

issue 67 | spring 2026

healthcare managers

“I want to make a difference to a place”

Robin Porter: from
council chief to ICB
chair

AI unplugged

Why the NHS must invest in
people not just machines to
navigate the tech revolution

We unhappy few

What happens to staff left behind
as the job cuts bite?

The heat is on

How climate change is already
disrupting the NHS



The union for senior health & care managers

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In reforming the NHS in England, this government has developed a nasty habit of facing both ways at once.

It says it wants a 'neighbourhood health service' but has crippled ICBs—the best-placed institutions to make it happen. It says it wants to devolve decision making in the NHS but is centralising power in Whitehall. It says it wants a shift from hospital to community, but resources—and attention—are still flowing inexorably

in the opposite direction.

Technology was the star turn of the Ten Year Plan. But the picture emerging from our new series on AI in the NHS (page 16) is of a government and NHS leadership in love with the gadgetry but averse to the reality: that a technological revolution is hard work, and much of it work for people, not machines.

The government says it wants to make the NHS a 'world leader' in things like AI and genomic medicine, but it's chosen to hollow out the skills and capacity the service will need to make that vision a reality.

The haemorrhage of digital talent isn't confined to ICBs, it's happening everywhere. If it isn't reversed the NHS risks becoming entirely dependent on big, mainly American, tech firms for its technological revolution. Firms whose leaders are often ideologically opposed to the NHS (but will happily take our money anyway).

Without enough tech expertise of its own, the NHS will have to buy off-the-shelf, take-it-or-leave-it solutions, because we won't be able to work with tech firms to develop the bespoke systems we need. Three words: Test and Trace.

This isn't just about protecting MiP members' jobs, important though that is. It's about the future of the NHS. A £180 billion organisation that doesn't retain in-house capability in technology will get taken for a long ride and will make big mistakes. It will lose the ability to understand what it's buying and the ability to make it work. Let's not let that happen. //

Craig Ryan, Editor
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heads up

News & noticeboard 2

analysis & opinion

Analysis: Rhys McKenzie on why the NHS Workforce Plan 2.0 can't ignore managers 8

Leading Edge: If we don't take management seriously, the NHS will be well and truly broken, writes Jon Restell 10

features

Prêt-à-Porter? Former council chief turned ICB chair Robin Porter is on a mission to reduce inequality and make the NHS more local. Interview by Craig Ryan 11

The Remainers: Rhys McKenzie talks to Sam Crane about the challenges facing staff left behind after the job cuts 14

AI in the NHS: Kicking off our new series, Craig Ryan argues the NHS must invest in people not just technology to make a success of the AI transformation 16

Hot mess: Climate change is already having a costly impact on NHS services, writes Jessica Bradley 19

regulars

Legal Eye: How are people on fixed-term contracts affected by redundancies? Jo Seery explains 22

Tipster: Career coach Charlie Keeney gives his tips on how to cope with losing your job 23

Meet Your Reps: Helen Robertson, Digital Health and Care Wales 24

healthcare manager

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heads up

News you may have missed
plus what to look out for

Job cuts latest—pages 3 & 5

NHS pay 2026—pages 6 & 7

Neighbourhood delays—page 7

Health department worst in Whitehall for leadership and change management

The Department of Health and Social Care (DHSC) has plunged to the bottom of the Whitehall league table in the latest civil service staff survey, with

officials signalling widespread disengagement and a loss of faith in the department's leadership and change management.

Less than 30% thought the DHSC's senior leaders

“have a clear vision for the future of the organisation”—far lower than any other Whitehall department and a drop of 19 points compared to last year. The department's overall staff engagement

score—a weighted index measuring pride in the organisation, attachment, inspiration and motivation—was also the lowest in Whitehall, dropping by 10% in a year.

The findings follow a year of upheaval at the DHSC with its ongoing takeover of NHS England and big changes in its top team, including the appointment of a new

permanent secretary, Samantha Jones, last year.

DHSC officials were much more positive about their immediate colleagues, with ratings for “my manager” and “my team” in the top half of the Whitehall league table.

See the full results of the 2025 civil service staff survey at mip.social/csss-2025.

noticeboard

13-15 April 2026

UNISON National Health Care Group Conference

Edinburgh International Conference Centre

Annual conference for UNISON health branches, including MiP.

unison.org.uk/events/2026-health-care-sg-conference/

23-24 April 2026

NHS Scotland: National Workforce and Education Conference 2026

Online

National conference for NHS workforce and education professionals organised by NHS Education for Scotland. Also hosts the UK-wide

Four Nations AI in Education Conference on Thursday afternoon. FREE to NHS staff.

mip.social/NES-2026

7 May 2026

NHS Employers: Do OD conference 2026

Central London

Annual FREE get-together for anyone who ‘does OD’ (that’s organisational development in case you were wondering), promising “forward thinking conversations” and “interactive learning” on the future of OD. Conference theme is ‘confidence in change’—and we could all do with some of that.

nhsemployers.org/events/od-nhs-2026-confidence-change

14 May 2026

FDA Annual Delegate Conference

Central London

Annual policy-making conference of MiP's parent union, with guest speakers (to be announced).

fda.org.uk/annual-delegate-conference/

10-11 June 2026

NHS Confed Expo

Manchester Central

The UK's biggest gathering of health and care leaders pitches up in Manchester this year. Lots of speakers, interactive workshops and networking opportunities galore, plus a chance to see Wes Streeting trying out the latest healthcare gizmos (probably).

nhsconfedexpo.org

16-19 June 2026

UNISON National Conference

Brighton Centre

National policy-making conference of MiP's other parent union.

www.unison.org.uk/events/2026ndc/

17-18 June 2026

King's Fund: Health and Care Explained

Online

The venerable think tank's boffins aim to unravel the mysteries of England's healthcare system in just two days. Sessions on the Ten Year Plan, ICBs and local government, the ‘triple shift’, plus an ‘ask us anything’ session.

www.kingsfund.org.uk/events/health-care-explained-2026-conference

KEEP THE DATE

30 June 2026: King's Fund Digital Health and AI Conference, central London (kingsfund.org.uk/events/digital-health-ai-conference-2026)

13-16 September 2026: TUC Congress 2026, Brighton (www.tuc.org.uk/events/tuc-congress-2026)

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

Yvonne Richards elected new MiP chair

MiP's new National Committee, elected by members last autumn, started its two-year term in January, electing Yvonne Richards (pictured) as MiP chair for the 2026-27 term.

Richards, a National Committee member for NHS England, joined the committee in 2024 and previously served as a vice chair for two years. She succeeds Geoff Underwood, who stepped down after four years as chair, but continues to represent members in South West England on the committee.

Newly elected National Committee members Helen Robertson (Wales) and Dave Whatton (West Midlands) were elected as vice chairs for the term.

The committee also agreed to co-opt a number of additional members. The full committee is listed in the table opposite.

MiP National Committee 2026 & 2027

Muyi Adekoya	co-opted, England
Sajidah Ahmad	NHS England
Clare Bannister	North East England
Kath Charters	Wales
Scott Diamond	co-opted, Scotland
Robert Dyer	co-opted, England
Roisin Kelly	co-opted, Northern Ireland
Jagjit Mandair	co-opted, England
Catherine McCarthy	co-opted, England
Prince Obike	South Central England
Felix Peckitt	London
Yvonne Richards	NHS England, MiP chair
Helen Robertson	Wales, MiP vice chair
Julie Siddique	co-opted, England
Alyson Taylor	East Midlands
Jayne Thomas	North West England
Geoff Underwood	South West England
Dave Whatton	West Midlands, MiP vice-chair
Chris Withers	co-opted, England



Back to office order reversed after unions and staff protest

NHSE England has "paused" its demand for staff to work in the office for at least 60% of their working time following opposition from staff and trade unions.

MiP and other unions filed a collective grievance on behalf of members after NHS England announced in December that it would increase its office-working requirement from 40% to 60%, without consulting staff or unions.

But in February, NHS England director Sarah-Jane Marsh confirmed the decision would not be implemented "at this time" and staff could continue to work 40% of their time in the office.

"This is a welcome and sensible step from the employer," said MiP's national organiser, Rebecca Hall.

Unions had called for the decision to be reversed, saying it was arbitrary and unsupported by evidence, and had ignored NHS England's lack of office capacity.

"MiP members were clear that changing in-person working requirements in the middle of a major organisational change process



NHS England director Sarah-Jane Marsh said the new rules would not be implemented "at this time" and NHS England staff can continue to work 40% of their time in the office.

made little sense," added Hall. "Making this change without any evidence base, and without engaging staff or their unions, suggested it was driven far more by politics than the needs of the organisation."

She welcomed NHS England's commitment to consult and engage with staff and trade unions over any future changes to in-person working arrangements. "We look forward to working with the employer to ensure future policy reflects the realities of modern working and works for staff," she said.

NHS England will also launch a formal consultation in October to consider how its estate should be used as it is absorbed into the Department for Health and Social Care.

Get free legal advice on your voluntary redundancy agreement

Due to the scale and speed of the redundancies in the NHS in England, it's important to get legal advice on your settlement agreement straightaway or your redundancy offer could be withdrawn.

MiP members can access free legal advice on settlement agreements through our solicitors, Thompsons. MiP has set up a streamlined system so all members in ICBs and NHS England can receive free advice within 48 hours.

Simply email your settlement agreement to:

- » NHSICB@thompsons.law (if you work in an ICB)
- » NHSE@thompsons.law (if you work for NHS England)

Please only use these mailboxes once you have your finalised settlement agreement.

It's also important to obtain financial advice on settlement agreements. MiP can't provide personal financial advice directly to members because the union is not FCA certified. But our financial advice partner Quilter offers a free, no-strings-attached, initial consultation to all MiP members. To use this service please contact info@miphealth.org.

Health policy

Ageing population *not* the main cause of demand for hospital care, study claims



ISTOCKPHOTO

Growing demand for hospital services may not be caused by an older and sicker population, as previously thought, according to a new study by the NHS Strategy Unit. Instead, other factors such as medical advances, service innovation and changing patient expectations may be more important, the researchers suggest.

