

issue 68 | summer 2026

# healthcare managers

**“We’ve got to diversify, invest and get smarter”**

London Ambulance chief Jason Killens talks to Healthcare Manager

**Tried, tested, trusted?**  
Why managing AI responsibly is the next big challenge for managers

**‘Staying is scarier than being made redundant’**

How staff are paying the price for England’s messy NHS reforms

**Let me shine**  
A short guide to supporting your autistic colleagues



The union for senior health & care managers

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# healthcare manager

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**I'm writing this in the press room at ConfedExpo in Manchester, where NHS England boss Sir Jim Mackey has just given his keynote. You know the drill: we've made your life hell, you've all done brilliantly, but, sorry, you're stuck in hell for the foreseeable (I'm paraphrasing). But then came something that snapped me out of my torpor.**

"With all the terrible stuff going on around the world, let's draw a line under it and just say, 'That's not happening in our place, it's not happening in our service.' And we can influence that," he said.

What did he mean? Mackey spoke the morning after masked men in Northern Ireland set up 'checkpoints' to harass black nurses going to work. Earlier in his speech, he had insisted the NHS had to protect staff from threats of "intolerance and division".

But I think he meant something deeper, more emotional here: that the NHS is more than just a way of funding and providing healthcare. It's an expression of our democracy and of cherished values that are under attack: fairness, treating people with respect, giving them the best treatment we can afford—just because they're our fellow citizens. It often falls short, but the NHS is a rare institution that actively strives to live up to those values.

That makes it powerful and precious, but also something fragile, to be reformed with care. But this restructuring has been carelessly planned and, so far, carelessly carried out. If you want just one micro-example, NHS England 'not realising' for 15 months that it had 500 staff who couldn't transfer to DHSC because of their nationality (see page 2) just about sums it up. There are dozens more.

This is why MiP wants MPs to amend the health bill so future reforms are done with the care the NHS deserves, with properly worked-out plans, reliable funding and honest impact assessments (see page 8). Politicians have the right to restructure the NHS, and may sometimes need to. But they have no business doing it carelessly and without parliamentary scrutiny. The NHS is too precious to be messed about like this. //

**Craig Ryan**, Editor  
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# heads up

News you may have missed  
plus what to look out for

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during pandemic—page 5

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## Overseas staff face dismissal over Whitehall nationality rules

**U**to 500 NHS England staff could be fired without compensation when the body is merged with the Department of Health and Social Care (DHSC) next year, because many overseas nationals are barred from working in the civil service.

The issue, which MiP says “has been known about” since

the start of the merger process, arises because civil service rules only allow nationals from the UK, Ireland, the Commonwealth and the European Economic Area to work for Whitehall departments, while the NHS can employ any staff able to work under UK immigration rules.

Staff caught by the rules would

not qualify for redundancy pay and some could face deportation if their visa status is dependent on their employment.

“These are serious concerns but NHS England and DHSC still have not set out a clear and workable solution for affected staff. The uncertainty is causing significant anxiety and distress,” said MiP chief execu-

tive Jon Restell.

Restell added that the situation reflected continuing uncertainty about the wider merger process, including future terms and conditions and protections for NHSE staff transferring into the civil service. “Staff need clarity urgently in order to make informed decisions about their futures,” he said.

## noticeboard

29 June—3 July 2026

### Social Care Co-production Week

A week of online events showcasing the power of co-production in social care, bringing together people with lived experience, practitioners and leaders. Run by the Social Care Institute for Excellence and supported by NHS England.

[www.scie.org.uk/co-production/week/](http://www.scie.org.uk/co-production/week/)

4 July 2026

### FDA Pride in London

MiP members are invited to join our partner union the FDA’s group at this year’s Pride in London parade.

Friends and family welcome. Register at the link below.  
[mip.social/fda-pride](http://mip.social/fda-pride)

17-19 July 2026

### Tolpuddle Martyrs Festival

Tolpuddle, Dorset (DT2 7EH)  
Annual festival organised by the TUC

to celebrate the founders of the trade union movement, with music, comedy, speakers, debates, food and drink.  
[tolpuddlemartyrs.org.uk/](http://tolpuddlemartyrs.org.uk/)

8 September 2026

### King’s Fund: Ten Year Health Plan—a year on

Yes, it’s been a year already. The venerable think tank’s experts and invited guests will pick over the plan’s first year and hopefully shed some light on why nothing much seems to have happened.

[kingsfund.org.uk/events/ten-year-health-plan](http://kingsfund.org.uk/events/ten-year-health-plan)

13-16 September 2026

### TUC Congress 2026

Brighton Centre  
158th annual congress of UK trade unions, with thousands of delegates, visitors and guests meeting for three days of networking and debate. MiP is represented as part of the FDA delegation.

[www.tuc.org.uk/events/tuc-congress-2026](http://www.tuc.org.uk/events/tuc-congress-2026)

18 September 2026

### NHS Alliance: NHS Strategy Directors Forum

Royal College of Physicians, London

New forum for strategy directors to talk policy, share learning and connect with their peers, operating under ‘Chatham House’ rules (what’s said here, stays here). Run by the NHS Alliance, the merged NHS Confed and NHS Providers. Chaired by Leicestershire Partnership’s David Williams.  
[mip.social/strategy-directors-2026](http://mip.social/strategy-directors-2026)

### KEEP THE DATE

24-26 October 2026: UNISON National Disabled Members Conference, Brighton ([unison.org.uk/events/2026-ndmc/](http://unison.org.uk/events/2026-ndmc/))

3-4 November 2026: WelshConfed 2026, Cardiff ([thenhsalliance.org/training-and-events/welshconfed26](http://thenhsalliance.org/training-and-events/welshconfed26))

17 November 2026: King’s Fund Annual Conference, London ([kingsfund.org.uk/events/annual-conference](http://kingsfund.org.uk/events/annual-conference))

## Are you in the wrong pay band?

Many NHS managers have seen their jobs change hugely in recent years. If your job hasn’t been re-evaluated recently and your job description is out-of-date, you may be getting paid less than you should be.

Your pay band depends on your job evaluation score which is based on your job description. Under new rules negotiated by NHS trade unions, all staff on Agenda for Change have the right to an up-to-date job description and to request a re-evaluation of their job if it has changed significantly.

To find out more, read the UNISON leaflet at [mip.social/banding](http://mip.social/banding). Contact your local MiP rep or MiP head office (MemberAdvice@[miphealth.org.uk](mailto:miphealth.org.uk)) if you need more support.

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

# New UK health secretary stresses “continuity” and no new money

**T**here will be no change in political direction and no let up in the government’s reform plans for the NHS, James Murray told a staff meeting shortly after replacing Wes Streeting as England’s seventh health secretary in less than five years.

In media interviews after his appointment on 15 May, the former Treasury chief secretary described himself as “continuity Labour government” rather than “continuity Wes Streeting”, but he signalled there would be no change to Streeting’s flagship policies, including the merger of the NHS England into the Department of Health and Social Care (DHSC), drastic cut backs to ICBs and tight financial discipline across the system.

According to sources present at the meeting, Murray “signalled continuity of political direction, acceleration of reform, firm commitment to integrating NHSE into DHSC, financial constraint, and a strong expectation that the system must deliver through transformation rather than relying principally



*Incoming health secretary James Murray is expected to unveil a new operating model for the new-look department its regional offices this summer.*

on additional funding.”

Reflecting his Treasury background, Murray “explicitly rejected” the idea that pressure on the NHS can be relieved by more funding, “instead emphasising reform, modernisation, prevention and better

use of existing resources”.

