represent constituencies for each English region and devolved nation, as well as NHS England.

MiP chief executive Jon Restell congratulated the successful candidates and said he was "delighted" with election results which saw a more seats filled than in previous years.

"Having a strong National Committee makes MiP a stronger union," he added. "The knowledge and insight of the incoming committee will be key in supporting MiP's campaigning work, our policy and how we organise during its two-year term."

The newly-elected National Committee will decide in the new year how the six still-vacant seats will be filled, but no further elections are planned in the immediate future. Elected members will serve on the committee until 31 December 2027.

MiP National Committee 2026-2027

NHS England:	**Yvonne Richards, Sajidah Ahmad**
North East:	**Clare Bannister**
North West:	**Jayne Thomas**
South Central:	**Prince Obike**
South West:	**Geoff Underwood**
Wales:	**Kath Charters, Helen Robertson**
West Midlands:	**Dave Whatton**
East Midlands:	**Alyson Taylor**
Yorkshire & Humber:	**Toni Yel**
London:	**Felix Peckitt**

Vacancies

Scotland (2 seats)
Northern Ireland (1 seat)
London (1 seat)
South East Coast (1 seat)
East of England (1 seat)

Estates

NHS faces new record bill for repairs to buildings

Imperial College Healthcare faces a repair backlog of £900m, including £425m at Charing Cross Hospital alone.

The bill for repairing dilapidated NHS buildings and equipment in England has soared to almost £16 billion—the highest level on record and more than the entire annual cost of running the NHS estate, new figures show.

The Estates Returns Information Collection (ERIC) report for 2024-25, published in November by NHS England, also shows a record £3.5 billion backlog of urgent repairs needed to avoid major disruption or a "catastrophic failure of services".

At £15.9 billion, maintenance backlog for NHS trusts has increased by 16% since 2023-24 and more than doubled in five years. It now exceeds the £14 billion annual cost of running the NHS estate, the ERIC report found.

Imperial College Healthcare, facing a potential bill of £902 million, had the largest backlog, followed by Guy's and St Thomas' (£532 million) and Barts (£523 million). The largest maintenance backlog outside London was at Nottingham University Hospitals (£443 million).

NHS Confederation chief executive Matthew Taylor said the figures were "worrying but not surprising" as the NHS had been "starved" of capital investment for more than a decade.

He welcomed new capital investment announced in the spending review earlier this year, but called on ministers to lift restrictions on trusts accessing private capital for new buildings, which he said would "free up public funding to tackle the maintenance backlog".

Commenting on the figures, King's Fund director of policy Siva Anandaciva warned that the maintenance backlog had a real impact on patients and staff: "It means one staff toilet shared by 35 staff in a GP practice. It means ligature points left in mental health facilities. And it means you can spend years on a waiting list," he said.

NHS job cuts

Government gives green light to thou of NHS redundancies in England

ISTOCKPHOTO

The government has finally given the go-ahead to plans make up to 18,000 staff in Integrated Care Boards (ICBs) and NHS England redundant as part of its controversial shake-up of the health service in England.

Plans to abolish NHS England and cut ICB staff by half, announced in March 2025, have been on hold for several months during a long-running row between the Department for Health and Social Care (DHSC) and the Treasury over the expected £1 billion bill for redundancy payments.

The deadlock led to NHS England chief executive Jim Mackey telling staff in October there was no longer a "rush" to make staff redundant, describing the restructure as "more of a gradual, managed process". The abolition of NHS England, which is due to be merged into the DHSC, was postponed until at least April 2027, while the ICB restructure was expected to spill over into the 2026-27 financial year.

But the funding breakthrough, announced in November, led to ICBs being told to complete their redundancy programmes in this financial year, as originally planned.

MiP said the months of delay had caused "avoidable distress to our members as working people" and put ICB leaders in an "intolerable" position. "The government should have started the next phase of these changes by apologising to our members and their leaders," said the union's chief executive Jon Restell.

Under the funding deal, the Treasury will not provide any new money for redundancies, but will allow the DHSC to overspend its 2025-26 budget by £1 billion to fund redundancy costs—on the understanding that the overspend will be

Government staffing plan for England delayed

The government has delayed the unveiling of its new workforce plan for the NHS in England until spring 2026, following demands for more consultations from health groups and trade unions.

The government had planned to publish the ten-year strategy this autumn, but only began consultations at the end of September after a coalition of 74 organisations, including unions, employers' bodies, royal colleges and think tanks, wrote to ministers calling for a "robust stakeholder engagement process".

Announcing the delay, health minister Karin Smyth said: "We have been struck by the enthusiasm of staff, the sector, stakeholders and colleagues in sharing their thoughts. Many of them have expressed that they would like more time to have conversations, test ideas

ZUMA PRESS

Health minister Karin Smyth: stakeholders "would like more time" to consider workforce plans.

sands

recouped in future years—essentially an advance rather than new funding.

Many ICBs have already begun consultations with trade unions, which are set to run through the Christmas period and into the new year. NHS England has instructed ICBs to only use the national model voluntary redundancy scheme (see opposite)—the core elements of which cannot be changed.

Both Commissioning Support Units, also due to be shut down under the reforms, and NHS England itself must also use the model scheme for staff exits. For NHS England staff, the application window for voluntary redundancy opened on 1 December 2025.

Restell warned "the rush to make people redundant by April" would "create big risks" for employers and staff, with consultations set to begin "at the worst time of year". Despite the "breakneck speed" of the process and "many gaps in key information", MiP reps would still demand "meaningful consultation", he said.

"Members are very worried about business continuity and safety during the transition—some functions may collapse—as well as long term damage to the capacity needed to deliver the Ten-Year plan," he added.

and work together to deliver a truly reformed service."

The new plan will replace the 2023 strategy devised by the previous Conservative government, which was widely criticised for its lack of consultation and questionable assumptions, and dismissed by Labour ministers as "fiction". The government has said its new strategy would plan for fewer staff than previously projected, with more flexible working, better training and "more exciting roles".

Voluntary redundancy

Unions refuse to back "grossly unfair" voluntary exit scheme for ICB and NHS England staff

NHS trade unions, including MiP, have refused to endorse NHS England's national voluntary redundancy (VR) scheme, describing some aspects of the scheme as "grossly unfair" and warning of "potentially serious" tax implications.

Unions were consulted on the terms of the VR scheme, launched in November as part of government plans to cut ICB staffing by half and abolish NHS England, but say many concerns about the scheme were ignored, and that it offers worse terms than comparable public sector VR programmes.

The unions particularly objected to the 'clawback' rules—a mechanism used by the Treasury to recover redundancy payments from former staff who find a new job in the public sector.

Under the new scheme, all staff who take voluntary redundancy will have to pay back a portion of their redundancy pay if they take a job with an NHS employer, an arms-length-body or a government department within six months. In previous VR schemes, the clawback rules have only applied to redundancy payments of over £100,000.

For very senior managers in ICBs and trusts, and executive senior managers working for NHS England, the clawback period will be extended to 12 months.

Commenting on the scheme, MiP chief executive Jon Restell said: "The clawback terms, apparently a Treasury red line, are the toughest ever sought, and many members are unclear what 're-employment in the public sector' means in practice."

Unions have also raised concerns about the impact of the scheme on staff who have used flexible retirement options, such as partial retirement and 'retire and return'. Under the national scheme these staff would lose their reckonable service when calculating redundancy payments, something MiP has called "grossly unfair" and called on the government to address. The model scheme also does not allow for payment in lieu of notice (PILON) and prevents staff from negotiating their own exit dates.

"The clawback terms, apparently a Treasury red line, are the toughest ever sought, and many members are unclear what 're-employment in the public sector' means in practice."

"The national VR scheme, which unions refused to agree, will add problems to the mix," added Restell. "PILON is not allowed and the tax implications of post termination payments for untaken notice are potentially serious. Partial retirement exclusions from contractual redundancy terms are grossly unfair and the issue needs an urgent decision by the department."

While the Treasury insists that these terms are non-negotiable, trade unions will still demand "meaningful consultation on schemes locally", Restell said. "We welcome Jim Mackey's willingness to reset the relationship with the unions around these changes."

MiP is working with its workplace reps at ICBs to respond to local consultations and will keep members updated throughout the process. In organisations where consultations have been completed, such as NHS England and Commissioning Support Units, MiP urged members to consider their circumstances "very carefully" before applying for voluntary redundancy. "Whether you choose to go or stay, you will be supported," the union said.

Executive pay

Urgent action needed to retain and recruit senior NHS leaders, MiP warns

NHS leaders are experiencing more work-related stress and lower morale, and are increasingly likely to want to leave their jobs—with the government's sweeping reforms of the NHS in England a major factor—according to a new MiP survey.

The survey, part of MiP's evidence to the Senior Salaries Review Body (SSRB), which recommends executive NHS pay levels in England, found that over two-thirds of board-level managers felt unwell due to work-related stress in 2025—up from just over half last year—with 72% going to work despite feeling ill.

Nearly three-quarters say the government's reorganisation of the NHS is undermining their ability to focus on patient priorities. "This is the most unsettling and chaotic time I have experienced in my 25-year NHS career," one respondent said.

MiP's evidence said morale among board-level managers is now at its lowest point, with less than a third saying they "always" or "often" looked forward to going to work—down from nearly half last year. Only 5% believe politicians value their work and many said that negative rhetoric is further damaging morale. "The NHS is a toxic environment right now," one member said.