The findings challenge the assumption that has driven the health policies of successive governments: that the

UK's ageing population was the main reason for growth in demand for NHS services. The UK government's Ten Year Plan, published last summer, said: "The NHS now stands at an existential brink. Demographic change and population ageing are set to heap yet more demand on an already stretched health service."

Analysing hospital activity in England between 2011 and 2019, the study found that only a small part of the growth in demand was due to

demographic change or population health. 'Residual non-demographic' factors and overall population growth were more significant, it said.

These 'non-demographic' factors accounted for most of the increase in demand for outpatient appointments, non-elective admissions and A&E attendances, as well as most of the fall in demand for maternity services. Only for elective admissions were demographic causes more significant—but growth in population numbers was a

Health campaigner Sharon Hodgson is new public health minister

Sharon Hodgson, a health campaigner and former aide to Keir Starmer, is the new UK minister for public health and prevention. She replaces Ashley Dalton, who stepped down in March to continue treatment for metastatic breast cancer.

Hodgson, 59, is the MP for Washington and

Gateshead South and has been in the Commons since 2005. She was Labour's shadow minister for public health from 2016 to 2020 and served as Keir Starmer's parliamentary private secretary for two years when he was opposition leader.

In a statement on social media, Hodgson said: "Having spent four years in opposition shadowing this role, as well as having led on several public health campaigns as a backbench MP since, I am deeply passionate about delivering on this important brief for the government."

As a backbencher, she campaigned for compensation for women injured by vaginal mesh implants and chairs the all-party group on the



New minister Sharon Hodgson has criticised the government for failing to compensate women injured by mesh implants.

issue. She has told MPs that her own mother suffered "life-limiting complications" after having one of the implants fitted.

As recently as this February, Hodgson said the government's failure to agree a compensation scheme was "insulting" to the thousands of

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bigger factor than ageing.

Non-demographic factors may include the availability of new medicines and treatments, advances in diagnostics and changes in patient expectations, government policy and funding—although the impact of each of these factors remains unclear, the researchers said.

The Strategy Unit is now planning further research to understand how non-demographic changes affect demand for NHS services. “These results are not the final word. They are a useful contribution, yet they remain frustratingly imprecise. Our work on this topic will therefore continue,” wrote the unit’s head of policy, Fraser Battye, in a blog post.

He suggested there could be a trade-off between innovation and the proposed shift towards community care: “If this is right, then we can have high levels of innovation and growth in cutting-edge medicine, or we can have a less hospital-centric NHS. It is hard to see how both can come about—unless very particular policy efforts are made.”

Read the full study at: mip.social/su-growth.

women harmed by the mesh implants. “All of these women and families, they were all gaslit. They were all told it was all in their heads,” she told the BBC.

Dalton, 53, the MP for West Lancashire, had been public health minister since February 2025, leading the development of the government’s national cancer plan, HIV action plan and men’s health strategy.

Responding to Dalton’s resignation, Health secretary Wes Streeting said: “She has achieved more as a minister than many politicians achieve in their entire careers. I’m so sorry to lose her from our team, but proud of her decision and her impact.”

NHS job cuts

Ministers must “come clean” on how shake-up will work, says MiP

A year after it ordered tens of thousands of job cuts in the NHS in England, MiP is urging the government to “come clean” about how the NHS will be run after the changes.

Health secretary Wes Streeting has claimed the cuts—mainly aimed at managers and corporate staff at all levels of the system—were necessary to tackle “inefficient bureaucracy”. But MiP and many other stakeholders have criticised ministers for lacking a clear vision about how the NHS will work after the cuts.

“We’ve now passed a year since the government announced the biggest cut to NHS staffing in well over a decade, yet the government’s plan for running the NHS after the fallout is still not clear,” said MiP chief executive Jon Restell. “They owe it to staff to come clean about the aim of the changes. Public servants deserve competent management of system design and decency in the way organisational change is carried out.”

Urging the government to also “be honest” with patients, he added: “How will vital services continue while ICBs and other essential functions lose half their workforce?”

Staff are now taking voluntary redundancy and leaving the NHS, the union warns, before ministers have spelled out which

parts of the system will run existing services and how new functions will operate. “This unnecessary risk will damage the quality of care the NHS provides”, said Restell. “Instead, ministers should get the structure in place and only think about headcount afterwards.”

MiP is also concerned that, despite the scale and speed of changes which have placed 30,000 NHS workers at risk of losing their jobs, there has been little scrutiny of the government’s plans. With no major legislation and few opportunities to debate the reforms in parliament, MiP says, many MPs are not even aware that the job losses extend beyond the national bodies to hit hospitals and other NHS providers in their constituencies.

Local government, including regional mayors and combined authorities, have also not been properly consulted about how the changes will affect local services and the local economy, the union says.

“These cuts were announced with no plan, no funding and no parliamentary scrutiny. This is no way to handle public service reform,” said Restell.

Ministers are expected to introduce a wide-ranging health bill into parliament this spring to formalise the abolition of NHS England, establish the new NHS structure and try to turn the Ten



Wes Streeting has faced “little scrutiny” of his reform plans, MiP says

Year Health Plan into operational reality.

The legislation will be an opportunity to put the cuts on the political agenda and “highlight the harm they are doing to the NHS”, Restell said. “It’s time for parliament to take the lead on preventing another chaotic restructure, given the risks posed to the NHS model. For example, it could set tests to be met before system change is allowed in future.

“MiP will keep engaging with policymakers as the legislation progresses, but we need the help of our members. You see first-hand the impact this has on services, on patients and on you as working people,” he added. “We need your support as we campaign for an NHS that is stable, allows form to follow function and recognises the vital work of the NHS managers who make it all happen.”

IAN DAVIDSON / ALAMY STOCK PHOTO

NHS pay 2026

Another below-inflation pay rise risks “industrial turmoil”, unions warn

Unions have warned that NHS workers are “angry” and “fed up” with another below-inflation pay rise, after the decision by the UK and Welsh governments to accept the recommendations of the NHS Pay Review Body for a 3.3% rise for most staff from April.

“Ministers have missed a vital opportunity and heightened the risk of industrial turmoil across the NHS, warned MiP chief executive Jon Restell.

“Our members are angry about this below-inflation pay award, which does not recognise the contribution made by managers at a time of upheaval and uncertainty, does not start to restore real terms pay levels and does not help the NHS attract and keep the workforce it needs,” he said.

It was now even more important, he added, that much delayed talks on reforming the Agenda for Change pay system (see

below) “deliver results”.

Although the award is lower than consumer price inflation, currently at 3.4%, UK health secretary Wes Streeting told the Commons that it was above the government’s “affordability position” of 2.5% and NHS organisations would have to find the additional funding from within existing budgets. But “none of the pay increases will be paid for by cutting frontline services,” he insisted.

Agenda for Change

Stalled pay reform talks set to restart

The UK government has agreed to restart long-delayed talks on reforming the Agenda for Change (AfC) pay system in England as part of its overall pay package for 2026-27. The negotiations on wide-ranging structural issues with the pay framework were originally recommended by the NHS Pay Review Body in 2024, but have made little progress.

Health secretary Wes Streeting announced in February that the government would “progress talks with trade unions and employers at pace” and implement “funded improvements” to the pay system this financial year.

Unions want the negotiations to cover issues such as compression between pay bands, lack of incentives for promotion and out-of-date grading for some jobs, although the government has yet to confirm the scope of

“The government must now clear the decks to set up proper talks with serious money on the table.”

—Helga Pile, UNISON

the talks.

Ministers have indicated that they want to prioritise improving pay for staff on the lowest bands and for graduate jobs in the NHS, and that any pay rises agreed later this year would be backdated to April 2026.

MiP chief executive Jon Restell said: “Unfair grading, weak differentials between bands and the lack of incentives for promotion must all be on the table, with credible funding, if the government is serious about fixing the longstanding problems with Agenda for Change and recognising staff properly.”

He called on MiP members

to give union negotiators “as much leverage as possible” in the talks “by expressing their anger” about the 2026 pay award (see above) and the “vital need” to invest in pay. “MiP members are brilliantly placed to explain the impact on staffing and services and we will make sure that their well-informed voice is heard in the next few months,” he added.

UNISON head of health Helga Pile said the talks needed “to restore the value wiped from NHS wages over the past

decade” as well as “fix problems with how the NHS pay system works”.

Most NHS workers were “still in the dark about who’ll benefit and by how much,” she said, as the government had so far only committed to improving salaries for graduates and the very lowest paid.

“For that to mean anything the government must now clear the decks to set up proper talks with serious money on the table. And get on with it fast,” she added.

MiP launches new Providers Network for reps

MiP has set up a Providers Network to help support MiP workplace reps working in NHS trusts and other providers. The network, which started work in January, is a space where reps can share knowledge, experiences and learn from their peers in a supportive environment.

The network is also a way for MiP to hear directly from reps about the challenges staff in providers are facing, and the opportunities for organising and promoting MiP as the union for NHS managers. MiP already has networks for reps in ICBs, CSUs, ambulance services and NHS England.

The Providers Network meets monthly and is open to all workplace reps working in a provider. For more details about this or other networks, contact MiP’s national organiser, Rebecca Hall: r.hall@miphealth.org.uk.

Streeting also said the award was above the 2.2% level of inflation forecast for 2026-27 by the government's spending watchdog, the Office for Budget Responsibility.

UNISON head of health Helga Pile warned that, due to the "hopeless pay review body process"—which unions have boycotted since 2023—NHS pay was "sliding behind living costs" and that "having a pay increase on time for once is only a small comfort".

She added: "Nurses, healthcare assistants, occupational therapists, ambulance staff, porters and all the other essential health staff need proper investment in their pay."

"Before Christmas the government finally started working towards a wider-ranging, longer-term deal," she continued.

"But today there's been a handbrake turn and a lurch back to the review body process unions have boycotted."

The award is expected to be included in April pay packets, the first time in six years the pay review body process has resulted in awards being paid on time. All Agenda for Change pay bands will be increased by 3.3% from April.