MiP chief executive Jon Restell said Murray needed to do more to rebuild trust with managers.

“The new health secretary says he wants to work with managers to drive improvements and deliver reform. But it may be two years too late. MiP members are up for reform—they’re the people who make it happen. But the shake-up of the last 18 months has led to avoidable harm and disruption.”

The target operating model for the new-look DHSC, originally expected this spring, is said to be high on Murray’s agenda. DHSC staff were told the health secretary wants “to test the model personally” ahead of publication in early June—although details of the model had yet to emerge at the time of going to press.

Murray, 42, has been MP for Ealing North in west London since 2019, and was previously a junior Treasury minister before becoming chief secretary last September. Before becoming an MP he was deputy mayor of London with responsibility for housing and residential development.

## NHS England exec pay system to be scrapped

**T**he UK government has agreed in principle to replace one-off bonuses for some senior managers in NHS England with consolidated pay awards as part of moves to scrap the controversial pay framework for executive senior managers (ESMs) working for the arm’s-length body.

The government accepted a recommendation from the Senior Salaries Review Body (SSRB) to withdraw the widely-criticised pay framework, under which

ESMs at the top of their pay bands receive non-consolidated lump-sum payments rather than permanent increases to salary. Over time, this has led to a gradual erosion of pay and reduced the value of subsequent pay awards.

But the government said it would not be in a position to withdraw the framework before April 2027 and that changes would need to be considered alongside the ongoing merger of NHSE with the Department of Health and



Social Care (DHSC). In its response to the

SSRB, the DHSC said that if the framework could not be withdrawn before the next pay round, future pay awards for ESMs would be fully consolidated.

MiP has argued for several years that the framework is no longer fit for purpose and should either be abolished or fundamentally reformed. The union continues to press the DHSC for clarity on implementation of the 2026-27 pay award and will keep members updated with any developments.

## Equality progress under threat as job cuts hit black staff hardest

**T**he reorganisation of the NHS in England is having a disproportionate effect on black staff, threatening to undo years of progress on improving diversity at senior levels in the NHS, according to MiP's Black Members Network.

In an open letter to ministers and senior officials, the network said that evidence from across the NHS suggests black staff are more likely to lose their job during restructuring than white colleagues, warning that BME representation at senior levels could decline as organisations reduce management posts. Members report that the removal of workforce representation standards



Prince Obike: "racism continues to go unchallenged"

has made it harder to monitor and address inequalities, the letter adds.

The network also highlights reports from MiP members about an increase in incidents of racism in NHS workplaces—including patients refusing treatment from black clinicians—and a perception among staff that discrimination is not

always challenged effectively.

The network's co-chair, Prince Obike, said "racism continues to go unchallenged in many NHS organisations", warning that the day-to-day experiences of too many black staff failed to live up to the commitments made in NHS policies and programmes.

"Too often, those who speak up about the disconnect between what is promised and what is experienced are marginalised or silenced," he added. "In the process, the humanity is being stripped out of decisions that affect the daily lives of black staff."

Uncertainty over restructuring across the NHS was damaging morale and undermining workforce equality, said MiP's assistant national organiser, Rosie Kirk. "Our members are telling us they feel anxious, unsupported and shut out of decisions that directly affect their livelihoods, with serious implications for

mental health and safety at work."

Kirk warned the loss of experienced staff and weakening of equality safeguards undermined efforts to build a diverse and supported workforce capable of delivering NHS reform.

The letter called on government and NHS employers to reinstate workforce representation standards, publish equality impact assessments for restructuring programmes, strengthen protections against unfair disciplinary action and give clearer guidance on supporting staff mental health during periods of organisational change.

MiP chief executive Jon Restell said: "This heartfelt letter shows the persistent gap between the espoused values of the NHS and the everyday experience of our black members. The government's forthcoming staff standard on tackling racism must bite the problem unlike earlier policy initiatives."

### VSM Pay

## Board-level NHS managers get 3% pay rise

**B**oard-level managers in England are set for a 3% pay rise for 2026-27—lower than most other NHS staff—despite evidence that pay levels for senior managers have fallen sharply in recent years.

After a delay of more than two months, the government finally accepted pay recommendations from the Senior Salaries Review Body (SSRB) for very senior managers (VSMs) and executive senior managers (ESMs) in England in late May. The 3% award is higher than the 2.5% ministers said was "affordable" but below the 3.3% paid to NHS staff on Agenda for Change.

The SSRB also covers VSMs working in Wales and Northern Ireland, but at the time of writing only the UK government has formally accepted its recommendations.

The SSRB report highlighted the long-term decline in senior manager pay. It reported that salaries for trust chief executives have fallen by 13% in real terms in the last five years, while those for nursing directors have shrunk by 14%. In contrast, AfC Band 9 salaries fell by 6% and medical director pay by just 3% in the same period.

Commenting on the award, MiP chief executive Jon Restell said: "We welcome the fact the SSRB did not accept the gov-

ernment's argument for a cap of 2.5% on the award, and that they have accepted the review body's recommendation. However, our long standing policy is that VSMs should get the same pay rise as their colleagues covered by Agenda for Change."

The timetable has yet to be confirmed, but it is understood that guidance on implementing the award is currently being prepared for NHS trusts and ICBs.

This will be first award under the contentious new VSM framework which links organisational performance to individual pay. Executives in organisations in segment five of the NHS Oversight Framework are ineligible for the pay increase unless they have been employed there for less than two years. The government is also considering extending the policy to organisations in segments three and four, with a decision expected to be reflected in the guidance.

MiP is opposed to withholding basic pay awards from executives in segment 5 trusts, "irrespective of their personal performance", said Restell, "as well as any extension to trusts in segments 3 and 4. The SSRB has identified risks with the approach and we believe these support the case to review this element of the new framework."

The government also accepted a

recommendation to improve training and knowledge-sharing for remuneration committees and chief people officers in a bid to tackle the growing pay overlap between very senior managers and Agenda for Change staff. NHS England figures show that 9% of VSMs were paid less than the AfC Band 9 maximum in 2023-24 and the SSRB warned this figure was likely to have risen due to subsequent higher pay awards for AfC staff.

"In discussion groups, and in evidence from NHS Providers and MiP, we again heard that individuals on AfC choose not to apply for VSM roles because the pay uplift would not match the increased demands and accountability," said the review body report.

MiP members have consistently reported that despite funds being set aside in previous awards to tackle the overlap issue, the money is not being used locally and pay anomalies are still commonplace.

"We hope this extra training helps address pay overlaps but it will only work if the system allows remuneration committees to make corrective awards," Restell added.

The Department of Health and Social Care has indicated that it will provide further guidance on pay overlap issues to trusts and ICBs later this year.

Covid inquiry

# Managers “failed” by system as pandemic brought services to “brink of collapse”

In her third report, Baroness Hallett found the NHS was “ill-prepared” for the pandemic and relied on “almost superhuman” efforts by staff to keep functioning.



**N**HS managers leading services during the pandemic were working in a system that was “under-resourced, underprepared and already under significant pressure”, MiP said in response to the latest report from the Covid-19 public inquiry.

The inquiry’s third report, published in March, described the impact of the pandemic on all four UK health services as “devastating”. It found the NHS entered the pandemic “ill-prepared”, with “severe workforce shortages”, ageing infrastructure, high bed occupancy rates and limited critical care capacity.

The inquiry, lead by Baroness Hallett, concluded that health services “teetered on the brink of collapse” during the pandemic and were only able to continue functioning “thanks to the almost superhuman efforts of healthcare workers and all the staff who support them”.