More than half (55%) frequently think about leaving their job, with 49% currently job-hunting and over a third (35%) intending to leave as soon as possible, the survey found.

MiP also warned that the pay overlap between executive and Agenda for Change grades has reached a "tipping point",

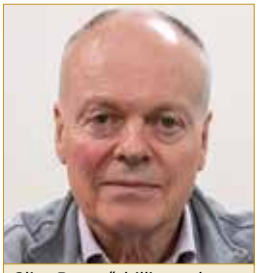
NHS reforms

Government shake-up risks "significant" harm to patient care and NHS staff, MPs say

An influential committee of MPs has strongly criticised the government for "poor practices" during its restructuring of the NHS in England, which it warned could have a "significant negative impact" on patient care and NHS staff.

A report from the cross-party Public Accounts Committee (PAC), published in November, said it was not "prudent" to restructure ICBs and abolish NHS England without first securing funding, conducting an impact assessment or "taking other steps to safeguard value for money."

It warned that "poor practices" with previous troubled government projects, like the New Hospitals Programme (NHP) and the HS2 railway network, "are being replicated here and will lead to wasted effort". The MPs called on the Department of Health and Social Care (DHSC) to stop making "unfunded announcements" and to publish the costs of the reforms, together with a full impact assessment.



Clive Betts: "chilling echoes of past failures".

ALAMY STOCK PHOTO

The committee also criticised NHS England for not being "realistic about the immense effort needed to reduce NHS elective care waiting times" and warned of a "significant risk" that AI and digital solutions were being treated as a "cure-all" in government plans. NHS England's approach to transformation was "deeply flawed in both monitoring of progress and the delivery of intended outcomes," the PAC said.

PAC deputy chair Clive Betts MP warned there were "chilling echoes of past failures on HS2 and the [NHP]" in the way the government had handled the reforms. "Our committee has long established that large unfunded commitments, without plans for delivery, while good at generating headlines, can only end one way," he said.

Commenting on the report, Dr Hugh Alderwick, director of policy at the Health Foundation, said the government's decision to restructure the NHS when it was "under massive pressure" was "risky, at best, given experience from a long line of previous reorganisations suggests they cause widespread disruption, take years to deliver, and rarely deliver the benefits policymakers expect."

A survey published by the NHS Confederation in November found that ICB leaders saw the government's reforms as the biggest barrier to improving local services—and a worse problem than funding shortages or rising patient demand. Continuing healthcare and safeguarding were the functions most likely to be cut due to the reforms, the survey found.

At the time of going to press, the DHSC had not commented on the PAC report but it is expected to give a formal response to MPs in the new year.

Read the PAC report, Reducing NHS waiting times for elective care, *at: mip.social/PAC-2025.*

threatening retention and the "natural pipeline" for senior roles. Only one in five executives surveyed were satisfied with the pay gap. Some long-serving executives now earn less than AfC Band 9 colleagues and the lack of on-call payments means the real overlap is even greater.

Only 2% of respondents said the new VSM pay framework, introduced earlier this year, made them feel more motivated, while more than a third said it had the opposite effect. Many criticised the link between organisational performance and annual pay awards, describing the framework as "punitive" and "manager-bashing".

Not a single respondent said the new pay system would make them more willing to take a job at a struggling organisation—a declared aim of the framework—while a third said they would now be less willing. Respondents described the two-year incentive period as "unrealistic", as turnaround efforts typically require three to five years.

MiP also called for automatic adoption of annual pay awards by employers, arguing that the new pay framework—which allows for locally-determined bonus payments in certain circumstances—had failed to take the "subjectivity and politics out of pay decisions".

Several respondents said "the optics" of executive pay rises were still difficult for trusts to manage. "My trust is subject to an inquiry into care failures, is losing a thousand posts and has Band 2 staff struggling to make ends meet," said one. "Most remuneration committees will feel obliged to do nothing other than implement a nationally-mandated award."

Read MiP's evidence to the SSRB in full at: mip.social/ssrb-2026.

Executive pay: MiP's Recommendations for 2026

- **A meaningful pay rise for all VSMs and ESMs**
- **A review of the new link between basic pay awards and organisational performance**
- **Raising the VSM/ESM band minima to eliminate pay overlaps with Agenda for Change**
- **Eliminate or reduce local discretion when allocating national pay awards**
- **Clear pay progression, related to appraisal outcomes**
- **Incentives for leaders taking on struggling organisations to be extended over a realistic time period**
- **Action to reduce the unpaid overtime VSM/ESMs are regularly working**
- **On-call payments for executive managers, in line with Agenda for Change and medical colleagues**

Agenda for Change

Government proposal for sub-inflation pay rise "not good enough", says MiP

Pay rises for most NHS staff in England should be restricted to an "affordable" 2.5% next year to deliver improvements to NHS services and avoid "difficult" trade-offs, the UK government has said.

In their evidence to the NHS Pay Review Body (PRB) for 2026-27, ministers said a rise above 2.5% would "affect the ability of the NHS to maintain or expand staffing levels".

Despite inflation running at 3.8%, the government claimed 2.5% is the maximum that could be afforded within the departmental limits set in this year's spending review. "Further pay awards above what is considered affordable will require difficult government trade-offs from within existing... budgets, including a reduction in ambitions for service or performance improvement," it said.

The evidence also indicated that the government would propose the same 2.5% pay rise for very senior managers in the NHS in England, who are covered by the Senior Salaries Review Body *(see above)*.

NHS trade unions—who have boycotted the PRB process since 2023—described the government's pay proposals as "not good enough" and an "insult".

MiP chief executive Jon Restell said: "Ministers had an opportunity to show staff that they are indeed valued by offering a fair pay rise, but this below-inflation figure comes nowhere near achieving that. It's frankly not good enough.

"The government's chaotic reorganisation of the NHS in England has meant staff have had a miserable year. Morale is rock bottom throughout the system," he added.

UNISON's head of health, Helga Pile described the proposals as "the final nail in the coffin" for the PRB and called for direct pay talks between NHS unions and ministers.

"Yet again ministers are trying to get away with giving staff a way-below-inflation pay rise. This is an insult," she said. "It will go down badly right across the NHS, just as workers are bracing themselves for the challenges of winter."

The PRB covers staff on Agenda for Change (AfC) grades in England, Wales and Northern Ireland. In recent years, it has recommended pay rises slightly higher than the UK government has claimed to be affordable, but each government can decide independently whether or not to accept the recommendations.

The Scottish government doesn't take part in the PRB process and negotiates pay directly with NHS staff and unions. Earlier this year, it agreed a pay deal worth 8% over two years with an "inflation guarantee".

Following the 2025 PRB report, published in May, the UK government committed to negotiate with unions to resolve long-running structural issues with the 20-year old AfC pay framework—including grading errors and compression of the pay bands, which discourages promotion—but talks had yet to begin at the time of going to press.

Restell described the continuing delay as "another kick in the teeth for staff". He added: "If the government are serious about fixing the NHS for patients and staff then these talks must start well before the pay award is due."

Read the UK government's review body evidence at mip.social/prb-gov-2026.

Rushing headlong into the dar

Despite the upbeat speeches from Wes Streeting and Jim Mackey, managers and leaders still have few clues about where England's NHS is heading, writes Geoff Underwood.

As I approached the revolving doors to leave the NHS Providers conference a few weeks ago, I asked one of the security staff if it was still raining. "It's Manchester," he said cheerfully, "it's always raining."

It was dark by the time my train pulled out of Manchester Piccadilly. After we'd left the city lights behind we kept on charging forwards but I couldn't see where we were going. Peering into the gloom it was difficult to see any signs of progress. I settled in as best I could for a long, uncomfortable journey and hoped the train operator would stick to the timetable they'd set out.

The auditorium had been well-lit earlier that day when Wes Streeting and Jim Mackey made their speeches, but I had struggled even more to see where the NHS was going—and felt even less hope that they would stick to the timetables they'd set out.

Regret, but no apology

In the weeks since, I've thought a lot about my experience watching those speeches. Sitting in the third row, I felt overwhelmingly angry and I've been trying to understand why.

My feelings of anger didn't come directly from what they said. The speeches were largely upbeat and positive and I generally like that approach from leaders. Debriefing with MiP chief executive Jon Restell afterwards, I recognised there were parts of both speeches I liked. They both acknowledged that people in the NHS, particularly in ICBs and NHS England, have been dealing with "uncomfortable" uncertainty about the reorganisation for too long. I didn't hear an apology, but I heard regret and some admission of responsibility from Wes Streeting as the minister in charge.

When asked about the impact on NHS staff of more racist rhetoric and behaviour, Jim Mackey was loudly applauded for setting out a very clear anti-racist position and for his unequivocal support for all NHS staff. Wes Streeting got slightly less applause for saying that the BMA was acting like a cartel and threatening the future of the NHS with their approach to negotiations over pay and conditions for resident doctors, but there was some support for his position in the room.

No, it wasn't what they said that made me angry. My anger came from the huge disconnect between their positive words and the confusing and damaging action they are taking. Here are three examples.

Trust issues

First, they say a key aim of their restructure is to cut bureaucracy. They are certainly planning to cut people—18,000 working people—but they argue that merging NHS England and the Department for Health and Social Care will remove a whole layer of duplication. But as they develop their new operating model they're adding layers too.

On the day of his speech, Wes

announced a new Advanced Foundation Trust Programme, revealing the eight trusts that will be the first to be assessed for this new status next year. Details published by NHS England (see mip.social/AFTs) confirm that existing NHS trusts and foundation trusts will be able to apply to become advanced FTs, which "will also have the opportunity to be designated as eligible to hold an integrated health organisation (IHO) contract to oversee the health budget for a defined local population".