Although the pay review body also covers NHS staff in Northern Ireland, the award had not been formally accepted by the Stormont executive at the time of going to press.

Health Minister Mike Nesbitt said it was "his desire to proceed" with the 3.3% award, but it could not be implemented until the Northern Ireland Assembly has set a budget for 2026-27, which he hoped would be "as early as possible in

the incoming financial year". Last year, pay awards for NHS staff in Northern Ireland were delayed by ten months as assembly members haggled over the budget settlement.

The pay review body no longer covers NHS staff in Scotland, where the Scottish government negotiates pay directly with trade unions. In April, Scottish NHS staff will enter the second year of a pay deal worth 8% over two years. The deal includes an "inflation guarantee" that will increase the award if inflation is higher in this April than when the deal was agreed in May last year.

Doctors, dentists and executive-level NHS managers are covered by separate pay review bodies which had yet to publish their recommendations at the time of going to press.

Ten Year Plan

New contracts delayed in setback for neighbourhood health plans

GP leaders have warned the government's plans for neighbourhood health services in England could "grind to a halt" after the roll out of new contracts was postponed by at least a year in another delay to the government's NHS reforms.

In its Ten Year Plan, published last July, the government promised the first 'single neighbourhood provider' and 'multiple neighbourhood provider' contracts would come into effect in 2026-27. But in February, NHS England said the need to hold a public consultation meant no neighbourhood services contracts will now go live until 2027-28 at the earliest.

A 'model neighbourhood document', offering guidance for NHS organisations on planning for neighbourhood health services, originally promised by NHS England in November and again in February, had also failed to appear at the time

of going to press in mid-March.

GP leaders warned that a lack of guidance and delays to contracts mean the government's neighbourhood health plans "could fail" and advised GPs not to wait for the contracts before developing new models for neighbourhood services.

"Waiting for single neighbourhood provider contracts to appear is not strategy and is unwise. Design the model before it is handed to us as a contract," the BMA said in a briefing for GPs. "This is likely the last realistic opportunity to intervene before behaviours, contracts and expectations become locked in."

Dr Katie Bramall, chair of the BMA's GP Committee said GPs and other potential



Dr Katie Bramall: providers left in a "vacuum"

providers had been left in a "vacuum" by the lack of guidance from NHS England.

"The neighbourhood model isn't going to fail because the concept is wrong," she said in

a BMA podcast (mip.social/bramall-2002). "I think the concept is sound. The risk here is that everything's going to fail or grind to a halt because we need discipline and we need rules, and we all need to be doing the same thing."

NHS England chief executive Jim Mackey has said local NHS organisations should concentrate on developing neighbourhood working "on the ground" this year, and that feedback from their experiences would inform the design

of the new contracts.

Speaking on the Prevention is the New Cure podcast (mip.social/mackey-1102), Mackey said: "I would expect us to hit obstacles where the system comes back to us and says, actually, we do need an organisational form, or we do need a specific kind of contract, or we need these financial mechanisms to support us—and we're absolutely up for that."

In March, NHS England also announced it was delaying the transfer of specialist commissioning staff to integrated care boards until April 2027—when NHS England itself is set to be abolished.

The staff, who centrally commission care for a range of rare and complex conditions, were originally due to move to ICBs last April, but the transfer has been repeatedly delayed. NHS England said ICBs would assume "a full leadership role" over the specialist services during 2026-27.

In a £180 billion service, management isn't an optional overhead

Managers are crucial to reshaping the NHS, but were completely ignored in the last government's workforce plan for England. With a new plan set to be unveiled this spring, ministers mustn't make the same mistake again.

In June 2023, then prime minister Rishi Sunak announced something that he said “governments from all parties have ducked for decades”—a national, long-term workforce plan for the NHS. The Long Term Workforce Plan, produced by NHS England and backed by the government, was described by Sunak as the “most ambitious transformation” in NHS staffing in its history.

It was ambitious in many respects—so ambitious that less than two years later the new Labour government called its workforce growth projections a “fiction” and committed to publishing a revised plan. After being delayed last year, that plan is now expected to be published sometime this spring.

Few disagreed with the need for a comprehensive workforce strategy. But the original plan was squarely focused on increasing clinical headcount rather than looking at the entire NHS workforce. The previous government lacked a vision for fundamentally reshaping how the NHS delivered care—it simply wanted to keep the status quo but increase activity through more clinical staff.

The current government insists it wants something different. Its message to the NHS has been blunt: “reform or die”. Any increases in funding or staffing, it says, would be conditional on the NHS changing the way it operates.

The challenge of delivery

Those changes were outlined in last

year's Ten Year Health Plan, centring on three major shifts: from hospital to community, from analogue to digital, and from treatment to prevention. These shifts, if the government is serious about realising them, will have major implications for where and how staff work. It makes sense then to rework the current workforce plan to reflect this change of direction.

When MiP surveyed its members, we found overwhelming support for these shifts and backing for the broader aims of the Ten Year Plan. But members noted that these three shifts were nothing new and successive governments have promised similar transformations. The challenge has never been to the vision—it has been about delivery. And delivery depends on having the right people, with the right skills, in the right parts of the system.

That has been made much harder by the government's decision to significantly reorganise the NHS and embark on significant cuts to management capacity across trusts, integrated care boards and arm's-length bodies. The decision to cut large swathes of the workforce was even published. And those cuts are already taking place, with staff leaving the NHS while the workforce plan remains in draft.

If the NHS is expected to reform, it cannot afford to hollow out the very capacity required to drive those changes. These cuts have undermined



EMANUEL HAS/UNSPASH

the government's reforms before they have had a chance to get started. The upcoming workforce plan may be the last chance to get the right staff in place to deliver the government's ambitions. NHS managers must be part of that conversation.

The case for management

There is an abundance of research that highlights the positive impact good management has on health services. The Institute for Government found that growing

agement

Rhys McKenzie is MiP's communications officer.



“Managers make up a small share of the workforce and an even smaller share of overall spending, yet they are consistently first in line for cuts. This is politically motivated but the evidence shows it is clearly counterproductive.”

management capacity can have tangible benefits for patients as well as the wider workforce: a increase in managers from 2% of staff to 3% has been associated with a 1% increase in patient satisfaction scores, a 5% increase in hospital efficiency and a 15% decrease in infection rates. These are not marginal gains—they represent thousands of safer treatments, shorter waits and better patient outcomes.

The Health Foundation has similarly concluded that sustained productivity improvement depends not only on clinical expansion but on investment in management and leadership. Likewise, analysis by the Institute for Fiscal Studies also suggested that management shortages may be contributing to weak NHS performance. Lord Darzi's review of the NHS, commissioned by this government in late 2024, found that many of the NHS's ills in recent years can be linked directly to the reduced number of managers over the period.

Even clinicians themselves are pleading for more managers. The Institute for Public Policy Research's workforce assembly—a two-year consultation with front-line health and care staff—found that the most common request was for “more and better managers”.

Why? Because when management capacity is stripped out, the work doesn't disappear. Someone else has to pick up the slack. As management capacity is squeezed, more administrative and operational tasks fall on clinicians.

When doctors and nurses spend hours resolving gaps in rotas, managing procurement, chasing estates repairs or navigating HR processes, it means less time treating patients. It contributes to burnout and makes little financial sense. There is nothing efficient about paying highly trained and highly skilled clinicians to plug managerial gaps.

Management in a £180 billion public service is not an optional overhead. The NHS is one of the world's largest and most complex employers—it needs managers to ensure it operates smoothly and effectively. Good management allows clinical care to happen safely and at scale.

Managers are crucial in driving down lists, improving patient flow in hospitals, ensuring services are delivered safely and making sure hospitals have enough medicine and equipment. They are the technology experts, the people who will make AI work well for patients and make sure the NHS uses data-informed decisions to increase activity and improve services. They commission the services patients interact with each day, lead transformation programmes, and coordinate multi-agency working. Managers translate policy into safe, functioning services on the ground.

Is the NHS over-managed?

Despite all the evidence to the contrary, we hear persistently that the NHS is over-managed. But the reality is the NHS employs a lower proportion of managers than many comparable health systems and far fewer than the average UK private sector firm.

Managers make up a small share of the workforce and an even smaller share of overall spending. Yet they are consistently first in line for cuts. This is politically motivated—managers are an easy target—but the evidence shows this is clearly counterproductive.

The public want a health service that delivers high quality, timely care, free at the point of use. Achieving that requires the whole NHS to work together as one team.

A credible workforce strategy would recognise this and go beyond simply boosting clinical headcount. It would factor management into its projections, recognising the link between good management and performance. It would identify the skills needed to deliver the government's three shifts and plan accordingly, and it would invest in management and leadership development just as it does for clinicians. Crucially, it would stop treating management as a cost to be squeezed and start recognising it as an investment in performance and productivity.

This is not about administration versus treatment. It is about aligning the workforce with the government's own priorities. Right now, ministers are asking the NHS to fundamentally transform how it delivers care, while cutting the very people needed to make that transformation happen. The workforce plan when published this spring offers a chance to correct that contradiction. //



Let's change the story and start taking management seriously

The NHS is regularly battered by upheavals in management structures and cuts to its specialist managers. Often badged as 'reform' or 'protecting the frontline', in reality they neither reform nor protect. They are the product of a fundamental lack of political seriousness, exhibited over decades, about the management capabilities needed to make the NHS work. This damages the NHS model, massively supported by the public, and does nothing to improve satisfaction with the NHS, now at a record low. We badly need a change of approach and we need parliament to make it happen.

Ministers tend to see their re-organisations as like re-laying a model train set. Yes, unpinning the track is finicky, but once the new set-up is in place you push the button and off the stupid little trains go again. That, unsurprisingly, is not how complex human organisations work.

In their NHS management career, a typical MiP member will have worked through a dozen major re-structures and myriad smaller ones. This builds some resilience, but the personal impact on individual managers can still be devastating. And it's just as damaging for the rest of the NHS team and for the safety, efficiency and quality of services to the public.

Take the government's ongoing NHS financial re-set. It is ripping through the management capabilities of every part of the service, including the NHS trusts delivering care to the public. While targeted at managers and other support roles, cuts to trusts also mean ward closures, clinical vacancy freezes and reduced access to services.