The report confirmed “what NHS managers have long known”, said MiP chief executive Jon Restell. “They were asked to lead services through the greatest public health emergency in a century while working within a system that was under-

resourced, underprepared and already under significant pressure.”

MiP said managers carried immense responsibility throughout the pandemic, coordinating emergency responses, implementing national guidance and maintaining essential services under “unprecedented strain”.

The union highlighted the report’s criticism of infection prevention and control guidance, which the inquiry said had left managers having to interpret complex and rapidly changing advice while safeguarding staff and patients. It also pointed to the inquiry’s findings that PPE shortages caused significant anxiety among healthcare workers, particularly BME staff, and placed unacceptable pressure on local leaders responsible for distributing limited supplies.

“The report demonstrates the heavy emotional and psychological burden placed on NHS managers, many of whom worked for months without breaks while supporting teams through bereavement, sickness and severe operational pressures,” added Restell.

NHS managers were told to implement

visiting restrictions in care homes without clear national direction and guidance, the inquiry found. Despite the devastating impact on patients and families and calls for a more compassionate approach to reducing infection rates, “managers found themselves with no choice other than to follow government mandates,” the union said.

The inquiry’s wide-ranging recommendations include expanding “surge capacity” in urgent and emergency care, a more powerful infection control body to be convened at the start of any future pandemic, clear guidance on visiting restrictions, measures to expand emergency bed capacity and sustained support for staff wellbeing. MiP welcomed the recommendations and called on all four UK health services to implement them in full.

“The central lesson from the report is clear: NHS managers did not fail during the pandemic; they were failed by the systems in which they were expected to operate,” Restell added.

*Read the third module of the Covid-19 public inquiry in full at [mip.social/covid-report-3](https://mip.social/covid-report-3).*

## Trusts

# “Under the radar” cuts to trusts threaten services and reforms, MiP warns

**P**lans to cut tens of thousands of management and support staff jobs at NHS trusts in England are “going under the radar” and risk damaging patient care and undermining efforts to reform services, MiP has warned.

Research published by UNISON suggests NHS trusts are planning to cut at least 21,000 jobs by 2028 as trusts attempt

to meet increasingly challenging financial targets. The findings come as providers face significant financial pressures, with trusts collectively reporting a deficit of more than £1.1 billion last year.

UNISON says the true scale of workforce reductions is likely to be higher, as not all trusts were able to provide complete responses to the union’s Freedom of

Information requests.

The research suggests that at least 3,600 clinical jobs are due to be axed, but the majority of cuts are targeted at management, corporate services and support staff. These cuts are on top the estimated 20,000 job losses already taking place at NHS England, Commissioning Support Units and ICBS.

## Wales

# Plaid ministers vow to end long waits

**W**ales’s new health minister, Mabon ap Gwynfor, has promised to “eliminate” two-year waits for NHS treatment in Wales “within months”, and reduce waiting lists to pre-pandemic levels within five years.

Setting out his priorities following Plaid Cymru’s victory in the 7 May Senedd elections, ap Gwynfor promised an “ambitious national programme” for ten new surgical and diagnostic hubs for Wales, and a “new approach to planned care” that would be “clinically-led, nationally-directed, and with a clear emphasis on modernisation.

“Through these measures, we will see two-year waits eliminated within a matter of months and the overall backlog reduced to pre-pandemic levels before the end of this Senedd term,” he told the Senedd on 2 June. But under questioning from opposition members, he repeatedly refused to say in how many months the target would be met.



Mabon ap Gwynfor promised an “ambitious national programme” to “eliminate” two-year waits “within months”.

The Welsh government said a plan for rolling out the new hubs would be unveiled before the end of the year. The plan would be “predicated on reinforcing local capacity and expertise... creating centres of excellence for long-neglected specialisms such as ophthalmology, and providing vital training opportunities for medical graduates,” ap Gwynfor said.

Latest figures show 2,600 patients in Wales had been waiting two years or more for treatment in March. The numbers have fallen sharply over the last year following a

£120 million investment by the previous Welsh government, but remain far higher than in England or Scotland.

ap Gwynfor said he would extend the extra investment for a further year but criticised his Labour predecessor, Jeremy Miles, for “throwing money at the problem” and “outsourcing and insourcing without building internal capacity”. The Plaid government would develop “a sustainable solution”, he said.

He also announced that the troubled Betsi Cadwaladr health board, which covers the whole of north Wales, would be restructured if it couldn’t turn around its performance within two years. “We know that Betsi Cadwaladr is a problem, I live there myself,” ap Gwynfor said. “Nearly half of the Welsh cabinet live in north Wales, so it’s in our interest to get this resolved.”

The new government’s other priorities include “improvements in access to ambulance and emergency department services” and recognising “the dedication of NHS Wales staff

who are working to drive the progress we all need to see,” ap Gwynfor added.

UNISON called on the new Welsh government to prioritise staff pay, following anger over this year’s 3.3% pay award for NHS staff in Wales.

“Staff need immediate action from the new cabinet minister, not more of the same,” said UNISON Cymru head of health



UNISON’s Tanya Bull: staff need “immediate action” on pay.

Tanya Bull. “Direct negotiations on pay are the only way to avoid strikes and start rebuilding trust. Without action on pay, the NHS will struggle to recruit and retain the staff needed to deliver safe, high-quality care for patients.”

MiP chief executive Jon Restell said many of the changes at providers were “going under the radar” because of the government’s more widely-publicised reforms to NHS England and ICBs—despite the potential direct impact on service delivery.

“Too often, cuts to management and support roles are presented as if they have no impact on patient care. The reality is very different” he said. “Every hour a doctor or nurse spends on administration is an hour they are not spending with patients.

“We should be making the best use of highly trained clinical staff,” he added. “That means ensuring they can focus on treating patients, not filling gaps left by reductions elsewhere in the workforce.”

The research also suggests the cuts are having a significant impact on the existing workforce. A survey of almost 20,000 NHS staff found that nearly two-thirds reported increased workloads and higher levels of stress following job cuts or vacancy freezes.

The cuts were particularly damaging at time when NHS staff “are already stretched to breaking point” and “morale is through the floor” warned UNISON head of health Helga Pile. “The public are all too aware how understaffing is a major problem, so they’ll be rightly alarmed when the situation’s getting worse.”

The report comes as trusts face mounting pressure to reduce waiting lists, improve productivity and balance their budgets, while also preparing to implement the gov-

ernment’s Ten Year Health Plan.

Restell warned that management cuts were a “false economy” because managers were “central” to delivering the plan.

“They are the people who redesign services, improve patient flow, tackle inefficiency and support clinical colleagues,” he added. “Cutting those roles risks undermining the very improvements ministers want to see.”

MiP has called for more oversight of workforce reductions and joined UNISON’s call for NHS organisations to be able to expand their workforce to meet growing demand, rather than reduce staffing “to achieve short-term financial targets”.

*Read the UNISON report, Less Fit for the Future in full at: [mip.social/less-fit](https://mip.social/less-fit).*

## Tech job cuts

# NHS job cuts a risk to cybersecurity as threat of AI-powered attacks rises “dramatically”

**T**he threat of potentially catastrophic cyber attacks on the NHS has increased “really dramatically” in recent weeks and is still “accelerating”, NHS England chief Sir Jim Mackey has said. His warning came just weeks after NHSE’s board was warned by its own digital experts that NHS job cuts posed an “unmitigated” risk to cybersecurity.

An NHSE risk assessment published on 4 June raised the risk level for cyber attacks to its highest possible level, with “frequent” attacks deemed likely and the potential impact assessed as “catastrophic”.