So, the future operating model of the NHS won't just have trusts and foundation trusts. We'll have trusts, foundation

rk

Geoff Underwood is a programme director at NHS South, Central and West CSU and chair of MiP's National Committee.

NIGHTHAWKSTUDIO ON UNSPLASH

trusts, advanced foundation trusts and advanced foundation trusts designated as eligible to hold an IHO contract, which will make them a kind of local commissioner, presumably alongside ICBs as strategic commissioners.

The future operating model looks more complicated and more bureaucratic to me, and more likely to slow the pace of change than to speed it up. In my experience, any "opportunity to apply to be designated" as anything means a whole lot of paperwork, a whole lot of meetings, and a whole lot of time and resources sunk into a bureaucratic process which won't directly deliver value to the population in itself.

Why add this whole advanced FT layer in at all? If you really want providers with IHO contracts to duplicate the role of ICBs, just cut out the advanced middle man and let existing trusts and FTs apply.

Talking a good game

Second, they say they want to end micromanagement from the centre. But this comes from the same people at the centre who have told every trust and every ICB in the country exactly how much of their budgets, down to the penny, per head-of-population, they're permitted to spend on management and running costs. This is micromanagement on a national scale. Macro-micromanagement, you might say.

They talk a good game about ending short-termism and ad-hoc demands. But they published the Medium-Term Planning Framework on 24 October, asking for the first draft of three-year plans for activity, performance, workforce and revenue to be handed in by December. Basically about six weeks' notice to plan the next three years.

Third, Wes Streeting said this in Manchester: "plans don't deliver change, people do". He's absolutely right, but he's treating the people who deliver change in the NHS appallingly.

> **"For all the nice words from Wes about valuing people in the NHS, I can tell you from my own experience that morale in the four CSUs, the ICBs, at NHS England and in many trust HQs is at an all-time low. And there is no end in sight to this disappointing, soul-destroying chaos.**

He and Jim Mackey have pulled the rug out from underneath every strategic leadership team in the NHS. Think about it—every trust (advanced, foundation or otherwise), every ICB, every part of NHSE and DHSC and pretty much every arm's length body, including the CSU that I work for, is losing hundreds, if not thousands, of staff or being closed altogether. These are the teams who will actually change the NHS from analogue to digital, from hospital to community and from illness to prevention.

Disappointing, soul-destroying chaos

Wes made his cheerful speech the day after it was confirmed that NHS England intends to cut 18,000 working people out of the NHS. This includes the teams that have been asked to write the three-year plans by Christmas. But now, as well as getting all that planning done, many will have to make some time in the first fortnight of December to decide whether they want to apply for voluntary redundancy.

That includes me. I work for a Commissioning Support Unit which is scheduled to close by March 2027. We know CSUs will close, but one sentence in the Ten-Year Health Plan was all the detail we were given. My colleagues are working flat-out to find alternative homes for our thousands of people, but as things stand I have no idea at all whether there will be a job for me in the future NHS or what it might be. This month, I will be asked if I'd rather leave than wait to find out.

For all the nice words from Wes about valuing people in the NHS, I can tell you from my own experience and from my conversations with MiP members every day, that morale in the four CSUs, the ICBs, at NHS England and in many trust HQs is at an all-time low. And there is no end in sight to this disappointing, soul-destroying chaos, as the restructures and closures are going to carry on until at least 2027. Like Jim said in October, there's no rush.

In my mind, I'm still on that train from Manchester, hurtling forwards in the dark to a future I can't see, while Wes and Jim are still laying out the track ahead and announcing things like new Advanced Train Stations. I just hope enough of us can stay on the train until it stops somewhere the NHS needs us to be. //

Let's remind ministers and the top brass why they need managers

In 2025, the UK government took us into the habitual NHS dead-end: cuts to management and non-clinical staff, disruptive system change and unexpected, complex legislation—leading to the NHS losing the skills, experience and goodwill of many dedicated public servants. All this in a service widely seen as needing more good management to solve its problems. We may have crawled at a snail's pace into that dead-end, but that's where we've gone.

The decisions in March were a big mistake and a big gamble. The execution since has been "terrible"—Jim Mackey's word, not mine. Stand by for a post-mortem book called *Never Again... Again* and whack another five years onto the Ten-Year Plan.

We hear ministers are worried about the planning for key goals like neighbourhood healthcare. But they shouldn't be surprised. We know from experience that the opportunity cost of a major NHS 'reform' is extremely high in terms of doing the things the public actually wants done.

I don't believe this is where Wes Streeting wanted to be when he became health secretary. Most MiP members will support a smaller, more strategic centre, more freedom for local managers and broadening the planning horizon with multi-year settlements. On the other hand, his record on manager-bashing is far from perfect—especially talk about "unnecessary bureaucracy"—and even worse are the arbitrary cuts to management and the system chaos he's unleashed.

Management regulation, the VSM pay framework and a leadership college are evidence that ministers are more interested in management than their predecessors. But they don't yet add up to a comprehensive workforce plan for managers. So before they make any more fateful decisions, let's remind ministers and the top brass why they need managers. Here's a list to help.

Managers get things done. They make sure money is used better, organise services to reduce waiting lists, improve patient access and safety and deploy potentially transformative technology like AI. The core balancing act between quality, safety, effectiveness, the proper stewardship of public money and a good workplace is down to managers.

Managers protect the front line. They make sense of a thicket of regulation and directives, shielding staff from the worst effects. Managers support and co-ordinate clinicians' work and ensure the burden of administration does not fall on doctors and nurses.

> "Managers are motivated by a strong public service ethos and dedication to patient care. The strength of the NHS model— still backed to the hilt by the British public— depends uniquely on managers' work.

Managers back the workforce. They solve problems for staff. Report after report has clocked good leadership—especially line management—as critical for an inclusive and diverse culture, flexible working, career development and better performance. Managers are leading the response to the growing racism directed at NHS staff.

Managers take a system view. They plan sustainable improvements and support clinicians in improving patient care and experience, and in reducing inequalities. Managers are the NHS workers who lead the effort to turn the government's ambitions for transformation into reality.

Managers are experts. The NHS nurtures management in all its forms. Managers come from many disciplines and walks of life, bringing their particular skills, knowledge and experience to their management roles. Many talented clinicians go into full-time management or have a management element to their job.

Managers are NHS workers. Studies show NHS managers are motivated by a strong public service ethos and dedication to improving patient care. The strength of the NHS model, still backed to the hilt by the British public, depends uniquely on managers' work.

The evidence is there if ministers want to look. Kirkpatrick and Maltby's 2022 study found even a small increase in managers (from 2% to 3% of staff in an average acute trust) "had a marked impact." Larger management cohorts in trusts "were associated with higher patient satisfaction scores, a 5% rise in hospital efficiency and a 15% reduction in infection rates." The study showed these improvements were driven by having more managers, not the other way round.

MiP wants 2026 to be the year when the NHS and its political leaders finally accept the case for investing in, valuing and supporting managers. Everyone in your union thanks you for your work and wishes you a peaceful and enjoyable festive season. //

“There’s a lot of green shoots here—the NHS is in a much better place”

TERI PENGILLEY/ UNP

Ahead of its planned merger with the NHS Confederation next spring, NHS Providers’ chief executive Daniel Elkeles tells *Healthcare Manager’s* Alison Moore that NHS trusts are “well placed” to deliver the Ten-Year Plan—but warns an unhappy workforce and a lack of investment still could throw spanners in the works.

It’s easy for people working within the NHS to be pessimistic about the future: tight budgets for years to come, disruptive reorganisations and access targets which seem unrecoverable are just a few of the issues managers face as they enter what is expected to be another challenging winter.

But Daniel Elkeles, chief executive of NHS Providers is optimistic–even Tiggerish—about the slightly longer-term future. In particular, he sees reasons to be cheerful in the recently published annual survey of the organisation’s members.

“In general, people are saying we think the quality of healthcare we’re providing has gone up, more than half of providers say they will hit their financial plan and optimism is quite high,” he says. “There’s quite a lot of green shoots here and the NHS is feeling in a much better place to deliver on the aspirations of the Ten-Year Plan.”

Even productivity—seen by the government as the NHS’s Achilles

heel and the key to unlock more funding—can be improved, he insists. "We have this amazing gift called artificial intelligence, which in everyone's normal life we use all the time... but the NHS hardly uses any of it," he says, pointing to what he sees as significant jumps in productivity where AI systems have been deployed. "But we're going to need a really clear programme on how we do that and we do need some money up front," he warns.

Elkeles suggests the NHS could leapfrog some technologies, as happened in parts of Africa where fixed telephone lines were never widely used and people moved straight to mobile phones. "There are all these technological jumps where you can avoid a huge amount of cost... the NHS is so far behind that the leap to get it to be modern is much less difficult than we imagined it," he explains.

While he concedes there is less money around than under the 1997-2010 Labour government, small amounts of investment can make a big difference in some areas, he says. "It's possible to do this without pump priming—you can do the maths which says that if [you] close a ward and spend money in the community, you get payback in a year. But you can't do that everywhere."

So some money will be needed to make the three shifts, he argues. The Providers' recent report on capital investment (mip.social/nhsp-investment) pointed to local authorities as the potentially the best additional source of capital for the NHS.