As management jobs are axed, the remaining specialist managers are seeing their portfolios of responsibility doubled or trebled. Much of the work done by departing managers and admin staff is being offloaded onto clinical managers—a very costly option if they're doctors—taking them away from clinical duties, service improvement and their frontline colleagues.

Micro-management, fire-fighting and burn-out are the order of the day. You can work out for yourself what is happening to investment in staff relations, digital and information systems and the

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A typical MiP member will have worked through a dozen or more restructures. This builds resilience but the personal impact can be devastating. And it's just as damaging for the rest of the team and for the safety, efficiency and quality of service to the public.

estate, and the specialist managers those functions need. These are all key components of any organisation's management capability, and all supposedly critical for the government's reform plans.

In the planning, system support and oversight bodies—ICBs, CSUs and NHS England—the cuts are even harsher, and were administered without any preparation. Staff are being made redundant—cockamamie rehiring alert!—before new responsibilities have been worked out. The cross-system relationships and innovations supported by these organisations are at risk and will take years to rebuild, as will the capacity to deliver flagship government projects like neighbourhood health.

Concerns about public safety during this chaos have also gone unaddressed, particularly in safeguarding and children's services, where ICBs have a far more hands-on role than is commonly realised.

We can't keep doing this every few years. Sooner or later, the NHS will be well and truly broken and dedicated staff will walk away. So let's change the story by taking management seriously. This goes beyond the number of specialist managers (although that is a big issue) or their regulation and professionalisation (two bits of government policy we support). Management capability is more than that. It is about the skills and competence needed by the NHS across many professions to deliver services effectively and improve public health.

It's also about giving clear national direction for the service, with properly defined responsibilities and stronger links between each part of the system and other parts of government—critical for changes such as SEND reform. The NHS works best when these are in place.

And it's about deciding on the model of management and sticking with it for more than a year or two. MiP doesn't have a set view on what that model should be (just choose one!), although we believe in devolving decision-making as close to patients as possible, and empowering frontline managers and clinicians to make the best use of resources and deliver the improvements everyone wants to see.

Parliament, starting with the upcoming health bill, should take the lead in demanding the NHS has the management capability it needs and the public deserves. //

I'm only here to make sure we're making a difference. If we don't improve people's health, I'll resign.

Former council chief Robin Porter has endured a baptism of fire since joining the NHS last year. Now set to chair Central East, England's largest ICB outside London, he talks to Craig Ryan about missions, mergers and making a difference.

“M y career's been schooled on taking personal accountability,” says Robin Porter, former council chief executive and incoming chair of the new Central East Integrated Care Board (ICB), which opens for business this April. “If we aren't delivering health improvements, I will resign, because I'm only here to ensure that we're making a difference.”

Porter says his “making a difference” is his motivation; it's a phrase he repeats many times during our conversation. A

humanities graduate, he served six years as an army officer before drifting into project management in the private sector—lucrative but “not socially and morally rewarding,” he recalls. “I wanted to make a difference to a place.”

That place turned out to be Luton. He joined the town’s unitary council on an 18-month contract and stayed for 18 years—including spells running the council-owned Luton Airport and managing school building projects—on his way to becoming chief executive in 2019.

“I absolutely, utterly loved Luton. It’s a fantastic place, huge opportunities, huge energy, but with very clear challenges,” he says. “It’s big enough to make a difference but small enough to get your arms around.”

Those challenges include some of the most deprived areas in England.

Porter recalls once “naively” asking a schoolgirl if she was looking forward to the summer holidays only for her to break down in tears. “For her, the holidays were about being hungry,” he says. “During school term she got two good meals a day... and she was now facing a couple of months of food uncertainty. That really crystallised for me why I wanted to become chief exec and what I wanted to do.”

That encounter led to his interview pitch for a “system” strategy—pointedly not a “council” one, he says—to eradicate poverty in Luton by 2040. It’s bold, it’s specific, it looks impossible. But that’s the point.

“The only way that was going to happen was to get the public sector working on a single mission, [getting] our voluntary, community and faith sectors and our population behind the strategy and—super importantly—getting the private sector involved,” he explains. “Getting big organisations to align their social responsibility programmes around this mission has “given it massive impetus”.

Adopted with cross-party support six years ago, Luton 2040 has already yielded tangible results: child poverty in Luton has fallen from 46% to 39%—impressive against a backdrop of rising figures nationally. “We’ve taken 5,000 people out of

destitution,” Porter adds proudly.

He “absolutely” sees a similar mission for Central East in driving down the “huge” health inequalities between “massively affluent areas”, like Harpenden and St Albans, and the “deep pockets of deprivation” found in Luton, Bedford and even parts of Cambridge. “I don’t think it’s right morally that we should be accepting those [inequalities],” he says.

Formed by bringing together Porter’s Bedford, Luton and Milton Keynes ICB (BLMK) with the neighbouring counties of Cambridgeshire and Hertfordshire, Central East is a huge patch, but comes with “huge opportunities”, he says, including several “world-class” hospitals and Europe’s biggest biotech campus in Cambridge.

Bringing home some of the £1 billion spent out of area will also benefit Central East residents by moving care closer to home and generating extra income for local trusts. “The socio-economic benefit of bringing that spend back into area is massive,” he explains.

By targeting that cash and the “uptick” in funding he expects from the area’s rapidly growing population where it’s most needed, Porter believes the ICB can reduce inequality without swiping resources away from more affluent areas.

As an example, he points to “really poor” early cancer diagnosis rates in Luton. “There’s a direct link between improving cancer services and health outcomes. But when you look at what we provide in Luton, there’s no community diagnostic centre there,” he explains.

“Being better off is absolutely healthier”, he says, so tackling health inequality, like Luton 2040, demands a whole-system solution.

An NHS strategy alone “is going to fail”, he warns. “The Ten-Year Plan is absolutely dependent... on system working with local authorities, the voluntary community sector and residents.”

That means focusing on “what happens in streets and neighbourhoods and places”, he says. Working with Central East’s incoming chief executive, Jan Thomas, Porter has developed a devolved structure based on the three county areas, with neighbourhood

delivery committees doing the groundwork on joining up services.

As an example of a “real integrated team”, Porter points to an urgent care hub he recently visited in Luton. Here, ambulance managers working alongside A&E consultants, social care services, community workers and hospice staff have reduced conveyances to hospital emergency departments by 4.5% at a time when conveyances have been rising nationally.

Porter left Luton Council in April 2025 to spend more time with his wife Laura, who was unwell and sadly died a few months later, and his young son, Jack. “It’s just not possible for me to be a single parent and do an exec role with the type of energy and gusto that exec roles need,” he explains. So it was “almost serendipity”, he says, that the BLMK chair job fell vacant at just the right time.

Having represented the council on the ICB’s board, he “knew the massive impact the NHS has on [people’s] ability to lead happy, sustainable, rewarding lives. The NHS is so incredibly central to what makes us a nation,” he says.

He sometimes misses the operational control he had at Luton. “The hardest thing to let go of is the decision making,

because it’s not my role to make decisions,” he says. Instead, his job is “ensuring we’ve got the strongest possible exec team, the strongest possible inclusive board” and “providing positive, appropriate challenge and support to the execs”.

But above all, he says, the chair and the other non-execs are “there to act on behalf of our 3.5 million residents”. He has insisted that all six non-execs—two for each county—have a “place focus” and live in their areas. “I want people around the board table who understand the needs of their places, who understand the differences between Bletchley and Hemel Hempstead,” he explains.

With its wholly bureaucratic chain of command going all the way up to ministers, it’s a pragmatic, if imperfect, fix for the lack of local accountability in the NHS. Formally, Porter reports to NHS England regional director Clare

Panniker. “We have a great relationship, she’s a hugely talented individual,” he says, but ultimately he sees himself as “accountable to 3.5 million residents for making a difference to their lives.”

Porter’s first nine months in the NHS have seen a firestorm of change.

ICBs are being merged at a blistering pace, and are losing half their staff while implementing sweeping but still poorly-defined changes to their powers and responsibilities—a triple upheaval that’s probably unprecedented in British public services.

We’ve got used to NHS leaders robotically intoning that all this is going to be “very challenging”, but with Porter you sense that he understands just how hard it’s going to be. And also that he’s done a lot of thinking about how—through devolution, integration and a mission approach—it might just be made to work.

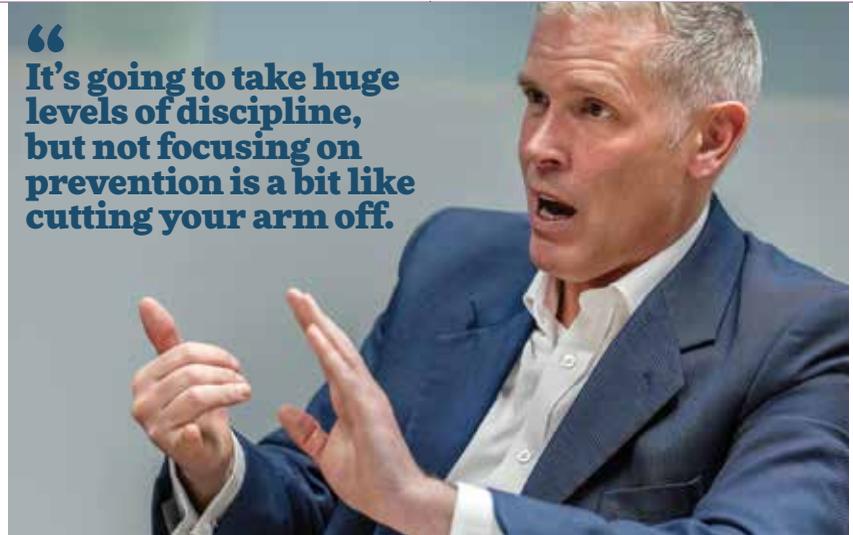
“We’ve had to reinvent ourselves and do it at speed,” he says, rejecting my suggestion that the reforms are chaotic: “The public service, for me, has got to move at speed. It’s got to evolve.”