Speaking at an NHSE board meeting on the same day, Mackey said: “We’ve all been a bit uncomfortable about how well prepared we were to cope with potential risk. But the risk environment has now changed really dramatically and is accelerating.”

NHSE non-executive direc-



*NHS England non-exec director Mark Bailie warned job cuts were “a material and currently unmitigated risk” to cyber security in the NHS.*

tor Mark Bailie, who is also chief executive of digital price comparison service Compare the Market, told the meeting that the release in the coming weeks of new large language models, like Anthropic’s Mythos, which were capable of detecting and exploiting vulnerabilities in security systems, would “materially increase” the risk of attacks on the NHS.

Back in March, Bailie had warned the board that the

impact of the voluntary redundancy (VR) programmes in NHSE and ICBs on the NHS’s technology workforce “represents a material and currently unmitigated risk” to cybersecurity.

A report from NHSE’s Data, Digital and Technology committee, chaired by Bailie, warned that “scarce specialist capacity is being drawn away from critical cyber and resilience work” due to the organisational upheaval.

“The approach to VR may be a symptom of a wider root cause [in] that we have a system which needs to be digital but doesn’t know how we grown and nurture the technology workforce.”

In response to the increased risk, NHS England said it has prioritised funding bids for cybersecurity projects this year and is carrying out an audit of vulnerable “organisational assets”. A major cybersecurity exercise is also planned for July.

NHSE’s risk assessment says preventative measures being ramped up included secure architecture, cryptography and new identity and access controls as well as 24-hour monitoring by the NHS Cyber Security Operations Centre. Mitigation measures include better backups, removing old technology, monitoring for “insider threats” and “proactive vulnerability management”, NHSE added.

# Centralising, costly and distracting this bill isn't what the NHS needs

The government's Health Bill, finally in front of MPs, provides a statutory framework for the chaotic reforms of the last year. Rhys McKenzie sets out MiP's view that, as it stands, the bill is another costly distraction that will centralise power but deliver few benefits to patients or staff.

**O**ver a year after most of its contents were announced to the media last March, the Health Bill is finally making its way through parliament. It represents the most significant reorganisation of NHS structures and governance in England since the 2012 Health and Social Care Act and, in many ways, it tries to reverse the main features of those reforms.

Andrew Lansley's legislation deliberately moved power away from ministers and into an operationally independent NHS England. Now much of that power is heading in the opposite direction.

## Another costly distraction

At its core, the legislation is about who runs the NHS and who has the biggest say in how services are delivered. NHS England will be abolished entirely, with many of its functions, staff and responsibilities moving into the Department of Health and Social Care (DHSC). Around half of NHS England's workforce is expected to go as part of the process.

History suggests that NHS reorganisations rarely deliver the promised benefits. What they almost always deliver is significant cost to the taxpayer, disruption to services and the loss of experienced staff. The current reforms are no exception. At least 20,000 jobs in NHS England, arm's-length bodies and Integrated Care Boards are expected to disappear, and that figure does not include the thousands more jobs being lost in NHS trusts.

The reorganisation is already

underway, causing major disruption at a time when there is a real opportunity to improve patient care and deliver meaningful reform. Instead, NHS organisations are embroiled in consultations, restructures and redundancy programmes. Experienced staff have already left the service and thousands more are still to go.

And all of this started before the bill was even published.

Ministers have argued that bringing NHS England back into the department will eliminate duplication and reduce bureaucracy. There is undoubtedly some overlap between the two organisations, but the scale of the proposed cuts raises serious questions. NHS England employs around 15,000 staff and the DHSC around 3,000. How can such a large proportion of those roles genuinely be duplicating one another?

The biggest irony in NHS reform is that efforts to reduce bureaucracy often end up creating more of it. Each reorganisation demands significant management time and diverts workforce attention. And with three major restructures in a little over a decade, NHS staff are exhausted. Rather than a vehicle to improve productivity, it's a recipe for further attrition.

## Democratic accountability or centralisation of power?

The bill grants the DHSC and the secretary of state a significant range of new powers. These include greater oversight of trusts and ICBs, responsibility for workforce planning, influence over



funding decisions and the ability to appoint chairs and board members across the system. Ministers will also have more powers to direct NHS organisations, including ICBs. As it stands, these powers will give politicians a much greater say in the day-to-day running of services – the only notable exception is that DHSC won't be able to interfere with individual clinical decisions.

The government says this is simply restoring the pre-Lansley model of accountability. If ministers are held to account on the performance of the NHS, they argue, they should have more control over how it's run.

But the bill goes much further than clarifying accountability and, in some areas, reaches even further back than Lansley. For example, ministers have not had the power to appoint and dismiss members of NHS boards since 2001. That marks a significant shift backwards, raising concerns about greater political interference in day-to-day decisions.

# Acting: eds



Rhys McKenzie is MiP's communications officer.

Full details of the Health Bill can be found at: [gov.uk/government/collections/health-bill](http://gov.uk/government/collections/health-bill).

**“Thousands of NHS managers have already lost their jobs before parliament has fully scrutinised the reforms. Yet there is no recognition in the legislation that successful reform depends on having the right people in the right place to deliver it.”**

This new suite of central powers also sits at odds with much of the Ten Year Plan. The plan talks about empowering local systems by giving them more say in how they deliver care and designing services around the needs of local communities. Yet this legislation concentrates power and decision-making in Whitehall. You cannot simultaneously devolve power and centralise it without the two approaches coming into conflict.

These additional powers also raise questions for the future. Wes Streeting was able to begin dismantling national structures and make large-scale workforce reductions before parliament had even seen—let alone approved—the necessary legislation. What could a future secretary of state with even more powers do without the approval of parliament, NHS leaders and the public?

MiP believes the government must do more to show how this concentration of power will lead to better outcomes for patients, staff and the public. NHS managers

and leaders should be given direction and left to get on with the job—guided by the best interests of patients and the public, rather than political expediency.

### ICB powers, patient records and Healthwatch

The Health Bill will also expand ICB's commissioning responsibilities and reshape the membership of boards to focus more squarely on commissioning rather than partnerships, removing ICBs' duty to have representatives from local councils, GPs and NHS trusts. It introduces a new requirement for ICBs to have a board member representing any mayoral authority within their area.

Taken together, these changes mean ICBs will be taking on more responsibility while simultaneously seeing their workforce and budgets cut by around half. Commissioning Support Units, which have provided vital expertise and management capacity to ICBs, are also being abolished. As a result, ICBs are likely going to struggle to take up the 'strategic commissioner' role the government expects of them.

The bill also attempts to introduce a single patient record and enable greater sharing of patient data among health-care organisations in different parts of the system. While there is broad support for better data sharing in the NHS, there are still serious concerns about data governance, patient consent, cybersecurity and the practical challenge of integrating multiple legacy IT systems across the health service.

Alongside these changes, the bill abolishes Healthwatch, the statutory body that champions patient experience, absorbing its statutory functions into the DHSC. It also merges the Health Services Safety and Investigations Body (HSSIB), which investigates patient safety

incidents, with the Care Quality Commission. The rationale for these changes is unclear and there is a risk that independent patient voice will be diminished.

### Management capability is critical

With its relentless focus on structures and power, the biggest omission from the Health Bill is management capacity and capability.

Thousands of NHS managers have already lost their jobs before parliament has fully scrutinised or approved the reforms. Yet there is no recognition in the legislation that successful reform depends on having the right people in the right place to deliver it.

MiP members are not opposed to reform—they are usually the people who make it happen. But the events of the last year have led to avoidable harm and disruption for members and the services they work hard to manage. These problems have arisen because a major shakeup was not properly assessed and planned, or implemented with sufficient care.