Placing NHS facilities in town centres can make a big difference to urban regeneration by boosting footfall, Elkeles explains. "If we could put a community diagnostic centre, a GP surgery, a child health clinic on every high street it would really be a big catalyst for growth... a lot of local authorities would say they could get the money to make this happen."

But government rules limiting each department's capital spending still get in the way of schemes which otherwise make sense, he warns. "This is not helping anyone. The public want to feel they live in a place which is prosperous, [where] they feel richer with lots of positive vibes... and here we are in the NHS able to create that. It's not logical. It's entirely within the government's gift."

There's no lack of will to innovate in the NHS, he claims. Since he took the helm of NHS Providers in May, Elkeles has visited 30 organisations around the country, asking each to show him a service they're proud of.

"What is totally extraordinary and wonderful is that everyone I have been to can show you something which is totally outside the box but which will deliver a bit of the Ten-Year Plan. What they're doing is the three shifts in action," he says.

"What you need to do is unleash the ability of people to do things. In the old regime, people who innovated did it despite the rules... I think the Ten-Year Plan is giving permission to create a framework which will make this all much easier."

But industrial action—a "big, big worry" for member organisations, he says— could still be a fly in the ointment. "Every time there's a week of industrial action the amount of effort that has to go into planning to keep patients safe, the amount of backfill and the opportunity cost of having to focus on that is massive.

"The survey is definitely showing that people are really worried about their workforce," he continues. "We've got high levels of stress, of burnout... [and] sickness rates have not fallen." Solving the NHS's workforce problem will require "really mature conversations" with trade unions and the government "about what in reality is possible", he says.

In the longer-term, he suggests that an AI-driven boost to productivity could lead to fewer but more highly paid staff—but admits reducing staffing levels would be difficult with more than seven million people on NHS waiting lists. The NHS must "get waiting times massively down" he says, which in turn will have a positive impact on economic growth.

Despite all the headaches they face, Elkeles insists senior managers remain passionate about the NHS. "These are really challenging difficult roles to do and given how complex and complicated it is we should be pretty admiring of the quality of leadership the NHS delivers," he says.

So should the NHS be paying chief executives more for running such complex organisations? "How different is a train franchise coming back into the public sector to an NHS provider, how different are utility companies?" he replies.

"I think what you discover is that healthcare is paid a lot less than a whole heap of people in other industries where I am not convinced that the jobs are so very different in scale and complexity," he says before adding quickly that evidence from another recent NHS Providers survey showed that managers are broadly satisfied with their pay.

Elkeles says the increased emphasis in recent years on providers working together means more clarity about the direction of travel for NHS organisations. How providers collaborate has already changed—horizontal and vertical integration and groups, for example—and this will continue, he explains, while stressing there is no single answer to what is the right configuration.

But he's hopeful that foundation trusts will get more autonomy. "When foundation trusts were at their best, they had less oversight and more ability to use their funds as they wished if they made surpluses," he says. "It's pretty clear that some of the oversight might not have been good as it should've been—and that lead to things like Mid Staffs."

He doubts we will go back to "such a relaxed regime" but giving trusts back the freedom to spend their surpluses would be "really powerful", he adds. "You want to put the incentive back—if you manage your resources well and you deliver good care, then there is an incentive to do something good for your organisation."

He is much more sceptical about the government's changes to public accountability in the NHS. With the removal of foundation trust governors and the abolition of Healthwatch, the NHS is losing "really valuable ways it can engage with

TERI PENGILLEY/UNP

Low paid staff deserve better—we can't run the NHS without them

A particular passion for Daniel Elkeles, a Cambridge history graduate, is rewarding low paid staff in the NHS. "We rely on a huge number of relatively low paid people to deliver a huge amount of care or to provide support services to enable other clinicians to provide care," he says. "You can't run the NHS without them—they are simply essential."

As chief executive at Epsom and St Helier's University Hospitals, and later the London Ambulance Service (LAS), he started the process of integrating thousands of staff who had been outsourced or were working for private companies into the NHS team. "It felt that the thing we could best do was bring them onto Agenda for Change and into the NHS properly," he recalls.

At LAS, this couldn't be done in one go, so Elkeles agreed a three-year transition with unions. "I think we created something really special. It was not perfect when I left, and there has been loads more work done in the last few months. But I think we did the right thing."

Many NHS trusts are now providing support services through wholly owned subsidiaries or 'SubCos', employing staff on different terms and conditions and frequently without access to NHS pensions. Here, Elkeles's view differs from 'corporate' view of his employer. NHS Providers, stressing the tough financial environment providers are working in, has been generally supportive of SubCos, which also offer tax advantages to trusts.

"My personal moral view is that if someone is working for the NHS, even through a SubCo, then they should have full access to NHS terms and conditions and the pension," he says. In the past, competitive tendering led to a "lowest common denominator" approach and undermined people's terms and conditions, he adds. "You have a second class set of people and you are perpetuating inequalities and poverty, because very often they have to rely on benefits," he adds.

"All of that feels rather unfair and morally wrong," he concludes. "The public sector should be a beacon and exemplar employer."

the public, users and local authorities to gauge how we are doing and what their needs are," he says.

The debate on accountability is not finished yet, he says—noting, for example, that everyone he has spoken to thinks staff governors are absolutely essential.

Closer to home, the merger of NHS Providers with the NHS Confederation means that all NHS organisations in England—commissioners and providers—will be represented by single body for the first time since 2011.

Who will lead the new merged body is not a done deal. Confed chief executive Matthew Taylor is standing down, but the top job at the merged organisation will be filled through an external competition, and Elkeles has already indicated that his hat will be in the ring. Much has yet to be decided, he says, but it's likely that the new body will aim to be cheaper for members who previously belonged to both—that could mean a smaller staff.

Elkeles points out that members of both organisations were very clear they wanted one body to represent them and influence government—something which will become even more important once NHS England disappears into the Department of Health and Social Care and won't be there to advocate for the service. The other message from members was that wanted an organisation that would "actually help us do our jobs better", he says.

Building on this, the new body is likely to offer more opportunities for peer learning and new ways to help the adoption of large-scale changes across the NHS, he explains, as well as services to tackle another problem identified by NHS Providers members: poor talent management and leadership development.

"Do we have a talent pipeline which works for everyone in the NHS? Not really," says Elkeles. "This new membership body would represent every employer in the NHS, apart from the Department of Health. Is there a role it could play in leadership development?"

Those themes will be explored in the next few months, he says. "People are saying they want to keep the best of what they got from both Confed and Providers—and do some things a bit better."

Both organisations have long sat in a twilight zone, representing the concerns of organisations but also working closely with NHS England and the Department. So how does he see the new organisation positioning itself?

"It's really important that it is not part of the infrastructure of the NHS—then you lose your legitimacy to be the voice of members," he says. "You have to be constructive, and you have to have solutions, and solutions that are based on reality... it feels to me that then you are adding a lot of value for everybody." //

Tough choices, empty promises

As we enter 2026, the NHS in Wales faces some stark choices and a likely change of government. But the parties vying for power at Cardiff Bay will need to up their game to meet the challenges ahead. Craig Ryan reports.

The NHS in Wales, like the country itself, is at a crossroads. It's almost certain that the Senedd elections on 7 May will see the first change of government since devolution in 1999. Leading the polls are Plaid Cymru and Reform UK, two parties united only by their fierce criticism of how Labour—languishing in a distant third—have run the NHS. In Wales, the NHS really matters, and all parties are desperate to convince voters they can do something to fix it.

The NHS in Wales is struggling. One in six people are on an NHS waiting list, and 10,000 have been waiting for more than two years. On cancer treatment, A&E and ambulance responses, performance is way off target. And health inequality is rampant: in the South Wales valleys, 11% of adults are in poor health and life expectancy can be 12 years shorter than in Wales's most prosperous communities. All familiar problems, but they feel particularly acute and immediate in Wales. A new government could be a chance to try something different.

"We can't keep throwing money—that's not the solution," says Helen Howson, director of the Bevan Commission, Wales's leading independent healthcare think tank. "We need to talk about a sustainable workforce, sustainable services and sustainable systems. We have to get our heads around that."

Not that there's much money to throw. Since 1999, spending on health and care has risen from 34% to 49% of the Welsh government's budget—and there's little to no chance of Westminster coughing up any more cash, despite Wales's undoubted needs. So, the key question, says Howson, is: "How do we build financial sustainability into a system that's going to have even greater demands on it in the future?"

State-funded healthcare systems are under demographic and economic pressure everywhere, but Wales is at the sharp end. "We're a sicker, more deprived nation with an older population as well," explains Nesta Lloyd Jones, deputy director of the NHS Confederation Wales, with an obvious "impact on the number of people accessing services or on waiting lists".

Howson says this "ball and chain that's been hung on us" means the next government in Cardiff Bay will have to show "bold, courageous leadership" and take "a really hard look at how we're using the resources we already have".

Research by the Bevan Commission found 20% to 30% "waste in the system"—but those savings won't be achieved by just cutting management jobs, as some Reform politicians have claimed. Beyond some low-hanging fruit like temporary

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PLAID CYMRU LEADER RHUN AP IORWERTH

HELEN HOWSON, BEVAN COMMISSION

NESTA LLOYD JONES, NHS CONFED WALES

BRIDGET CATTERALL

LAURA ANNE JONES, REFORM UK WALES

ALAMY STOCK PHOTO

SCOTTISH FIRST MINISTER JOHN SWINNEY (SNP)

ALAMY STOCK PHOTO

JACKIE BAILLIE, SCOTTISH LABOUR

ALAMY STOCK PHOTO

DR SANDESH GULHANE, SCOTTISH TORY

ALAMY STOCK PHOTO

NEIL GRAY, HEALTH SECRETARY (SNP)

Back from the brink—for more of the same?