The NHS has seen “huge demand increases,” he says, “but it’s also had a lot of extra money”. He believes he can bring the skills honed in local government during the dramatic funding cuts of the austerity years “to help the exec team and colleagues across the organisation cope with the brave new world.”

Prevention will be a “huge” part of coping, he says. BLMK has had a ‘prevention by default’ strategy for primary care since early 2024, but Porter accepts that previous attempts to reduce demand by boosting public health and preventative services have been quickly derailed by other, shorter-term priorities. Pressure to cut waiting lists, reduce A&E delays and improve ambulance response times won’t go away.

“Yes, it’s going to take huge levels of discipline,” he says, but “not focusing on prevention is a bit like cutting your arm off.” The ICB must work “collaboratively” to make sure all partners—including trusts—“buy into the absolute need to keep focusing on prevention”. Otherwise, he warns, “the issues are going to get worse and worse.”

“**It’s going to take huge levels of discipline, but not focusing on prevention is a bit like cutting your arm off.**”



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But will slimmed-down ICBs have enough clout to enforce that kind of discipline? ICBs may have stopped performance managing trusts but will still have leverage, Porter suggests, through commissioning, managing and monitoring contracts, while “working in concert” with the regional teams managing trusts’ “overall performance”.

The mysterious ‘strategic’ commissioning that is now ICBs’ main job just means better—and better-informed—commissioning, he suggests.

“We’re going to be absolutely data-focused, focused on keeping people out of the healthcare system.” ICBs will need to “radically change” their approach, he says, “so that we’re not buying tomorrow what we’re buying today—because our populations need a different focus.”

But as trusts begin to encroach on ICB territory by turning themselves into ‘integrated healthcare organisations’ (IHOs)—with contracts to manage and commission all health and care services in their patch—some ICB managers fear they are being set up to fail. But Porter insists he wouldn’t have taken the job if he thought ICBs were just being managed out of the system.

“We’re going from micromanaging hospitals to delivering the Ten-Year Plan”, an “absolutely central and important role,” he says. The government’s policy is “still evolving and we’ll deal with it as it becomes clearer”. But he suggests IHOs may emerge as a sort of local

subcontractor for ICBs, covering a much smaller area like Luton or Bedford.

“We are going to crack on with a clear approach that we’re going to be around for the medium to long term, and I’m not going to worry about stuff we can’t control,” Porter adds.

What does keep him awake at night is the pace and scale of the merger and its impact on “the dedicated, wonderful colleagues who are going to lose their jobs”, he says. “It’s very challenging organisationally but also at a human level.”

He insists his merger is not a takeover by any one ICB or a process of cherry-picking the best from each and bolting them together. “In our heads, it’s not a merger,” he says. “We’re forming a new organisation from the three previous ones. Being super clear with the team that this is a new organisation with a new mission, a new energy, has been really important.”

What would success would look like for Central East if we are sitting down again in a few years’ time? “Success looks like tangible outcomes,” Porter replies, in particular, “measurable” improvements in the board’s five priorities: early cancer diagnosis, musculoskeletal self-care and support, cardiology, co-ordinating care for advanced illnesses and acute mental health. “Across each of those five, we will see tangible improvements for our 3.5 million residents.” It’s not a question of hoping, he insists. “That’s what will happen. I’m confident about that.” //

Precious few &

As well as bringing job losses, NHS restructuring puts more pressure on staff who stay, with bigger workloads, more responsibilities and the emotional dislocation of losing colleagues. Rhys McKenzie talks to MiP national officer Sam Crane about supporting staff navigating this tricky transition period.

When major public sector reform is announced, attention usually focuses on those who leave. People who are losing their jobs, and maybe their livelihoods, often need immediate support. And the loss of their knowledge, skills and experience can significantly affect the organisations they once worked for.

But the experience can be equally unsettling for staff staying in the new structure. They face uncertainty, increased workloads and the pressure of maintaining services during significant upheaval.

Doubling up

Staff who stay on after major organisational change are often expected to pick up more work, says Sam Crane, MiP's national officer for the East of England and North London.

"I've just come from a meeting this morning," she says, referring to an ICB where voluntary redundancies are underway. "There were five people in a team—there's one person left. That one person is now covering the workload previously undertaken by five people. It's unacceptable."

The employer says that once the full reorganisation is complete the remaining team will have less work than before. But in Sam's experience, workloads don't necessarily reduce. And even if they do, eventually, what about now?

The transition period—when some people

have been made redundant but the new structure has yet to take shape—can be especially challenging. Staff may take on new roles alongside their existing responsibilities. In this situation, "somebody's going to have to double up," says Sam. "MiP members tell me, 'I've got a new job, but I can't drop the old job until April.'"

Juggling these competing priorities creates pressure in terms of capability as well as workload. When senior managers leave and are not replaced, "that work doesn't just disappear", says Sam—staff at lower grades are often expected to take it on without additional support or recognition. "You've reduced roles and sometimes layers... and you expect people to pick up all these new responsibilities, which may be on a different level of working," she explains.

And when organisations are merging, staff are often pooled for jobs away from their usual workplace. In Sam's experience, employers usually try to manage this, but it's not straightforward. "You've got staff working in different places that have been merged into one, so where's their base? It's a minefield," she says.

Moral injury

As well as workload pressures, redundancies can have a significant emotional impact on staff who stay on. Staff whose posts are marked for redundancy must undergo what Sam calls a "very stressful" pooling process if they want to stay on—effectively competing with colleagues for a limited number of jobs. Those who are

betw

successful may feel relief but know it likely comes at the expense of a colleague who will lose their job.

This can be made worse when job descriptions are so generic that it becomes almost impossible to meaningfully differentiate between candidates.

MiP hears from members that the moral injury sustained by those who stay can be upsetting. While she recognises that employers do try to support people, “all the wellbeing and interview support offered doesn’t take away that anxiety,” Sam says.

Staff exits can be abrupt—there are often no goodbyes, no leaving dos, no extensive handovers—colleagues just vanish. “One day you’re chatting with your colleague in the office, on Teams, working on projects together—the next they’re just gone. It can be really debilitating,” Sam says.

Take action, get support

Your employer has undergone a major reorganisation and significantly reduced its staff. Some functions have gone but new ones have been taken on. You’re slotted into a new role, but what was a five-person team is now just you and a senior manager. Your workload inevitably increases and you begin taking on more and more delegated responsibilities from your manager. Do you have any recourse, or do you just need to adapt to this ‘new way of working’?

“Absolutely you have recourse”, Sam says. If your role and/or workload has significantly changed during or after organisational change, she advises updating your job description and objectives with your line manager. “If it’s changing, get it down on paper, get it agreed with your line manager—that’s the first step,” she says.

If it’s agreed that you’re working at a different level, you can ask for your job to be re-evaluated. This could lead to your job being graded

at a higher-level, meaning you will be paid fairly for the increased responsibility. MiP can give advice and direction to members who believe their job needs re-evaluating.

In terms of workload, staff should try to document the additional work they’re expected to deliver, Sam says. “If a five-person team becomes just one or two, then work naturally must come out of that team. The employer must be clear about what work stays and what goes—one person can’t be doing the job of five people.” She recommends discussing workload issues with your line manager in the first instance to agree fair and reasonable duties for the role, and short, medium and long-term actions and objectives.

Where possible, MiP also strongly advises members to formalise their current working arrangements as soon as possible during organisational change. For example, if you work flexibly with the support of your current line manager, it’s best to have this formally agreed. You may not have the same assurances after the reorganisation. Your local MiP reps can support you with this.

Employers can do more

I asked Sam if it’s reasonable to expect employers to do more to support staff during the sort of massive politically-driven restructuring going on in England—or are they just navigating in the dark like everyone else?

Sam recognises that the scale and speed of the government’s changes, combined with a lack of clarity about how they will be delivered, has made the process extremely difficult for employers to manage. However, many can and should be doing more, she says.

Clear, consistent and early communication is vital, Sam explains. Staff are being offered voluntary redundancy without knowing the future form and function of their

organisation. Many people want clarity—even if that means redundancy—but they may miss out on opportunities in new departments, new teams and new roles that would have appealed to them if they had known those opportunities existed.

It is essential for employers to thoroughly audit existing skills within their workforce before recruiting externally, particularly while staff are at risk, Sam says. “You need to be very careful before you send an advert out when people are sitting there losing their jobs—what message does that give?” Looking across the whole organisation, rather than within narrow silos, can help to identify redeployment opportunities, prevent unnecessary loss of expertise and reduce anxiety among staff who fear they are being overlooked, she suggests.

Sam also urges employers is to allow form to follow function. “I’m pleading with them to wait until after the new organisations are in place before changing policies on areas such as flexible working, on call arrangements and in-person working,” she says. Where multiple organisations like ICBs are being merged, there are often competing policies and different expectations among staff. “Wait until everyone is in place, the functions of the organisation are clear and then review as one organisation and as one workforce,” she adds.

When redundancies happen, the people left behind mustn’t become an afterthought. They often face increased workloads and heavier responsibilities, as well as bearing the emotional toll of a chaotic reorganisation in which many of their colleagues disappear almost overnight. Managing change with clarity and fairness not only protects staff wellbeing but is essential to ensuring the organisations that emerge are stable, effective and capable of delivering on their new priorities. //

AI IN THE NHS

In the first story of our new series on AI in the NHS, we explore the gap between the government's claim that the NHS is "the best-placed system in the world" to take advantage of AI, and the reality of digital job cuts and disengaged staff. If the NHS is serious about AI, it needs to invest in people as well as kit, writes Craig Ryan.



The UK government isn't under-promising about what AI can do for the NHS. The Ten Year Plan (TYP) is almost breathless in its enthusiasm. AI tools, it says, will improve diagnosis and treatment, accelerate clinical trials, optimise hospital workflows, facilitate 24-hour access, empower patients and enable personalised care plans. AI will also relieve staff shortages, reduce burn-out and be a "trusted assistant" to doctors and nurses—and much, much more besides. And it will even save money—six pounds for every pound invested, the government claims.