This approach must change. The Health Bill is an opportunity to do things differently.

MiP believes that before embarking on major structural change, ministers should be required to assess the impact on management capacity, communicate with and consult affected staff and trade unions, and demonstrate how services will continue to operate safely and effectively throughout the transition. MiP wants to see the bill amended to reflect this.

We have been and will continue to brief MPs on these amendments and on the value of managers to a reforming government. Parliamentarians now have an opportunity to strengthen this bill and help ensure that reform delivers better outcomes for staff, services and the public alike. //



## This is what toxic change looks like—we need to change direction now

**N**HS managers in England are carrying an unacceptable burden. Not only the pressures of the day job, but the psychological toll of nearly 18 months of organisational change. This does not feel like just another restructure, the latest in a long line of chops and changes. Unpromised, dragged out and badly planned, this shake-up is leading directly to burnout, depression and long-term ill-health. Worse still, leaders seem to be pricing this into a micro-ideology around the financial reset, in which distressed people resigning to protect themselves is chalked up as some kind of win.

MiP members describe feeling stressed and betrayed. Nine out of ten MiP members in NHS England, for example, say work is harming their wellbeing. Years of uncertainty about jobs and structures have created a climate of fear and instability, with managers expected to make decisions without knowing what the future looks like. Many are left asking: Will my role exist? Do I still matter or am I just disposable? As one member said to me, “Staying feels scarier than being made redundant.”

Researchers agree that uncertainty is often more stressful than change itself. When people don't know what's happening to them, anxiety rises, concentration falls and engagement drops. In the NHS, this is being made worse by a messy reorganisation in which people have to deal with plans made on the hoof, fragmented processes, and shifting timelines and messages. This is what experts call 'toxic change'.

The impact on people is severe. Our members report change fatigue and a growing sense of helplessness. They are feeling a loss of professional identity, pride in public service and their ability to do a good job. Trust in leaders is falling fast. Those leaders, themselves suffering from burnout, are struggling to support their teams. Occupational health services are stretched and unable to meet rising demand. This is a system under strain, unable to discharge legal duties to safeguard mental health—and it is the people holding it together who are paying the price.

“**Many are left asking: Will my role exist? Do I still matter or am I just disposable? As one member said to me: “Staying feels scarier than being made redundant.”**”

The damage does not stop with people. The NHS suffers too. Anxious, disengaged managers cannot deliver transformation. Productivity falls. Sickness absence rises. Institutional knowledge is lost as experienced staff leave. Safety risks abound. An arbitrary financial cut dressed up as genuine reform risks becoming a cycle of instability and decline.

And ultimately, the public pays the price. The NHS depends on committed, skilled managers who feel safe, valued and able to do their jobs well. When those managers are worn down, patient care is affected. A system that makes its own workforce unwell cannot deliver the high-quality care the public deserves.

This harm is not inevitable. It is avoidable—and therefore unacceptable.

So what needs to change?

First, the people at the top must recognise the scale of the problem and treat the psychological impact of reorganisation as a serious system risk. And also take action on the related equality impact.

Second, there must be honesty and clarity. Staff deserve clear timelines, clear structures and clear communication—not vague promises and shifting plans.

Third, consultation must be real. That means engaging trade unions early, sharing actual proposals and giving staff a genuine say in decisions that affect their lives.

Fourth, a trauma-informed approach must be applied. Change must be managed in a way that is open, supportive and respectful—not imposed from above in ways that deepen distress.

Finally, proper support must be in place. This includes access to mental health services, trained managers who can spot early signs of distress and real investment in staff wellbeing.

NHS managers have shown extraordinary commitment, especially in recent years. They deserve stability, respect and care—not endless uncertainty. If we are serious about protecting the NHS, we must start by protecting the people who make it work.

Enough is enough. //

# “We’ve got to diversify our workforce, invest in different people — and get smarter”

After a year leading the UK’s largest paramedic service, London Ambulance chief Jason Killens is convinced things have to change. He talks to Alison Moore about a challenging and complex job now set to get even harder.

**“W**e have to straddle the health service and the emergency services camps—we have a foot in both,” says London Ambulance Service Trust (LAS) chief executive Jason Killens.

It’s not a new dilemma—and is far from a binary choice—but ambulance services increasingly see themselves as part of the NHS. That means casting off the mantle of being a ‘scoop and run’ service, concerned mainly with how quickly it can reach patients, load them into an ambulance and deliver them to hospital.

Now the job is also about providing advice over the phone, accessing alternative services better placed to help and giving care at the scene—using the skills of paramedics and others to keep people out of A&E.

Killens has run LAS since the middle of last year and is also chair of the Association of Ambulance Chief Executives (AACE). He and his team spend a lot of time speaking to trusts and ICBs, and will do so even more as neighbourhood health evolves. He works closely with London mayor Sadiq Khan, and the leaders of the capital's three police forces, fire brigade and the RNLI are also likely to feature in his phone contacts. "Twenty per cent of our time is working with emergency service partners, 80% of it is with the NHS," he says.

The job is challenging and complex, Killens says, but ten years as an ambulance chief executive means he has experience to bring to it—just as well, as the indications are that the job won't get any easier.

**Demand for ambulance services is growing by around 3-3.5% a year but that doesn't fully capture the particular pressures in some areas: LAS has seen the number of 999 calls involving mental health rise by 90%** in two years; it's now exploring with mental health providers what's driving this increase and how these patients can be best managed.

The Right Care, Right Person policy—where police will not attend someone in mental health crisis where there is no immediate risk of serious harm or death—has changed the way LAS reacts to some cases. "We've had to deploy different kinds of response to deal with it... we're putting a couple of paramedics through a specialist course for mental health," he says. In practice, the policy is "largely okay", he adds, although "sometimes there are some operational tensions around who will take primary responsibility for a particular patient." Ambulance crews need access to alternative services in the community for these patients to avoid more trips to A&E, he stresses.

All ambulance trusts are already

under pressure to improve response times. LAS narrowly missed the 30-minute target for category 2 responses in 2025-26 and will be aiming for 25 minutes this year. That reduces to 21 next year, with a final target of 18 minutes by 2028-29.

Killens insists the money is there to achieve 25 minutes. Although the trust needs to find more than £20 million in "cost improvements", all but a tiny fraction of that has been identified, he says.

But getting to 18 minutes will be tough. "I hate this phrase but it's going to be about working smarter, not harder," he says. This could involve working with partners to change the response model within the existing rules while lobbying for more fundamental changes, as well as "modernising" some workforce practices.

**Hospital handovers have improved to an average 17 minutes—better than the national picture and just shy of the 15-minute target**—and LAS has not experienced the persistent issues which have left ambulances queuing outside A&E in other parts of the country. "It's about leadership and it's about process," Killens says. "It's the flow through the whole hospital, it's not just [about] the handover at A&E.

"One of the key things is getting colleagues [in other NHS organisations] to see the risks... that we have 200 people stacking up waiting for an ambulance," he adds. "It's about sharing the risk and everyone being aware of where the risk sits."

The ambulance service has been plagued by sexual safety issues—including harassment and inappropriate behaviour by staff, and verbal and physical abuse by patients and the public.

While ambulance crews are vulnerable—working in twos, without the back up available in other emotionally fraught environments like A&E—verbal abuse is often aimed at control room staff. Half of LAS staff said they had experienced physical or verbal abuse in the last staff survey, Killens explains.