After a big scare last year, the SNP are now clear favourites to extend their rule at Holyrood into a third decade, pointing to incremental reform rather than radical change for the NHS in Scotland. Rhys McKenzie reports.

Politics is a strange beast. After Labour steamrolled to victory in the UK General Election last year, taking with them 37 Scottish seats, it looked like the writing was on the wall for Scotland's party of government: the Scottish National Party.

The SNP, in power since 2007, had slipped from scrutiny to scandal and were ejecting party leaders at a rate the UK Tories would be proud of. It was clear the SNP were about to be usurped by a revitalised Scottish Labour.

Or so it seemed.

But the SNP did what it has done for the past 18 years—it rallied. John Swinney brought stability back to the party, capitalised on Labour's collapse in popularity at UK level and highlighted a new enemy moving over the border: Reform UK. Just in time for the Scottish Parliament elections on 7 May, the SNP has gone from a write-off to a sure bet and there is even talk of an outright majority—a remarkable feat in an electoral system designed to produce a proportional result, and something the party hasn't achieved since 2011.

They say a week is a long time in politics. A year must be an age.

But there are no certainties in politics, something the SNP's rivals will be at pains to point out as we edge closer to election day. The Hamilton, Larkhall and Stonehouse by-election last June acts as a reminder, if one was needed, that not everything is predictable. Scottish Labour's narrow victory over the incumbent SNP and a resurgent Reform showed that effective campaigning can still change the tide.

In the lead up to May's elections expect much of that campaigning to focus on health. The NHS in Scotland is facing many of the same challenges seen throughout the UK: chiefly waiting lists, hospital and ambulance delays and patients struggling to see their GP.

The situation is so dire that the Scottish Household Survey found public satisfaction with the NHS in Scotland has dropped to its lowest level in a decade. Over half a million Scots are on some form of NHS waiting list—roughly one in nine of the population. Waits of more than three years are the highest on record and the number of waits longer than two years is going up too.

The SNP's rivals—particularly Scottish Labour—feel this is an area where they can do damage to the government. Scottish Labour's health spokesperson Jackie Baillie even accused the government of "shamefully

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staff, streamlining administration and energy consumption, the big money will come from shifting the NHS towards prevention and "co-producing health locally with people", Howson explains.

"Are current services doing the right thing to the right people at the right time, in the right way? Are we over-treating? Are we doing things we don't need to?" she says.

She gives the example of a hand surgeon—one of the Commission's 800 'exemplars' of good practice—who developed a non-surgical treatment for Carpal Tunnel, slashing staff costs and treatment times and freeing up theatre capacity. "If you can do it with hands, you can do it with feet, surely?" says Howson. Encouraging and spreading these "great ways of thinking... can't be directed from the top down," she adds.

Looking to up Labour's game, health secretary Jeremy Miles announced in June that Wales would become a 'Marmot nation'— putting into practice the thinking of Professor Sir Michael Marmot: in short, that the key to better population health and sustainable health services is integration—not just health and care but all services and policies affecting health, including housing education, poverty reduction and discrimination.

Wales already has integrated health and care boards but "the priority is still on the acutes", explains Lloyd Jones. The Confed has called for a new performance and financial framework that moves the goalposts towards health outcomes rather than traditional activity measures. "Unless we shift the priorities... into community and preventative measures, the money will still go where the spotlight is."

An experiment with 'joint outcome frameworks' in the Cardiff area shows how this might work. Local councils and the health board pool their budgets and work together to get the best outcome for each patient—which might be care at home rather than more expensive hospital treatment. "Having these joint frameworks means the money shouldn't be a barrier," Lloyd Jones says.

This long-term stuff hasn't featured much in election campaigning, with opposition parties naturally focusing on waiting lists, and making the usual promises to recruit more doctors and nurses. So far, neither Plaid nor Reform have gone much beyond pointing to problems and promising, vaguely but vociferously, to fix them.

Plaid has at least published some proposals, promising to cut waiting lists with temporary 'surgical hubs' and a new 'executive triage service', as well as 'using technology' to speed up diagnoses and improving collaboration between Wales's seven health boards. Health spokesperson Mabon ap Gwynfor says the plan "shows we are serious about fixing the NHS", but the details remain sketchy with no indication of how the schemes would be staffed or funded.

Plaid is keen to burnish its prevention credentials, with leader Rhun ap Iorweth recently pledging to boost prevention spending and put a public health minister in the cabinet. The party also wants to end the "artificial" distinction between health and social care with a new 'national care service', despite Scotland scrapping a similar scheme earlier this year.

The dilemma remains that, in a resource-constrained system, investing in prevention means taking money way from hospitals and other 'visible' NHS services, something politicians talk about but rarely do. How will Plaid resolve that? We still have no idea.

Reform UK—leading in some recent polls—has been left scrambling to catch up. *Healthcare Manager* understands that, this autumn, party officials wrote to Welsh healthcare organisations asking for 500-word summary of their priorities. In October, Nigel Farage told the BBC that the party has a "full-time team" working on policies that would bring "fresh thinking" to the NHS in Wales. "We're taking this very, very seriously indeed... but it's too early to give answers to all of these things," he said.

Laura Anne Jones, Reform's only member of the Senedd, has worked hard to distance the party in Wales from Farage's repeated musings about scrapping the NHS funding model, insisting that Reform would keep the NHS "free at the point of use". Both Jones and deputy leader Richard Tice have claimed that the Welsh NHS doesn't need more money, just fewer managers.

> **"So far, neither Plaid nor Reform have gone much beyond pointing to problems with the NHS and vaguely promising to fix them.**

Reform would "cut wasteful bureaucracy and unnecessary management, putting clinicians back in charge. This alone frees millions to invest in frontline care without extra taxes, ensuring prescriptions remain free," Jones told the Senedd in September.

Reform's manifesto for last year's UK general election did sketch out some eye-catching policies, including running operating theatres at weekends, tax breaks for NHS staff, vouchers for private care to clear waiting lists and a public inquiry into "vaccine harms". It's unclear whether any of these pledges would apply in Wales.

Under Wales's new electoral system, no party will get near a majority in May, and Plaid is more likely than Reform to be able to form a stable coalition. Whoever wins, parties will have to forge some sort of consensus on the future of the NHS in Wales.

The long-term investment and change the NHS needs won't be delivered by another auction of meaningless promises. Instead, politicians need build a new partnership, not just with each other, but with councils, community groups, national NHS leaders and local managers. If they can do that, maybe NHS Wales become a beacon for how state-run healthcare can transform itself for the modern age.

But at any crossroads there are three possible paths, not two: carrying on, pretending we can do everything, ignoring the trade offs and hoping for the best, is always a short-term option— and it's a path well-trodden in the past. But Wales's next government may quickly find that path is blocked not very far ahead. //

> **“The SNP know their record on waiting lists will be under attack from all sides. But as the party in power only they can take action now to show voters the direction of travel after the election.**

fiddling the figures” to “cover up” the true extent of waiting times.

And the daggers are out for managers. Scottish Conservative health spokesperson Dr Sandesh Gulhane said waiting times can only be reduced by backing his party’s plans to ‘cut red tape, reduce the number of middle managers and surge resources to the frontline’.

The SNP know their record on waiting lists will be under attack from all sides, but as the party in power, only they can take action now and give voters a clear indication of the direction of travel for their post-election plans.

The Scottish government had already pledged an extra £200 million to tackle waiting lists as part of its Operational Improvement Plan, published in March 2025. The plan promises weekend and evening appointments for scans and greater use of digital technology to establish the Hospital at Home scheme— where patients are monitored at home as if they were in hospital, using apps and wearable technology. The scheme has opened an additional 2,000 ‘virtual beds’, according to the government.

In November, the government announced another £22.5 million is to be spent on reducing waiting lists, through more outpatient appointments and increasing inpatient and day case procedures across several specialities.

The government is also taking steps to improve ambulance response times and reduce handover delays. A big part of this is the new Scottish Ambulance Service’s Integrated Call Hub—a unit set up to triage patients who don’t need to go to A&E and link them instead them to other health services, easing pressure on paramedics and hospitals.

Health secretary Neil Gray announced in November that almost 100 staff have been recruited to this unit to boost support to the ambulance service heading into winter. Work was also underway to recruit 269 newly qualified paramedics before the election.

The performance of A&E departments throughout the country is also under intense scrutiny. A report by the Royal College of Emergency Medicine this summer claimed 800 deaths in Scotland last year were linked with long A&E waits.

In response, the Scottish Government has expanded use of specialist ‘frailty teams’, now operating in every A&E in Scotland. These provide “specialist, multidisciplinary assessment and care for vulnerable patients” and are “designed to accelerate early discharge, reduce delays, and shorten hospital stays”, according to the government.

The SNP say this approach is working and patient flow is improving, with two thirds of frailty patients being discharged directly to home and frailty patients spending on average two weeks less in hospital than similar patients not admitted to a unit.

Perhaps the biggest pre-election NHS pledge so far came at the SNP’s conference in October, when first minister John Swinney announced plans to introduce walk-in GP surgeries across Scotland. The first of 15 pilot sites, open seven days a week, will be operational “within the year”, says the government, which claims the scheme will provide over one million more GP and nurse appointments per year.