The TYP also claims "the NHS is the best-placed system in the world" to take advantage of AI. Here, we need some salt: the conversations I've had in recent weeks with managers, tech professionals and clinicians paint a very different picture. It's one where staff feel confused, unprepared and often disengaged, digital and data teams are overstretched and under-resourced, and many people with the skills and experience to work with this transformative

technology are losing their jobs.

But don't take my word for it. In December, the tech intelligence network Digital Health published a survey of NHS digital leaders. It should make uncomfortable reading for the AI enthusiasts in Victoria Street. Almost two-thirds said they felt unprepared to deliver the TYP's digital commitments and a whopping 96% said workforce pressures were holding back progress. Only a third felt ready to deliver key government programmes like the Single Patient Record and the Federated Data Platform.

Leaders variously described their organisation's digital readiness as "poor", "chaotic", "immature" or "patchy". And preparing to implement AI was right at the bottom of their priority list.

AI doesn't work straight out of the box. Which is why there's such a big gap between the government's promises and the reality on the ground. Developing, testing, deploying and learning to use AI systems in healthcare is a time consuming and labour intensive business.

The assumption that “you buy the technology and that’s the job done” is wrong, says Pritesh Mistry, research fellow in digital technologies at the King’s Fund and a former tech manager at Guy’s and St Thomas’ trust. “There’s a whole wrap-around of enabling factors that are needed to support the technology actually being used.”

As well as making sure new technology is compatible with existing systems, which hasn’t always been the case, he says, you need a deep understanding of the problems AI systems are supposed to solve. “We often hear about technology being implemented without considering the work people do and how they’ll have to change the way they work to get the best out of it,” Mistry explains.

“If there’s insufficient capacity—not enough time for people to do the training, to have exposure to the technology, to get the right support to use it, then it doesn’t get used,” he adds.

Experience shows that “if you just hire IT people to implement a solution, it doesn’t work,” Mistry continues. But involvement of non-tech staff in AI projects has been “patchy”, with development often left to IT services and a few “very digitally involved and experienced people”, he says. Ensuring technology is fit for purpose and usable by staff comes “from co-production, from working with the people who are going to be using the technology”.

That isn’t happening enough, says Tom Micklewright, a GP and digital transformation lead for Cheshire and Merseyside ICB. “It’s already hard enough to pull clinicians off the front-line, even for mandatory training, and this just becomes another thing to take them off”, he explains. “And if I’m going to get involved in making sure AI is safe, I can’t do that in a lunch break. It’s a lengthy bit of work.”

A study of the early use of AI in chest diagnostics, published last year in *The Lancet*, found procurement and deployment of AI took longer than expected, in large part due to high clinical workloads, limited AI knowledge and a lack of time for staff to participate. “AI may not address service challenges as straightforwardly as policymakers anticipate,” the

study concluded.

Failing to engage clinicians and managers creates a “bottleneck” in the implementation of any new technology, warns Karl Grundy, an industry expert and CEO of Digital Health. “You need them involved in terms of software design and usability, but also for optimisation within the organisation and to win hearts and minds,” he says.

This “buy-in” is important, Micklewright adds, because “as a clinician, I’ve got to trust the tech if I’m going to use it.” Involvement also deepens understanding, helping to ensure the technology is used “responsibly”, he says, pointing to a recent example where GP trainees were found to be using ChatGPT to



“If I’m going to get involved in making sure AI is safe, I can’t do that in a lunch break. It’s a lengthy bit of work.”

DR TOM MICKLEWRIGHT, CHESHIRE & MERSEYSIDE ICB

look up medical queries and summarise consultations.

Mistry has warned about the risk of a “disenfranchised culture” towards technology,

where previous unmet promises and failure to involve staff in innovation breed scepticism and disengagement. Going by my recent chats with non-tech managers about AI, this threat is real. A typical response was a snort, followed by a swift retort about computers that take ten minutes to start up and WiFi that doesn’t work through walls.

“Staff will be promised a step change that technology will unlock, but in reality often it doesn’t get realised,” Mistry says. “There’s money for the technology but not for the change—people are often unsupported for the change to happen.”

This is why, Grundy says, AI came bottom of the list of priorities in Digital Health’s survey of tech leaders. “We still have organisations going live with new EPR [electronic patient record] systems, or people that don’t have full

meds management and things like that,” he explains. “If you haven’t got an EPR system... and you’re not collecting data on the health of your residents, there’s no point in having an AI system.”

In primary care, “contractual gets done first,” Micklewright explains, pointing to the momentum behind online patient records and prescription ordering—both enshrined in GPs’ contracts. “And second, it’s demands from NHS England”. But there’s been little direction from NHS England on AI, he says. “It’s just been: ‘Start using AI. We’re not going to tell you which [systems], what to use it for or how to fund it—and we’re certainly not going to give you any money to try things out.’”

Another big threat to the government’s AI ambitions seems entirely self-inflicted. Redundancies triggered by the government’s NHS reforms is cutting a swathe through the service’s precious reserves of digital expertise just when they’re most needed. Some tech managers I’ve spoken to—mostly off-the-record for obvious reasons—seem close to despair.

“It’s pretty grim, to be honest, to see digital being gutted everywhere at the time of a technological revolution,”

says Felix Peckitt, MiP national committee rep for London and assistant director of data architecture at North Central London ICB.

Both the TYP and the model ICB blueprint identified digital as a priority for investment, “but the very opposite is happening,” he points out. “It’s very difficult and confusing for everybody working in this area because it feels like the people that have the most to offer are being shown the door.”

With the loss of key digital staff from

ICBs—only one board retains a chief digital officer—and the swift exit of national digital leaders like chief data officer Ming Tang and chief technology officer Sonia Patel, the NHS risks losing its “future lifeblood”, Grundy warns.

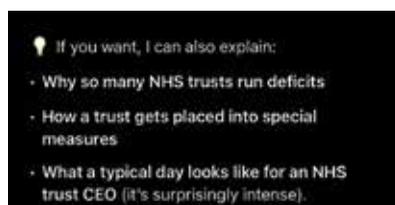
It’s “hard enough already” to recruit data and tech professionals to the NHS when salaries are much higher in the private sector, he says, “so when you actually choose to make these people redundant, it does seem a bit odd... You need to ring-fence the right people.”

On top of this, there’s continuing confusion about who is going to ‘do digital’ in the new model NHS. NHS England says digital leadership will transfer from ICBs to trusts and regional teams “over time”, but the way things are going, there may not be much ‘leadership’ to transfer.

“ICBs have been told to get rid of digital, but we’ve got no one to hand it over to,” says Micklewright. “And how does it work for general practice? Commissioning Support Units used to be the main source of digital support and leadership for GPs, and now they’re going as well. So who’s actually driving this?”

A recent report by the Commons Health and Social Care Committee concluded there weren’t enough digital skills in the NHS to realise the government’s ambitions. Action is needed, the committee said, both to boost the skills and confidence of NHS staff generally, and to expand the digital and data workforce.

This is another challenge for the new workforce plan. Mistry says that, while the NHS can’t compete on salaries, “there’s an opportunity” to grow the digital workforce by offering jobs that are “more satisfying”, have “more impact” and provide better work-life balance. “I think it’s probably needed, but we don’t know. That’s part of the problem,” he adds. “The NHS hasn’t done a good job of understanding how big the [digital] workforce is and what we’re going to need in the future.”



AI: growing a learning ecosystem

Most experts agree the most important AI investment the government can make isn’t in the technology itself, but in the skills of the people who are going to use it. An investigation into the NHS’s early experiences with AI by researchers at Edinburgh University (mip.social/ai-lab) found that effective transformation will “require efforts to promote the creation of a learning ecosystem, improving knowledge flows and engagement/ownership by frontline care providers.”

AI training for non-digital staff is often tightly restricted in the NHS, says GP Tom Micklewright (see page 17). In particular, training in clinical AI, safety and analytics needs to be “radically accelerated and broadened” and there’s also an urgent need for digital project management training so the NHS can stop buying “off-the-shelf” AI products from big tech firms and “work with small companies to build something bespoke”, he says.

The Ten Year Plan does include some proposals for upskilling NHS staff, including:

AI to be made part of the education syllabus for doctors, nurses and other clinicians by 2028

A “personalised career coaching and development plan” for all NHS staff by 2035

“Skills escalators”: a skills-linked trajectory for career progression for all staff

Reducing the burden of “unnecessary” mandatory training to free up time for priority training areas such as AI

A general promise that NHS staff “will be AI trained, digitally confident and have skills in modern leadership, transformation and innovation”

It’s still unclear how these initiatives will be funded or delivered, although the new NHS workforce plan, expected this spring, may offer further clues.

Some managers fear the NHS could get stuck in an outsourcing spiral as it tries to ramp up AI adoption in the years ahead.

If digital staff “are spread too thin, we won’t be able to deliver anything, and that provides a further excuse to dismantle,” says Peckitt. This could leave the NHS totally reliant on big tech firms, without even enough in-house capacity to function as an intelligent customer.

The danger here is the NHS ends up “outsourcing its competence” as well as the project itself, Peckitt warns. NHS staff “need a level of maturity” to use AI tools, because they can often produce “plausible” results or “something that’s almost right”, he says. “But you need it to be absolutely right. So you need someone who knows what that is.”

The government’s widely-ridiculed AI Skills Hub—developed by PwC for the Department for Science, Innovation and Technology at a cost of £4.1 million—is a case in point, he says: “They inadvertently gave an excellent education on the dangers of artificial intelligence by outsourcing their thinking and having something generic but plausible-looking generated for them without inspection.”

Mistry says there is “qualitative evidence” that organisations like Alder

Hay, Leeds Teaching Hospitals and Great Ormond Street, which have invested in their own digital workforce, technology skills for clinical staff and technology infrastructure, “are able to do more with technology and deploy it to have greater impact”.

And he cautions the government against moving too quickly with AI deals to avoid “cementing in a legacy technology”. AI is changing so rapidly, he says, that “if you’re locked into a five-year contract, how will you benefit from technology that’s going to be so much more advanced in two years’ time?”