De-escalation training is among "the interventions we can deploy", he says, but the trust is also encouraging the use

of body-worn cameras to record incidents and is engaging with the London mayor, the courts and the CPS about using the full extent of sentencing powers. Staff who have been abused or assaulted need to feel justice has been done, Killens adds, but he wants to get ahead and prevent abuse happening in the first place. Initiatives in London have included the recent "all we want for Christmas is respect" campaign. More broadly, AACE has written to all four health ministers in the United Kingdom to ask for more action in policy terms.

**Asked if the ambulance sector has the managerial capacity to cope with such unprecedented change, Killens stresses that capability is just as important as capacity.** "I think we've got enough people but I think we have a job of work to do to ready those people.... [so they have] the right experience and skills for what we need," he says.

To that end, the AACE has been working with business school Hult Ashridge to offer courses to staff aiming for a chief paramedic or chief operating officer job in an ambulance trust. CPOs are relatively new roles and can only really be filled by someone already working in the sector, although COOs could come from outside.

Keeping the troops on board is a key part of any CEO's job: like community and many mental health trusts, ambulance trusts have a dispersed workforce operating from different sites and working variable hours.

Killens devotes some of his time to a twice-yearly series of 'roadshows', which see him travel to different ambulance stations over a period of three to four weeks to hear from staff. "The fact that I've done the job, I can talk the language they talk in... you could run a conversation with a group of staff about what's irritating and frustrating for them in a way which resonates with them. A colleague who hasn't got that background—it's not impossible for them to do but it will be harder," he says.

There's always been a delicate balance between internal promotions and external appointments in the ambulance service. Currently, five out of nine

ambulance chief executives in England have worked on the frontline, higher than in the past. As a former chief paramedic in London, John Martin, chief executive of the South Western Ambulance Service, has shown that being a CPO can be the route to the top job.

**Killens's own path included working as an emergency medical technician in London before moving into operational management,** ending up as executive director of operations. Along the way he was strategic commander for the 2012 Olympic and Paralympic Games and was involved in the response to the London bombings in July 2005. Having gone into the NHS to help people, he thought he could do more in a management role, he explains.

Killens then led the ambulance service in South Australia for three years, an experience he describes as “formative”. Half the workforce—generally in rural areas—were volunteers and the service made extensive use of aircraft to reach patients over a vast geographical area. “You don't have that in London—a fixed wing aircraft landing in Oxford Street to pick someone up,” he jokes.

“The issues were the same for staff and obviously patients are the same, but the context in which you are operating is just very different,” he says. “I learnt a lot about me—my leadership, what was good and what was not so good.”

He always intended to come back. Returning to the UK in 2018, he ran the Welsh Ambulance Service for seven years. “It was a blend of what I'd had before in London and what I had had in Australia,” he says. “It's a national service but the context is different. The politics are closer, a direct line of communication and accountability to government, no NHS England in the middle. There was much more autonomy in how you configure the service and what you can do, and ultimately that is what led to changing the service delivery model and targets in Wales.”

Killens initiated a different way of measuring ‘success’ for the Welsh ambulance service. In England, the focus has been almost entirely on response

“**I've done the job... I understand what's irritating and frustrating.**”



times—especially the category 2 response (including suspected strokes, seizures and burns), which has dominated the narrative for several years. Wales, in contrast, now has a more nuanced system which looks at clinical outcomes as well as response times.

The new system was introduced just as Killens left, and he sees some clear advantages over the English system, which can inhibit ambulance crews from doing the best for some patients, he says. Convincing the government of this may be an uphill battle but he feels progress is being made.

**AACE represents ambulance services across all four UK nations. They are “all in different places but the challenges are basically the same,”** he says. All four are dealing with increased activity and can see bigger increases coming down the track. “We know that an elderly population uses the ambulance sector more. What that says is that the activity is going to continue to rise.

“We either carry on with the existing

model we've got and put in a lot of very expensive double [crewed] staff to take ever increasing numbers of patients to emergency departments, [or] the sector starts to shift and pivot and invest heavily in advanced practice, in specialist paramedics in multidisciplinary teams, connecting better with local alternatives that already exist in the NHS,” he explains.

“We have to diversify the workforce, invest in different people in our organisation with different skills and get smarter by managing the vast majority of the 999 activity we see—where we can safely do it—in communities.”

A community-based approach to urgent care will give patients a better experience and ambulance clinicians greater job satisfaction, he adds, but a fast response and transfer to A&E will always be

needed for emergency cases and the trust needs to do that consistently well.

Ideally, commissioning for ambulance services would evolve too, he says. He would like to see regional commissioning for the 999 service with NHS 111 services being run by ambulance trusts on a regional basis too. Better co-ordination between the two services would allow patients to reach the right service regardless of how they enter the urgent and emergency care system. “We think we are best placed to do that... because we'll be able to offer at scale,” he says.

LAS engages with around five million people a year—both through 999 and 111, where it provides services in every part of the capital. The CEO job in London may have come up earlier than he expected, Killens admits, but it was not something he could refuse. “Why would I say no to... being in the privileged position of working with such great people and leading an organisation which is pivotal to London's success?” he says. “It's a great leadership role in a great organisation of 11,000 people. And I'm having fun!” //

# Reforming NHS pay: what's at stake?

NHS jobs are more complex than ever, but the pay system has failed to keep up. As talks between unions and the government on reforming Agenda for Change finally get underway, Rhys McKenzie sets out MiP's agenda for boosting morale, keeping talent in the NHS, and improving productivity and patient care.

**T**he NHS Agenda for Change (AfC) framework is one of the largest national pay frameworks in Europe. Created in 2004, it attempted to harmonise the pay and terms and conditions of over one million employees—covering most NHS workers in all four nations of the UK.

Before AfC was introduced, pay rates for the same roles at different NHS employers could vary wildly. Equal pay claims were commonplace and workplace grievances about earnings regularly put pressure on employers. Although AfC was far from perfect, it had the desired effect of limiting these disputes and has broadly held steady for over 20 years.

Negotiations are now underway between trade unions and NHS employers to reform the framework following a funded mandate from the UK, Welsh and Northern Irish governments. The last time AfC saw any significant change was in 2018, as a result of a three-year pay deal. Those reforms removed overlapping pay points between bands, reduced the number of incremental steps and accelerated progression to the top of pay scales. It streamlined the framework, making some improvements, but it was not enough to address the structural issues still prevalent today.

Any further changes introduced by the 2026 talks, including any pay increases, will be backdated to April 2026 and will be funded with additional money on top of the 3.3% already awarded to staff.

With job cuts, rising pressure on services


and ongoing restructuring, these talks are not the immediate focus for most NHS staff, including a many MiP members. But there is a great deal at stake. Most NHS unions, including MiP and UNISON, will consult members on next steps, whether a deal is reached or the talks break down.

The outcome will determine if unions move on from the 2026 pay round—or move into a formal dispute. The staff side position is clear: the 3.3% imposed award is not enough, and these talks represent the government's last opportunity to rebuild trust and deliver improvement.

## What's on the table?

While a radical overhaul of the framework seems unlikely, there is now a consensus that parts of AfC no longer reflect the realities of a modern workforce. Which parts of the framework will be up for discussion has not been confirmed, but the scope of the discussions will depend on how much money the government is willing to put down—a figure which remains unknown.

While nothing has been ruled out, the UK government has given us a direction of travel, saying its priorities will be to improve pay “for



those in the lowest bands” and for graduates “across all professions”.

Unions support this direction. Pay in the lower bands is struggling to keep pace even with the minimum wage, let alone the real living wage, and compression at this level is weakening incentives for progression. Entry-level graduate roles in the NHS at Band 5 also lag behind equivalent roles in the public and private sectors, risking the long-term supply of talent into the NHS.