To deliver this, the Scottish government agreed with the BMA to allocate an additional £531 million over three years to recruit more GPs. Health Secretary Neil Gray said “this is the largest investment in core GP services to date in Scotland” and the additional money will “help us as we shift the focus of care from acute to community”.

So far, the Scottish government has resisted pressure to reform NHS structures—at least to the extent we’re seeing in England. Structures remain relatively stable despite the rationalisation of some specialist health boards. But both Scottish Labour and the Scottish Conservatives have commitments to sweeping changes to NHS organisations in Scotland.

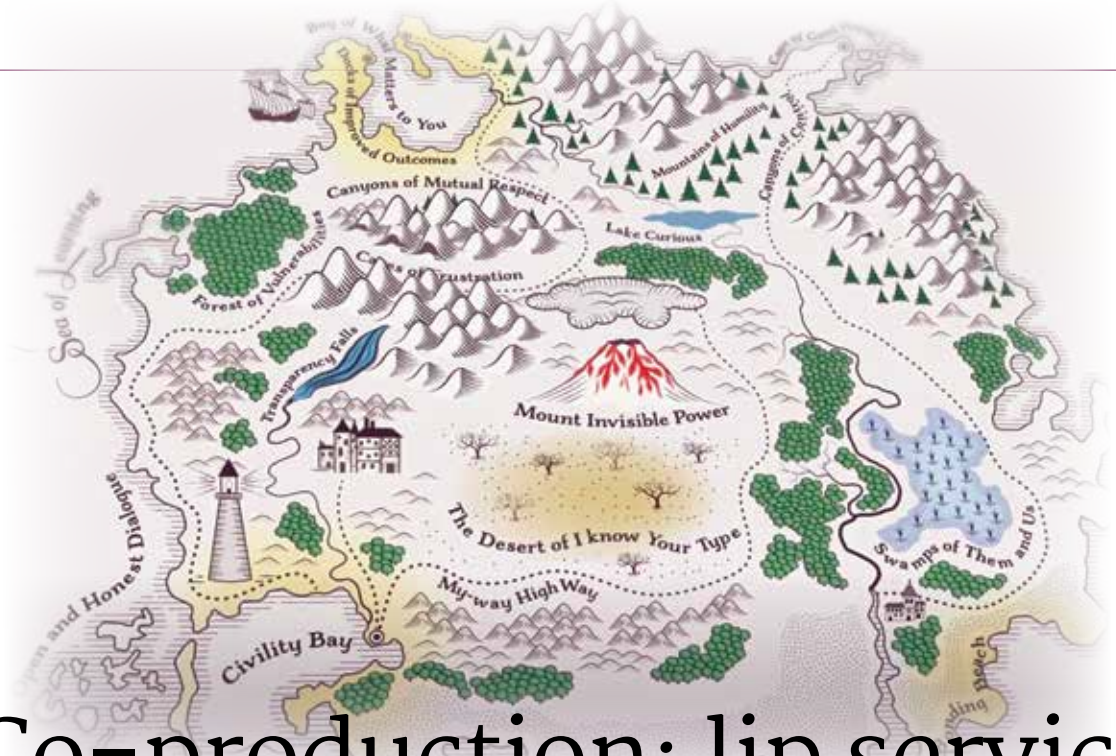
The Scottish Conservatives have vowed to remove “layers of management and bureaucracy” and substantially reduce the number of “middle managers”. Scottish Labour say they will “reform the NHS to cut unnecessary bureaucracy”—in an approach that looks similar to Wes Streeting’s in England. But with structural reform high on the UK agenda, expect it to creep up the agenda in Scotland too whoever wins in May.

One policy area unlikely to change whoever forms the next government is NHS staff pay. In 2026-27 Scottish NHS staff enter the second year of their two-year pay deal, worth 8% and backed by an inflation guarantee that will trigger higher pay awards if the CPI rate of inflation exceeds the current settlement.

The Scottish government will be quick to point out that Scottish NHS workers command the highest wages in the UK. At Band 8A, Scottish staff are paid almost £5,000 a year more than English counterparts on the same grade. Trade unions argue this differential is a result of pay being negotiated directly between unions and the government—something MiP hopes to see continue whoever wins May’s election.

As we approach the final stretch, the SNP look increasingly likely to extend their span in government to its third decade. But with Scottish Labour and Reform still in play, they’ll hope the pressure will be enough to shift the government’s policies if not the SNP government itself.

And as recent history has shown, a lot can change in six months. Expect further twists and turns before election day. //



Co-production: lip service or meaningful change?

The NHS talks a good game on co-production, but many patients and carers still feel service changes are done 'to' them not 'with' them. As Jessica Bradley discovers, meaningful co-production means building lasting relationships and sharing decision making power.

Co-production can be interpreted in many ways, but is generally understood as the process of consulting and including the public in designing and changing the services they use. The practice—which originated in the disability and mental health rights movements—advocates for an equal relationship between the people running services and those who use them.

While co-production can be applied to many NHS projects, including the design of new services and the reconfiguration of existing ones, the term is increasingly being prefixed with 'meaningful', in an effort to move beyond what many see as performative efforts to apply the concept.

"Co-production is often seen as tokenistic because people suspect a decision was already made before engaging with the public," says Dan Wellings, senior fellow at The King's Fund. True co-production, he says, requires a different way of working. "It's not a technocratic solution," he says. "You have to let go and realise that the answers to some problems might not lie in the system, but in communities."

There are four pillars to effective co-production according to Isaac Samuels, chair of the National Co-Production Advisory Group and an advisor on co-production to several NHS bodies :

- sharing power to make decisions together
- building relationships and trust
- valuing all perspectives
- outcomes-focused action

To enable a "reasonable" conversation, Wellings says, the parameters within which the co-production team is working should be set early on. Staff must be upfront and honest with the co-production group about what can and can't be co-produced, he explains, depending on the budget and other factors, and about what decisions have already been made.

"This might be a conversation about who's best placed to provide services on mental health for young people," he says. "The answer might not be the NHS provider, but a community organisation, for example."

A group of researchers and family carers working with Warwick University recently collated their learnings into a 'toolkit' (mip.social/copro-warks) for co-producing research projects with family carers of people with a learning disability. The seven 'golden rules of co-production' they came up with are

just as relevant to service providers, the team say.

Joanna Griffin, a psychologist and research fellow at Birmingham University, who worked on the project, says: "People talked about being brought onto a project at the end when everything has been decided already, which felt tokenistic. They emphasised the importance of having lived experience experts from the beginning.

"They also talked about wanting to feel like an equal partner in meetings, which includes not using jargon or acronyms, or people's titles," she adds.

The toolkit also highlights the need for researchers and service providers to be sensitive to the fact that people are often talking about difficult and personal subjects, and to not push them to talk beyond what they're comfortable with.

To effectively tackle health inequalities, services must also engage with people from minority ethnic communities or those living in the most deprived areas, who are often systematically excluded from decision-making processes, explains Wellings.

"Sometimes you know some groups will be disproportionately [more] represented than others, but if you're really going tackle health inequalities, you need to engage the groups of people that services often refer to as 'hard to reach'," he says.

Isaac Samuels says experiencing 'meaningful' co-production felt like being an equal partner in shaping his own care. "At the individual level, co-production can be as simple as a clinician asking, 'What works for you?' rather than assuming they know," he says.

"For me, that made all the difference when I was involved in a mental health project. Staff didn't just consult me, they listened, adapted appointments around my life, and acted on what I said."

Fiona Flowers is head of practice improvement at campaign and advisory group Think Local Act Personal and was the lead for developing Making It Real, a co-produced framework setting out the principles of good care, which is used by the Care Quality Commission and many other NHS organisations (see makingitreal.org.uk).

Flowers says the keys to effective co-production are trust, good relationships and a willingness to make mistakes along the way.

"If people know we're coming from the right place, we can learn and improve together," she explains. "A lot of the fear around co-production comes from people worrying about saying or doing the wrong thing, but at the heart of it, it's really just about being human with each other—and that's what people value most."

According to a review of research by NHS England (mip.social/copro-nhse), managers and leaders have a crucial role in the co-production process. Leaders must ensure that co-production is systemic, and that requires culture change at strategic, operational and individual levels, explains Flowers.

"Visible leadership around co-production involves verbally championing it, and ensuring you're providing the mechanisms and support in order for it to be a reality," she says.

But existing cultures and ways of working within the NHS can make it difficult to embed meaningful co-production, warns Anthony Lawton, a consultant, former NHS manager, and author of *Fit to Care—Insights From the Nursing Frontline*. "Managers can be stuck, so we need to change that mindset of command and control into a flow process, and to focus on the patient—that's missing," he says. "Everybody thinks about their own silos, and what they need to do to tick their KPIs."

This could explain why a lot of NHS work with the public revolves around feedback on existing services to check they're working, rather than working with people on what services they need, Wellings says.

"Some leaders are very open about the fact that they have very little power to act because of the top-down initiative... they're measured on waiting lists and targets rather than being held to account on meeting the needs of the local population," he explains.

Co-production isn't new, but how it should be embedded in NHS services is still being discussed and digested. There are some pockets of good co-production in the NHS, Wellings says, where people are fundamentally trying to change the way they work in a meaningful way. "But it still feels like the exception, rather than the norm," he says. "Where this work is done really well, it can lead to genuine transformation in how services are provided." //

Co-production and the Ten-Year Plan

While there has been a shift in intention towards co-production in the NHS since the pandemic, the UK government's Ten-Year Plan offers few concrete proposals on co-production, despite its emphasis on giving patients more control and bringing services closer to local communities.