Despite the government’s lofty ambitions, nine months on from the Ten Year Plan, job cuts and the lack of a coherent national strategy for delivery have left digital teams and AI-enthusiastic managers and clinicians adrift in a sea of uncertainty.

Peckitt points to the success of the London Secure Data Environment, a project linking up the health records of Londoners, as an example of what NHS digital teams can deliver. “We can do remarkable things. But to get rid of people at this time and leave people without a clear direction during a time of technological inflection is irresponsible,” he says. //

The Heat is



ON

*With global temperatures hitting a new high last year, climate change is now the biggest threat to human health. The NHS needs to move fast, not just to cut its own emissions, but also to adapt to the operational impact of a warmer climate, writes **Jessica Bradley**.*

Our rapidly warming climate has numerous operational implications for the NHS. As well as mounting pressure to lower its carbon emissions, the health service needs to adapt to the inevitable effects of climate

change on patient need and staff wellbeing.

According to the Met Office, 2025 was the warmest year on record. The World Health Organisation says climate change is now the leading threat to global health and it also threatens to disrupt the NHS's ability to deliver high quality care.

There is evidence that climate change is already starting to affect people's health. In summer 2018, for example, a fire on Saddleworth Moors led to a surge in people ringing emergency services with breathing difficulties. And during the 40°C heatwave in 2022, there were approximately 3,000 excess deaths among people over 65 in England.

In the coming years, there will be changing patterns of infectious diseases, with higher temperatures increasing the risk of diseases like Dengue Fever, Lyme disease and West Nile fever, through mosquitoes, sand flies and ticks. Worsening air pollution also means a higher risk of respiratory and cardiovascular illnesses.

The UK government's 2023 report on the health impact of climate change predicts that, without ef-

“There’s a potential staff welfare issue working in intolerable heat... the 2022 heatwave, with temperatures over 40C, pushed the UK into national emergency territory.”

forts to adapt and decarbonise, heat-related deaths will increase nearly six-fold by the 2050s. And experts warn there will be an increased risk of PTSD, depression and anxiety due to more frequent and severe flooding.

But impacts of climate change won't fall evenly across the population, says Chris Naylor, senior fellow in health policy at The Kings Fund. “People in lower income areas already with worse health outcomes will be disproportionately affected,” he says. Experts also warn that

the impact of climate change will fall disproportionately on children, people with disabilities, the homeless, and those in prison or social care settings.

Working in intolerable heat

According to the government's climate risk assessment, flooding and heatwaves will increase the risk of operational disruption in the NHS. This includes interruptions to critical services such as water, energy, transport and the supply chain, as well as physical damage to NHS buildings requiring temporary closures.

Heatwaves and hotter summers will bring many more challenges for NHS staff, says Neil Cartwright, NHS England's Greener NHS programme manager in the North East and Yorkshire.

As an example, he points to the failure of two data

centres during the 2022 heatwave which resulted in Guy's and St Thomas' hospitals losing access to their clinical IT system. During the same heatwave, a survey of critical care clinicians reported that almost a fifth of UK hospitals had to cancel operations because operating theatres were too hot.

“There's a potential staff welfare issue with colleagues working in intolerable heat in wards and clinics that are getting hotter and hotter,” explains Cartwright. “The 2022 heatwave, where we saw temperatures over 40°C, pushed the UK into national emergency territory. For the first time in recorded history, we had a red heat warning and a Level 4 Health Alert issued simultaneously. If temperatures like that had persisted for a week, the health impacts and disruption to essential services would have escalated rapidly.”

“The gloves are off”

The NHS is responsible for 5-6% of the UK's carbon footprint. This includes emissions from buildings, anaesthetic gases, supply chains, commissioned health services and travel.

“The biggest chunk of the NHS's carbon footprint is medicines,” says Naylor. “Producing them is an energy intensive process.”

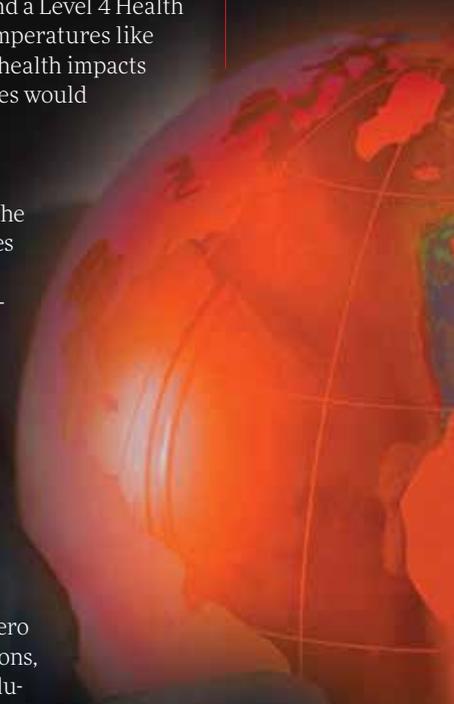
But, he adds, if the NHS can reduce the £300 million worth of medicines wasted every year, it could save money as well as carbon.

In England, the NHS has a legally binding commitment to reach net zero by 2040 for its direct carbon emissions, and by 2045 for the emissions it influences. NHS England says NHS carbon emissions fell by 14% between 2020 and 2025 – the equivalent of one million fewer people flying from London to New York.

In trying to reduce emissions, many NHS trusts have run campaigns to reduce waste and unnecessary interventions. In 2020, a multidisciplinary team at Charing Cross Hospital achieved a 25% decrease in cannulation during emergency attendances in one year, reducing emissions by 19 tonnes of CO2 equivalent. And Great Ormond Street Hospital launched “The Gloves Are Off” campaign, which led to 36,600 fewer disposable gloves being used every week.

On a national scale, NHS England set targets in 2020 to reduce the use of desflurane, an anaesthetic gas with a huge carbon footprint. It was fully decommissioned in routine surgical practice in 2024.

“The NHS targets are ambitious,” says Tom Hardie, senior fellow at The Health Foundation. “With the wider



supply chain, this is very complex, but there are ways this can be done.”

NHS England’s Net Zero supplier roadmap is the key initiative for reducing supply chain emissions, setting out the steps suppliers need to take to align with NHS targets. From 2030, suppliers who can’t verify their progress through carbon emission reporting will be excluded from NHS contracts.

Tick-box approach

Last year, NHS England published a Climate Adaptation Framework to help NHS organisations identify and address relevant climate risks. “Some NHS trusts are starting to assess heat, flooding and wider climate risks, largely because they have dedicated staff capacity to do it and because foresighted leaders are choosing to prioritise the work,” says Cartwright.

“What worries me is that this is not yet happening consistently across the wider health and care system, despite the UK Climate Change Committee warning that the UK is not adequately prepared for the effects of climate [change],” he adds.

Naylor warns that progress within the NHS is being held back by decision-making that focuses on minimising short-term costs rather than delivering best value in the long term. “The way we provide health-care at the moment isn’t sustainable in any sense of the word,” he says.

Environmental targets for NHS trusts can be met in a “tick-box” way depending on individual senior leaders’ commitment to tackling climate change, Naylor explains.

His research has led him to conclude that the current accountability arrangements for environmental sustainability in the NHS are too weak.

“There isn’t much in terms of consequences; no one at board level is held to account if they miss one of the greener NHS targets,” he says.

There’s a lot to be gained by the NHS working closely with local authorities and other partners, Naylor adds, as Newcastle NHS Trust has done through its partnership with the government and other local bodies to take collective action to reduce air pollution.

‘It starts from the top’

It’s also important to focus on preventative, community-based healthcare, experts say, as acute hospitals have been found to have the biggest environmental impact.

“Anything that involves intervening early and avoiding hospitalisation can reduce the need for



Inspiring change—in your own time

Angela Hayes, a nursing fellow and project lead at the Centre for Sustainable Healthcare, works on the Green Nursing Challenge, an initiative that promotes sustainable nursing practice in community and secondary care.

Hayes says having an understanding manager allowed her to pursue her passion for sustainability, but it was important to learn how to frame her ideas to get the time and resources she needed.

When she worked in the NHS as a clinical nurse specialist, Hayes set up a sustainability committee. Members started several community projects to raise awareness of air pollution, and the importance of not keeping car engines idling on the hospital site. The committee also led a Green Team competition, in which six teams of clinicians competed to offer the best sustainable quality improvement idea.

Until her manager secured additional funding, Hayes had to find time outside work to work on sustainability projects. “It wasn’t easy, when I was doing it on my own,” she says. “I learned that it was probably best to frame it as a quality improvement initiative that will benefit patients and reduce demand on the service, rather than say it’s better for the environment, which isn’t seen as a priority.”

carbon-intensive hospital care,” Naylor says. Initiatives such as patient empowerment and lean, efficient care pathways, can bring clinical and financial as well as environmental benefits, he explains.

The issue of sustainability needs to also be integrated and aligned with other system priorities, such as those set out in the NHS Ten Year Plan, says the Health Foundation’s Tom Hardie.

The foundation advises that in shifting from analogue to digital healthcare, NHS organisations should follow ‘green digital’ principles, including lean approaches to digital product design, energy use and data storage, as well as adopting ‘circular economy’ approaches.

But, crucially, Hardie argues, senior leaders need to build sustainability into strategies so that it becomes “business-as-usual” rather than a “do on lunch break” project driven by a few passionate people. “It starts from the top, with boards of NHS provider organisations taking sustainability seriously, putting it into strategy, and setting out clear actions,” he says. //

I'm on a fixed-term contract. Do I have any redundancy rights?

When employers are making redundancies, it's often wrongly assumed that people on fixed-term contracts will go first. But these staff do have rights—sometimes even after their contracts expire. Jo Seery explains.

In this edition we look at the rights of staff on fixed-term contracts (FTCs) when the employer is planning to make employees redundant.

A FTC is a contract of employment which terminates:

- » On a fixed date—for example, 12 months after the start date
- » On the completion of a particular task or project
- » On the occurrence or non-occurrence of a specific event (except retirement)—for example, a member of staff returning from maternity leave

Can a FTC be terminated early?