But for reform to deliver meaningful change, it must go further. The recent NHS staff survey in England highlights the scale of the challenge: only a third of staff are satisfied with their pay and nearly a third frequently consider leaving their role. There has also been a decline in the proportion of staff who would recommend their organisation as a place to work.

### **What does meaningful change look like?**

Alongside dealing with pay compression in the lower bands, action is also needed at the upper end of the scale. The pay differential between Bands 7 and 8A has narrowed over time, meaning the increase in responsibility, accountability and workload between the bands is not matched by a proportionate rise in pay—actively discouraging progression into senior roles.

Worse still, most managers moving into Band 8A lose all eligibility to overtime and un-social hours payments. While this is supposed to reflect a more regular working pattern with greater flexibility in managing working hours and workload, the reality is that most managers are regularly working additional hours without any compensation, contributing to burnout and work-related stress. While staff in Bands 8A to 9 should be able to access time off in lieu instead of overtime, we know from our members that this is rarely granted in practice.

As a result, promotion can in some cases lead to lower take-home pay. This isn't right. Combine this with the long wait for pay progression and you can see why this specific bottleneck was the primary issue for the NHS pay review body when it started this process by recommending action to address structural issues in AfC.

MiP has long called for action here and welcomed the introduction of an intermediate pay point for Bands 8A to 9 in 2024. However, staff still have to wait five years to reach the top of their band. More must be done to ensure promotion is well rewarded and pay progression reflects both experience and merit.

The NHS is also increasingly struggling to recruit and retain senior managers, as pay for many leadership roles fails to compete with the private sector and other parts of the public sector. Roles such as operational managers, programme directors, digital specialists, finance managers and transformation leads can often command significantly higher salaries elsewhere, often in less demanding environments.

The NHS pay system needs the flexibility to retain its staff and attract managers with the necessary skills to deliver the government's priorities.

### **The right band for the job**

The job evaluation system that underpins AfC is also under increasing strain. Designed in the early 2000s, it is widely seen as poorly suited to modern NHS roles. Digital, data, integrated care system leadership and other complex senior roles—many of which didn't exist 22 years ago—often sit uneasily within existing job profiles.

Despite national guidance, different NHS organisations can reach different banding outcomes for similar roles, leading to unequal pay for comparable work. MiP believes all staff should have a right to request an annual band review, but this would require a significant strengthening of job evaluation capacity across the NHS. The system must be properly funded and managers need adequate training and support to apply it consistently.

Ultimately, the success of these talks will not be judged by one single issue, but by whether AfC is made fit for a workforce that has changed fundamentally since it was introduced.

NHS roles are now more complex than ever, but the pay system has failed to keep up. Without meaningful reform, existing structural pressures will continue to undermine morale, weaken retention and limit efforts to improve productivity and patient care.

Once talks have concluded and a deal is on the table, MiP will consult members immediately: you will have your say on your pay. Please make sure you are subscribed to MiP emails and check the website regularly for updates. You will decide what happens next.

In the meantime, MiP will continue to make the case for a system that makes progression fairer, rewards responsibility properly and addresses long-standing compression at both ends of the pay scale. A modern NHS needs a pay system that properly reflects the value of the people who keep it running. //

# AI can help? IN THE NHS

Managing AI responsibly will be one of the biggest challenges facing NHS managers in the coming decade. Governments are keen to ride the latest technological wave, but trust in AI varies wildly and big questions about governance and regulation remain unanswered, writes Craig Ryan.

**T**here's an old joke in digital that 'AI' is anything that doesn't work yet. Once it starts working we call it something else: 'software' or just 'the system'. AI chatbots like ChatGPT and Co-Pilot have only recently arrived on our laptops and phones, but the NHS has been using forms of artificial intelligence for many years.

"Think of things we take for granted now: speech to text, that used to be AI; image recognition, that used to be AI," says Paul Jones, chief digital and information officer at Leeds Teaching Hospitals. "But now they work, we give them a different title."

Leeds has been running an AI-supported breast cancer screening programme—originally developed in response to a shortage of radiologists—for several years. Scans are first viewed by an AI system and a consultant radiologist, Jones explains. "If they agree, that's fine. If not, then a second radiologist gets involved. So, you're getting twice as much work out of this quite rare resource. That's brilliant." Nowadays, he adds, the AI is "about as good as the consultants but in slightly different ways".

This is 'machine learning', a more 'traditional' form of AI that's trained to recognise patterns in data and images. We tend to disapply the scary 'AI' label to these technologies because they're tried, tested and trusted.

## Plausible bullshit

Many of the newer generation of AI tools in which the government places so much faith fall into a different category: 'generative' AI, which produces new content by 'scraping' existing information sources. In the NHS, this includes ambient voice



technology (or 'AI scribes') which listen to consultations and produce notes, or 'decision support' systems aiming to help doctors diagnose conditions and recommend treatments.

Speaking to managers and clinicians over recent months, trust in these tools seems highly variable—ranging from generalised mistrust of anything AI to the kind of breathless enthusiasm that could land you a job at the Tony Blair Institute.

Generative AI raises different safety and governance questions to "traditional" AI, says Felix Peckitt, assistant director of data architecture at West and North London ICB, and MiP National Committee rep for London. "The outputs... can be very plausible even to experts. So the problem is that something being plausible and looking right is no longer enough to tell us whether it's true," he explains.

This "plausible bullshit" will be familiar to anyone who's taken one of Google's 'AI Summaries' at face value. Then there's 'agentic' AI, a form of generative AI which actually does things, like sending emails, booking appointments or ordering supplies. "That also becomes a problem of accountability," adds Peckitt. "When



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programmes are interacting with people, interacting with other software and doing things, you need to monitor that and have clear accountability.”

### The genie’s out the bottle

We have to solve these problems because, unlike drugs or traditional AI, everyone has access to generative AI tools. The increasing use of ‘shadow AI’—tools not tested or approved for the purposes they’re being used—in healthcare demands a national, organisational and managerial response.

“We’re increasingly seeing clinicians turn to ChatGPT because they use it for everything else,” says Jordan Fulcher, a clinical pharmacist and consultant for

AI-powered solutions provider Wolters Kluwer. “The genie’s out the bottle... we know that giving people a slap on the wrist and saying, ‘You shouldn’t be doing this,’ won’t stop them using these tools.”

Tom Micklewright, GP and digital

lead for Cheshire and Merseyside ICB, says some newly-trained GPs have been using ChatGPT for medical queries without realising the dangers.

“ChatGPT doesn’t use journal sources, it will be pulling in data from Reddit, blogs and everything else,” he explains. The data these GPs are inputting will be used to train the ChatGPT model, raising security risks too. “The data centres are all in the US and aren’t necessarily GDPR-compliant,” he says.


The big difference between this and just Googling medical information, which doctors have been doing for years, is that you have to use your doctor brain to make sense of Google’s search results, but ChatGPT pretends it actually has a doctor brain.

At Leeds, generative AI deployment is currently limited to the AI scribes used in emergency departments, Jones explains. The risk here is “that we train doctors to be lazy and just click on it without checking the notes”. But doctors have always known that not checking notes means “gambling with their professional registration”, he says. “I think [the risks] are mainly about training, culture and responsibility.”

### Earning trust

Kavitha Vimalasvaran, a consultant cardiologist at Frimley Health, is a pioneer of AI technology in cardiology and expert in tech governance. Whether it’s a new drug or new tech, “clinician trust is earned through proper governance, transparency and—most important—experience,” she says. “You have to get experience using it and buy-in from all the stakeholders.”