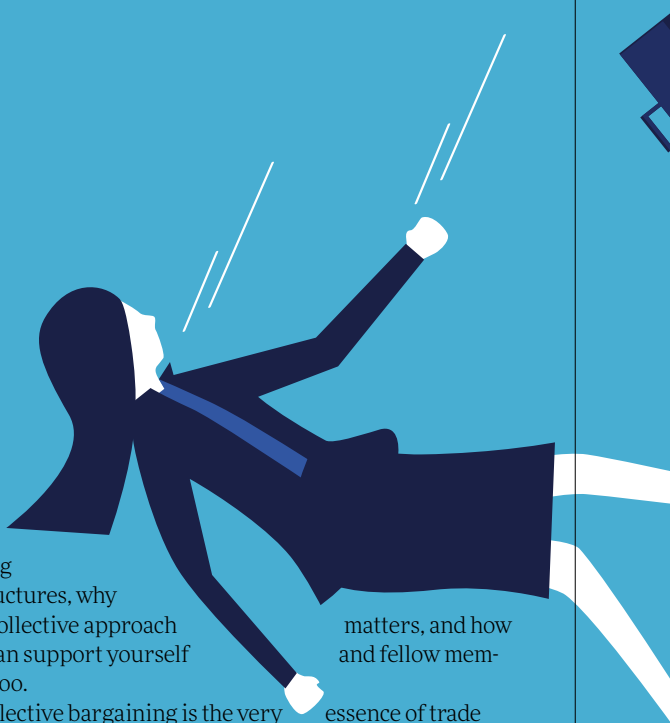
The Plan leans heavily on expanding use of AI in the NHS, an area from which co-production has been notably absent so far. Research by the Health Foundation found that one in six patients actually think AI will make services worse. This shows "a need to engage and involve communities in the roll-out to build support for the AI ambition", argued Dr Natt Day (pictured), head of public involvement and engagement at UCL Partners, in a recent blog for the NHS Confederation.

In North-East London, Day is involved with a pilot of AI-screening technology and a phone-based clinical coaching service for patients at high risk of needing unplanned emergency care. "Throughout the project, we've involved local residents in developing the information materials, including the information about data and algorithm use, to provide transparency and build trust in the work," Day explained.

Some of the new models of care being developed under the Ten-Year Plan, such as Neighbourhood Health Centres, seem fertile ground for co-production approaches, but they are not mandatory. The NHS Confed's briefing on neighbourhood services says it's "essential" that the development of new services is "community-led" and this "may" include co-produced service design (see: mip.social/copro-confed).

NHS JOB CUTS: you'll never walk alone

After stalling over the summer thanks to a government funding row, the NHS redundancy process in England has cranked into life again. MiP's Rhys McKenzie explains how the union will back you, and how members supporting each other and acting collectively is the best way to navigate this difficult process.



As we explored in the autumn issue of *Healthcare Manager*, change in the NHS is inevitable. Since then, the Department of Health and Social Care and the Treasury have signed off on the national model voluntary scheme and given the NHS in England the green light to start cutting thousands of jobs. By the time you read this, the process will have likely begun.

Last time, we focused on the mechanics of job cuts—the options employers can use and your rights as working people. Staff and union resistance to unfavourable Mutually Agreed Resignation Schemes has limited their use, but employers have now started to roll out voluntary redundancy schemes and, depending on take up, may move on to compulsory redundancies.

You can refer back to Corrado Valle's article in the last issue (*HCM65*, available online at mip.social/redundancy-1) to remind yourself of the differences between these ways of cutting jobs. The MiP website also carries the latest guidance and news on the job cuts nationally.

This article will not focus on any particular voluntary scheme. Instead, we'll outline how your union supports you collectively during restructures, why that collective approach matters, and how you can support yourself and fellow members too.

Collective bargaining is the very essence of trade unionism. By standing together, staff can secure better outcomes than any single person ever could. It's what gives trade unions influence and power. It's the only reason employers are willing to negotiate on terms and conditions, and it is the most effective method of protecting staff during change processes.

These days, it can be forgotten that the members of a union *are* the union. A trade union is only as strong as its collective membership. Collective representation starts with members—even if they're not workplace reps.

You and your colleagues shouldn't have to face change alone. Offering support to your peers—checking in,

sharing information and highlighting concerns—will go a long way in easing anxieties around the process.

When you or colleagues have concerns, it's important to feed these to MiP workplace reps and national officers, who can use partnership structures to raise them with the employer. You can do this by speaking to your local rep, at a member meeting or drop-in session online, or by contacting MiP Member Advice directly (mip.social/help).

It's also important to engage with employer-led consultation processes early and encourage your fellow members to do the same. This helps ensure that any subsequent communications from the employer are thorough and accurately reflect what staff think and feel.

Make sure you attend all staff briefings during the change process and gather as much information as you can. When you're invited to one-to-one meetings with your line manager, it's important to go along and outline any individual issues, such as flexible working arrangements and caring responsibilities. These meetings, early on in the process, are not adversarial, so having a union representative with you is not normally necessary.

MiP reps and national officers

MiP reps in your workplace and national officers (MiP staff) will support members collectively as much as possible during an organisational change process. They will use existing partnership arrangements to meet regularly with the organisation's leadership and HR department throughout the process.

During these meetings, your representatives will raise concerns on your behalf, request changes, and hold your employer to account on their legal obligations.

When consultations open, your representatives will ensure members have a channel to give feedback—either though member meetings, surveys or written feedback.

MiP's representatives will engage with the employer to ensure your concerns are taken into account and work with them to solve problems and reach agreements. Employers have a legal obligation to meaningfully consult with you and your representatives.

Your representatives will respond collectively to a consultation on your behalf, requesting clarification, changes to terms and improvements to the final documentation. Employers will formally respond to the concerns raised and outline any revisions in the final scheme.

The response to the consultation will be shared with members at a each employer. By law, your employer does not have to agree with every objection or suggestion, but they must genuinely consider them and have good reasons for rejecting them.

MiP will also provide you with our overall position on your specific redundancy scheme. Not all schemes are created equal—terms and conditions can vary greatly, including differences on payments, clawback terms and selection criteria. If we believe a scheme has specific drawbacks, or indeed incentives, we'll make sure you know about them.

If the scheme is voluntary, you are under no obligation to put yourself forward. If you do, you will still have the full support of your union, regardless of our position on the scheme.

Following the consultation period, MiP will continue to keep you informed as much as possible as the redundancy scheme progresses. We will continue to engage with the employer locally and seek to exert influence at a national level if changes are being driven by the government and NHS England.

Individual support

With voluntary schemes, bespoke individual assistance for every application is not possible because you're under no obligation to apply or to accept an offer. It's a voluntary process, so there's not much more unions can do after the consultation period has ended. If the employer has fulfilled its legal obligations, then the terms of the scheme are unlikely to change.

MiP will generally provide you with individual support at the settlement stage if you have been approved, or at the appeal stage if you have been rejected. MiP members are entitled to free legal advice on settlement agreements from MiP's legal partners, Thompsons Solicitors. Seeking legal advice on settlement agreements is a prerequisite before they can be accepted and become binding.

If you are rejected and would like to appeal that decision, your local reps or the national officers for your area will look into your case and offer support as necessary. If you have been treated unfairly, MiP will support your appeal.

It's important to take financial advice before accepting any settlement. All members are entitled to initial financial advice through MiP's financial partner, Quilter.

If you think your employer is not fulfilling their legal obligations in any redundancy process, it's important to let your local reps know as soon as possible. While employers can legally cut jobs, anything that does not seem right should be reported and MiP will seek clarity and a legal opinion if necessary.

Similarly, if you believe you are being treated unfairly during a voluntary redundancy process—for example by being discriminated against due to a protected characteristic, your working hours or because you have been on leave, you should let MiP know as soon as possible and the union can give you further support.

Managers often sit at the most pressured point in any organisational change process. They are expected to support teams while managing their own uncertainty. This puts managers in extremely difficult positions. They are often seen as the implementers of change—not as staff who are also going through it.

Change rarely arrives with certainty. That's why supporting each other collectively—through peer support, engaging with consultations and enabling your representatives to speak on your behalf by giving them feedback, gives us the best chance of successfully navigating what's ahead.

Managers deserve support every bit as much as the teams they lead. No one should have to face change alone—and if we stand together collectively, no one has to. //

Sarah Schnider is an employment rights adviser at Thompsons Solicitors, MiP's legal advisers. For more information visit: thompsonstradeunion.law.

Redundancy: know your consultation rights

With redundancies happening all over the NHS in England, remember that your employer is legally-bound to consult with you and your union—and that consultation must be 'meaningful'.

By law, employers who propose to make 20 or more staff redundant at one establishment in a 90-day period, must consult in good time with the appropriate employee representatives. This duty, set out in the 1992 Trade Union and Labour Relations Act, also applies when an employer proposes to dismiss and re-engage staff on different (usually inferior) terms and conditions—a practice commonly known as 'fire and rehire'. But what does fair consultation look like?

What are fair consultations?

The judgment in the case of R v British Coal Corporation and Secretary of State for Trade and Industry, gives a helpful foundation by setting out the requirements for fair consultation under the 1992 Act:

1. Consultation should commence in the formative stages of the proposed changes, allowing employees to raise opinions early in the consultation process
2. The employer should provide adequate information on which the employee and their representatives can respond
3. The employer should allow adequate time (at least 30 days, or 45 if more than 100 staff are involved) so representatives and staff can respond
4. Conscientious consideration is required from the employer; this means that employees' responses to the consultation are genuinely listened to and not simply disregarded.