This depends on the terms of the contract. If it does not provide for termination before the end of the fixed term, an employer will be acting in breach of contract if they terminate it early, and the employee can claim damages up to the end of the contract.

If the contract provides for early termination with notice, the employer must give the required notice before dismissal. If the employee has two years' continuous service or more, the employer must give the reason for dismissal and act 'reasonably'—by consulting with the employee and considering alternative employment, for example. But an employee with less than two years' service may still claim that their dismissal amounts to less favourable treatment in comparison to permanent staff doing broadly similar work and with a similar level of skills and experience.

Do employees have any rights when their FTC isn't renewed?

Non-renewal of an FTC will be treated as dismissal in law, and an employee with two years' service or more may be able to claim

unfair dismissal. Staff are entitled to written reasons for their dismissal—which in most cases will be redundancy or 'some other substantial reason' (SOSR).

If the FTC is not renewed because the need for work of a particular kind has reduced, redundancy will be the reason given. To rely on SOSR, the employer must show that the FTC was for a genuine purpose, which was known to the employee when they were employed and that that purpose has ceased to apply. A common example would be a fixed term employee covering for someone on maternity leave.

Can fixed term employees be selected for redundancy first?

Generally, no. Under Regulation 3 of the Fixed Term Employee Regulations 2002, employees have the right not to be treated less favourably than comparable permanent employees just because they are on a fixed-term contract—unless the different treatment can be objectively justified.

Employers risk a claim for discrimination if fixed term employees are selected for redundancy first. In *Whiffen v Milham Ford Girls School*, the Court of Appeal upheld a claim for indirect sex discrimination when the employer selected staff on FTCs first for redundancy. Whiffen successfully argued that the requirement to be a permanent employee in order not to be selected for redundancy first was not justified and amounted to 'a provision, criterion or practice' which put women at a disadvantage—because women were more likely to be employed on FTCs.

Can fixed term employees ask to be treated as permanent?

Yes, an employee on a fixed term contract will be regarded as permanent provided they have four years' service or more on a

series of FTC's, and this could not be justified objectively at the time of the most recent renewal. This provision is intended to encourage secure employment by preventing the abusive practice of keeping staff on successive FTCs.

The employee can request written confirmation that their contract is no longer fixed term. The employer must reply within 21 days, either accepting the request or giving concrete and precise reasons for refusing.

Can an FTC be 'suitable alternative employment' in a redundancy situation?

This depends on all the circumstances. In one case an employee was held not to have unreasonably refused a job which would only have lasted two months, while in another, the employee was held to be acting unreasonably by refusing a job which was expected to last between 12 and 18 months.

In conclusion, selecting employees for redundancy simply because they are on an FTC is likely to be unfair unless it can be objectively justified. Employers should consult with staff on FTCs and consider suitable alternative employment where they are at risk of redundancy, just as they should for comparable permanent employees. //

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

How to design your future after redundancy

Career coach and former NHS manager Charlie Keeney offers his tips for coping with redundancy and laying good foundations for your next move.

Redundancy is often a profound personal and professional rupture. For healthcare managers with a strong sense of purpose and commitment to public service, it can disrupt identity, security and confidence. As a career coach and former NHS manager, who took voluntary redundancy in 2023, I've learned that coping well is about laying the right foundations for what comes next.

1. Put your wellbeing first

Redundancy activates stress responses that impair judgement, resilience and health. Prioritise sleep, movement, nutrition and emotional support. This is not indulgence, it's good self-management for your entire future.

2. Allow the emotional impact

Relief, grief, anger, fear, pride and guilt may all coexist. Compulsory or voluntary redundancy often carry loss, injustice, disorientation and self-doubt. Acknowledge what this is costing you, rather than dismissing or rationalising it away.

3. Separate your job from your worth

Redundancy isn't a personal failure. Highly capable, committed managers are affected because systems and politics change, not because of their performance. Your contribution for colleagues and patients doesn't disappear with your post.

4. Slow down before you speed up

The urge to do something immediately is understandable, especially when income drops and your lump sum begins to shrink. But decisions made in fear often narrow rather than expand future options. Take a deliberate pause to process

what's happened before committing to your next move. Establish a new structure for your day: a planned wake-up time, a walk and an 'anchor' activity like a social catch-up or that house or garden project you've put off. A ticked 'done list' for the week creates momentum and counteracts potential dips.

5. Refresh your work and career story

Redundancy can distort self-perception. Develop an accurate, future-facing account of who you are and everything you can offer. Try this three-stage process I use in my coaching:

Reflect on you at your best. What were you were relied on or thanked for? When did you feel most effective? Gather a few stories to show the impact you had.

Refocus on what matters to you now. What gives you energy or drains you? What can't you tolerate again? What do you value most: autonomy, structure, pace, stability, innovation?

Relaunch with a confident narrative about you and what you can bring to the current jobs market. Plan deliberate action to achieve what you want next.

6. Take stock of what you want next

This is a rare opportunity to design your future, not repeat the unsustainable experiences of past jobs and working environments. Consider the full scope of the role you want—autonomy, workload, values and organisational culture—not just job title and salary.

7. Stay connected

Redundancy can be isolating, but having rhythm and connection in life can ease loneliness. Talk with trusted peers who understand your past jobs and the demands of the system you worked in. It's easier to

regain perspective in conversation than in isolation. Schedule contact with others two or three times a week: walks, a coffee, a park run, a class or a volunteering shift. If you're worried about explaining yourself, rehearse a simple line like: "I'm enjoying a short break after voluntary redundancy to work out what's next for me."

8. Get support from your union

Unions like MiP offer procedural protection, but also advocacy, clarity and professional grounding. Engage early to access all the support and resources available.

9. Consider coaching

Coaching can help you to rebuild confidence, process uncertainty and make intentional decisions. It can make the difference between just reacting to redundancy and using the transition well. Transition-focused coaching focuses on capabilities, values and energy, and helping you to form deliberate preferences about what's next. Then you'll be ready for coaching to support your direction and decision making.

10. Redefine success for this chapter

Success after redundancy doesn't always mean quickly finding another salaried job. Sometimes it's recovery, recalibration or choosing a different pace or direction. Remember: how you care for yourself now will shape what you can offer next. Foundations first, then go forward with clarity and intention. //

Further reading: William Bridges's classic *Managing Transitions* explores the psychology of transition, not just change itself. David Epstein's *Range: Why Generalists Triumph in a Specialized World* can help you to reframe your career stories and recognise your assets.

“I want to use my personal and managerial experience to make positive change.”

After undergoing an “absolutely horrendous” investigation at work, Helen Robertson decided to become an MiP rep. She talks to **Craig Ryan** about using her experience for the “common good” and her new challenge representing Wales on MiP’s National Committee.



“I like representing people,” says Helen Robertson, MiP’s rep at Digital Health and Care Wales (DHCW), “because I’ve got a lot of experience and knowledge now.” Being a rep is about “supporting people” as well as “really understanding what’s going on in the organisation”, she explains.

Redundancies are coming to the NHS in Wales, and DHCW—a national body providing digital and data support to NHS organisations—is one of the first in the firing line. Despite digital health being a high priority for the Welsh government, 47 of DHCW’s 1,200 staff have recently been placed “at risk” of redundancy.

“It’s crazy, isn’t it?” says Helen. At a recent accountability meeting, she asked DHCW bosses if ministers were even aware that digital staff were being made redundant at such a critical time. “I didn’t really get an answer,” she says.

Talk of redundancies as ‘headcount reductions’ obscures the reality that “there’s a person on the end of it, and they could be the only breadwinner in the household,” Helen says. She sees her job as a rep as “making sure that every ‘i’ is dotted and every ‘t’ is crossed, that the process is fair and we’ve done everything we can to protect that person and their job.”

Helen decided to become an MiP rep—a role she’d done years before for UNISON—after “quite serious” allegations were made against her in a case that dragged on for two years before being dismissed. “What I went through was horrible, but I knew it would be great for me if I could help someone else through it and share that experience for the common good,” she says.

The investigation was “absolutely horrendous, not just for me but for the whole team,” she recalls. “We’re quite immature as an organisation and I think the way they approached it was wrong.” Managers are often “seen as guilty and have to prove their innocence,” she says. “That’s how I felt and quite a few managers I’ve spoken to have felt the same.”

With the economic costs and the “emotional cost for staff” of long, drawn out investigations, “there’s so much time and money wasted,” Helen adds. “I know there are people out there going through the same thing, and I want to use my

personal and [managerial] experience to make positive change.”

She wants to see mandatory training for investigators and a “triage system” to weed out spurious or trivial cases before a full investigation is launched or staff are suspended. The triage panel could include line management, a union rep and someone from HR, she suggests.

Being a union rep requires “a lot of tenacity”, she says. “You can’t take no for an answer, and not everyone’s comfortable with that.” She doesn’t think her career has been affected but it “wouldn’t have bothered me because I know my own mind,” she adds. “It’s about managing personalities really, and I’ve found there are ways of winning people over to your way of thinking.”

Helen also wants to highlight problems facing older workers, particularly women experiencing menopause. “Sometimes you’re completely on your game, but the next day you’re completely out of sync. I think there’s more we can do to support those women to feel stronger and more vital in their roles,” she explains. In general, she doesn’t think the NHS has yet got its head around the idea of people working into their late sixties. “I don’t think they know what to do with us,” she says.

Helen recently joined MiP’s National Committee as one of two representatives from Wales. “We’re a small nation with our own challenges,” she says, so it’s important for Wales to “have a strong voice” in MiP, especially at a time of uncertainty, with May’s Senedd elections likely to see the first change of Welsh government since devolution in 1999.

Building MiP’s presence in some of Wales’s largest employers, like Cardiff and Vale, is a top priority, she says. “We don’t raise what we do and who we are enough. We need to say, ‘this is your management union. We’ve got the skills, the knowledge and the experience. We understand the job you’re doing because we’ve done it ourselves.’” //

“What I went through was horrible, but I knew it would be great for me if I could help someone else through it.”

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

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The Spirit of Brotherhood by Bernard Meadows



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Chief Executive, MiP



MANAGING our NHS