Fair means meaningful

In short, fair consultation requires meaningful consultation. The employer has an obligation to engage with employees and their representatives—which will be the trade union where one is recognised—so that their voices can be heard and their opinions explored.

The consultation process should be used to facilitate ideas, with a view to reaching agreement on the decisions to be taken on the proposed changes. All four stages discussed above should be conducted in good faith. Judicial commentary on consultation shows that employers should define the objectives of the proposed changes, so that staff and their representatives have a clear understanding of them and can give an informed response.

In the NHS, consultations will usually be with the recognised trade unions, including MiP. For example, the trade union framework agreement for NHS England stipulates that consultations on redundancy will take place within the Partnership Forum. Within this structure, employers and representatives should work with a genuine aim to reach an agreement, by following the four steps above, in good faith for as long as reasonably possible.

What happens when employers fail to meaningfully consult?

If an employer acts disingenuously—meaning they have not adequately engaged with the consultation in good faith—a tribunal claim is possible under the 1992 Act.

Section 188(2) of the Act states that consultation should aim to prevent and reduce redundancies, or where this is not possible, mitigate the consequences. Section 188(4) sets out the information employers must provide on their redundancy proposals, which includes the business reasons, to ensure the consultation is meaningful.

In the case of Susie Radin Ltd, the Court of Appeal provided useful insight into the importance of meaningful consultation, by holding that an Employment Tribunal could make a protective award for failure to consult on redundancies even if there was no evidence that meaningful consultation would have produced a different outcome. Such protective awards are punitive on the employer and are not intended to compensate employees for financial loss.

In the judgment, Lord Justice Sir Peter Gibson confirmed "the absolute obligation on the employer to consult, and to consult meaningfully", and that for "such consultation to be in good time and to be conducted with representatives who are fully informed by reason of the required disclosure specified in section 188(4)... the employer must undertake the consultation not as an end in itself but with a view actually to reach agreement."

It is clear that the duty to consult is not a mere box ticking exercise.

The costs to an employer who breaches their consultation obligations can be high: a tribunal can award up to 90 days' pay per employee—a limit set to double to 180 days from April 2026 under the government's Employment Rights Bill. //

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

Matt Greenough is a speechwriter, communications consultant and leadership coach. Visit wordsmatter.uk for more info.

The art of persuasion: how to get people to say yes

Influencing consultant **Matt Greenough** offers his top tips on how to build trust, connection and influence that lasts.

Persuasion needs better PR. In a polarised age, it's too often seen as a dark art, a way for blaggers to win arguments or advertisers to bend people to their will. But in the NHS and other public services, we rely on influence every day. It helps others to see things from our point of view and makes it easier for them to say yes. Whether you need to persuade colleagues to try something new, or give difficult news to patients and their families, these ten practical tips will help you build trust, connection and influence that lasts.

1. Start with trust

If people don't trust you, nothing else matters. Influence begins with credibility: doing what you say you'll do, being honest about what you don't know and treating others fairly. Small acts of consistency build a reputation that makes your future arguments far more convincing.

2. Give before you get

One of psychologist Robert Cialdini's classic persuasion principles is 'reciprocity'. People feel a natural pull to return a favour. Offer help, information or support first, and others will be more inclined to give you time, effort or agreement later. A small gesture of goodwill can open big doors.

3. Frame your message carefully

'Framing' shapes how people see an issue before they even think about it. Would you rather eat a yoghurt that's "95% fat free" or "5% fat"? The words change the feeling. So, when you're making your case, choose frames that match your goal. Talk about safety not risk, opportunity not burden, improvement not change.

4. Make it social

Taking cues from others is one of the brain's favourite shortcuts. If you want people to adopt a new behaviour, show them that others already are. Instead of saying "no one's completed the new form yet", try "most teams have already started using the new form successfully". Social proof turns compliance into belonging.

5. Ask better questions

Influence is a conversation, not a lecture. Former FBI negotiator Chris Voss reminds us that good questions promote open, healthy dialogue rather than put people on the defensive. Questions that start with 'what', 'how' and 'why' encourage reflection and ownership.

"What about this is important to you?"

"How can we make this work better for everyone?"

"Why do you think this has been hard to solve?"

You'll learn more, lower resistance, and often let the other person persuade themselves.

6. Borrow authority (but earn it too)

Voices people see as knowledgeable or experienced are more persuasive. That might mean referencing evidence, guidelines, or respected peers. But authority without empathy sounds arrogant. Combine expertise with curiosity.

7. Create small commitments

Big yeses start with small yeses. Get agreement on a first step. A pilot, a trial, or even a shared definition of the problem. Once people have made a small public or written commitment, they're far more likely to follow through. Momentum is persuasive.

8. Use emotion, not just logic

We like to think we're rational, but emotion drives most decisions. Stories, examples and visuals stick longer than statistics. If you want people to care about a change, show its human impact before the numbers.

9. Mind your anchors

Daniel Kahneman and Amos Tversky found that our brains cling to the first number or idea we hear, even when it's effectively meaningless. That "anchor" quietly shapes what feels reasonable next. Once it's out there, everything else is judged against it. Choose your starting point with care.

10. Find common ground (unity)

The most powerful form of persuasion is shared identity. Talk about "we". Remind people of your common purpose—providing quality care, supporting teams under pressure, improving lives. Unity builds trust and softens disagreement.

You don't need to use every technique every time—decide which make most sense in your context. The most persuasive people listen well, show empathy, and build relationships before making demands. Next time you're trying to persuade, slow down, ask a good question, and remember that people say yes not when they must but when they want to. //

meetyour**reps**:**Felix Peckitt**

"We've got power and influence. It's important we use it."

Felix Peckitt, assistant director of data architecture at North Central London ICB and MiP's newly elected National Committee member for London, in conversation with **Craig Ryan**.

"I don't want to leave power on the table," says Felix Peckitt, explaining why he successfully stood for election to MiP's National Committee this autumn. September's Unite the Kingdom rally and the rise of right-wing movements "actively hostile" to trade unions and the NHS "really spooked me", he explains. "As managers and trade unionists we've got power and influence... it's really important to use that and not be complacent."

MiP enjoys "good working relationships" with management at North Central London ICB (NCL), where Felix is assistant director of data architecture, "but I understand it's been hard won—not just by our union but by the whole movement," he says.

Becoming an MiP rep has helped his managerial practice, Felix says, "because you get [access] to senior people faster and more exposure to difficult management conversations—from people who really trust you." It also gives him "a lot of credibility", he says, "because I can demonstrate that I care about the wellbeing of staff and the craft of management."

Felix, who has Tourette's Syndrome, has faced discrimination in previous jobs, "but being part of a union has given me more back up for that," he says. Since 2023, he's been a trustee of Tourette's Action—the UK's leading charity supporting people with the condition—an experience he's quick to recommend. "It gets you great board experience and another view of health services to wrap around your existing knowledge," he explains.

The charity campaigns for better diagnosis and treatment for the 300,000 people in England and Wales with Tourettes. Only 12 providers offer Tourettes services and there are no NICE guidelines for the condition. "That's got to change," Felix says.

In his day job, Felix leads a team of five engineers designing systems to support GPs and crunching the data clinicians and managers need to plan services, and develop new medicines and forms of care.

This isn't 'back office'; it's vital work without which the NHS couldn't function effectively—systems succeed or fail, Felix says, according to "how information flows from one part to another". An analyst's job is "creating knowledge", he explains, "so we know what's happened and why it's important, and the right decisions are made."

> **"AI is a very powerful, transformative technology but it's not an end in itself... AI is hungry for data and it needs a good diet—it can't just have junk food.**

With its heavy reliance on AI, analysts should have a central role in delivering the Ten Year Plan—"AI is hungry for data and needs a good diet. It can't just have junk food," Felix explains. But he sees a "disconnect" between government promises to invest in data and the reality of uncompetitive salaries and analyst redundancies. "In other sectors technical skills are rewarded at the same level as management and leadership skills—that's how you get some of the best technical talent."

While AI is a "very powerful, transformative technology... it's not an end in itself", Felix says. Effective implementation demands not just technical knowledge but the skills managers offer—"leadership, building good relationships and strong clinical pathways, and a focus on equity".

Felix's ICB is now set to merge with next-door North West London, creating a 'mega-ICB' with a population of over 3.5 million. "People are still bruised from the last restructure which only concluded about three months before the new changes were announced," he says. Plans to cut 50% of ICB staff had been on hold until funding was confirmed in November, leaving staff in a state of limbo for months, but are now proceeding "at a blistering pace", he explains.

"We're working with the employer to give members clarity quickly and ensure a fair process. But even if the process is fair and transparent, it can still really, really hurt," he adds. Nationally, there's danger that ICBs may cut staff aggressively only to re-employ some "under the guise of investment", he warns. "But we're not going to let employers walk into a fire and rehire situation by accident."

As he prepares to take up his National Committee seat in January, what are Felix's priorities for MiP? Beyond meeting "members' immediate needs in navigating the restructure", he wants to see the union expand its influence over "critical issues" like reducing inequality and implementing new technology. "I think we're uniquely placed as a professional group to look at the governance of generative AI and its safe and effective use," he says. //

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

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Chief Executive, MiP

MANAGING our NHS