Her own experience implementing an AI ‘co-pilot’ for echocardiograms at Frimley’s heart clinic, taught her that



**“If there’s any deviation from what’s expected, there’s a way to share that and a human in the loop to intervene.”**

KAVITHA VIMALESVARAN, consultant cardiologist, Frimley Health

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## My digital mistakes—and how to avoid them



Leeds Teaching Hospitals' digital chief Paul Jones fesses up to his six biggest mistakes managing digital projects in the NHS.

**1. Don't listen to (individual) doctors:** "This one gets quoted out of context! But *individual* doctors don't care about the views of other doctors—that's why they take another medical history every time you turn up at hospital." Instead, Jones says, "listen to a representative group of doctors whose leadership has some authority"—like the BMA or a group of GPs. "Spending time with those people is time well spent."

**2. Don't set the bar too high:** This is the belief that "the IT project cannot go live unless it's 100% perfect, when often it's replacing a solution that's barely 50% good," he says. "It may have taken half a day before but because it was half a day of activity, it didn't feel wrong."

**3. Don't focus just on delivering:** "We think it's finished because we've gone live and we can go and do something else now," he says. Instead we should be "engaging with the teams who are using it to get the best value out of it."

**4. Don't assume digital saves money:** "All our business cases are 'let's deploy this and we'll save money, when there's very little evidence,'" Jones says. "Ambient voice technology might be one that does, but when you deploy an electronic patient record, frankly, everything in your hospital slows down."

**5. Don't make invalid assumptions:** "We don't try to change the weather; we dress for the weather," Jones says. "When I worked [for NHS England], we often started with: 'Well, let's assume every hospital is the same.' So, we were starting from the position of 'let's just get this wrong.'"

**6. Stop switching policies:** "If we don't change direction soon, we'll end up where we were going," sums up this mistake, Jones says. "We spend an awful lot of money delivering the system but never push through and get the full value. The pivot away from shared care records... was really disappointing. It was really starting to deliver benefits."

"time and investment has to be put into the education of your team." It takes time for sonographers "to familiarise themselves with the tool, to build trust and uncover issues," she explains, "because you can't be going in thinking, I'm going to believe this 100%."

With proper governance and guardrails, "clinicians will feel a bit more secure because they know if there's any deviation from what's expected, there's a way to share that and a human in the loop to intervene so patients don't get harmed," she adds.

Frimley's AI steering group is widely seen as a model for other trusts. "It's a clinically-led governance mechanism that brings together all the right people before AI is deployed," explains Vimalavan. "Anyone with a potential project for their department or pathway can present their case... and we will discuss feasibility, what clinical and digital resources are needed and allocate that."

To get Frimley's echocardiogram project off the ground, "we wrote our business case and got funding from the ICB. But the problem wasn't really the

money, it was everything else—there's huge amounts of co-ordination involved," she explains. That included getting the algorithm and echo machines to work together, setting up servers, integrating with the trust's electronic patient record, training and evaluation.

### Good governance

Good governance of generative AI demands transparency about information sources and "making sure the underlying content is really trusted," says Wolter Kluwer's Jordan Fulcher. The firm recently developed an AI tool that sits on top of its 'UpToDate' library of peer-reviewed medical information, used by NHS doctors for over 30 years. It's now being trialled by several NHS trusts.

Clinicians trust the system because "it gives you the recommendations you would want if you asked another doctor," says Fulcher. Unlike ChatGPT and Co-Pilot, "it has the evidence and the references and you know where it's coming from, because all the authors are clinicians."

While individual clinicians must understand any AI tools they're using to make clinical decisions, there's also a duty on trusts and the NHS as a whole to "support them and make sure they're [using] tools that are trusted," he adds.

UpToDate doesn't serve up any AI-generated content, the AI tool is just a way of interacting with already-trusted information. But that's not the case with the scores of mental health chatbots that have appeared in recent years—many downloadable, without any clinical oversight, from app stores.

"A whole bunch really have no trust because there's nothing backing them up," says Ross Harper, chief executive of Limbic.ai, the only mental health chatbot licensed as a Class IIa medical device. "There's no clinical evidence, no third party validation and no live deployments in clinical settings."

Limbic is now used by almost half of NHS Talking Therapy services. "Our entire strategy is to leverage trust," Harper says. "Being peer-reviewed... is one way to build trust. Third party accreditations on information governance, data security and quality management is another. The best way to build adoption [of AI tools] is to be the most trusted solution."

### The crock of gold

Proper governance, guardrails, building trust—these things take time. They can't be rushed by politicians eager to find a crock of gold at the end of the AI rainbow. But could our light-touch regulatory approach and the associated lack of national guidance on using AI—generative AI in particular—actually be holding up deployment rather than speeding it up?

A commission led by Professor Alastair Denniston is reviewing the current regulatory regime, which is fragmented, confusing and relies heavily on self-reporting by tech firms. In May, the UK medical devices regulator proposed allowing approval of many generative AI tools without any independent scrutiny (see page 19). In the same week, the *Health Service Journal* reported that safety concerns with AI scribes used in dozens of NHS hospitals were going

unreported because staff didn't understand the regulatory system.

In a change of approach, NHS England published a list of approved AI scribes last year, but GP Tom Micklewright says it wasn't as useful as hoped. "AI providers just self-certified to be on the list," he says. "No one's looked at their documentation. No one's made sure they're safe, which means it still falls on GPs or doctors to do it."

Duplication with AI assurance is "burdening clinicians with more mind-numbing paperwork" and "wasting millions", Micklewright claims. He wants to see AI treated like drugs, with "a central process that says, 'Everything here is safe, approved, meets the standards. We'll take care of that, you just make sure you're using it correctly.'"

Unsurprisingly, his view finds an echo in parts of the tech industry that have taken the trouble to meet independent quality and safety standards. "Proper regulation is the way forward," but we need to redefine how it will work for generative AI because it's a consumer-level product that anyone can access," says Fulcher.

Limbic's Ross Harper warns that good innovation will be stifled without a consistent regulatory regime and national contracts for developing AI tools. "It can't work if every trust and region has to do their own evaluation—they're just not set up for that," he says. "If the evaluation markers are clear, transparent and definitive, everybody can get on board with why one solution was chosen above others."

### Harnessing power, taming risks

These problems can hamper deployment of more established forms of AI too. Frimley Health was only the second trust in England to develop an AI tool for echo imaging, "and my goodness it has been really tricky to implement that," says Kavitha Vimalasvaran. "The procurement and governance is often fragmented, leading to duplication, and it slows adoption down massively because everyone is working in silos."

While many AI tools have regulatory approval, she explains, few can show

## AI regulation: a high-stakes balancing act

The National Commission on regulating AI in healthcare ([mip.social/denniston](https://mip.social/denniston)), chaired by Professor Alastair Denniston (*right*), has the tricky job of coming up with a regime that ensures AI is used safely and ethically, without scaring off innovators inside and outside the NHS. It's expected to report later this year.

The commission is sponsored by the Medicines and Healthcare products Regulatory Agency (MHRA). But the MHRA itself appeared to jump the gun in May, publishing proposals—apparently without consulting Denniston—which would see many generative AI tools, including therapy chatbots and clinical decision support software, classified as lowest-risk, 'Class I' devices.

Devices or software which don't interact with the body are classified as Class I by default. These devices require no independent validation and can simply be self-certified as compliant by manufacturers.



Ross Harper, the boss of Limbic.ai (*left*), the only therapy chatbot approved as a Class IIa medical device in the UK, says reducing barriers to innovation is important, but patient safety and clinical accountability "cannot become secondary considerations. AI mental health tools should continue to meet clear, proportionate standards that reflect their real-world impact on patients and services."

April's withdrawal of OpenEvidence, a medical knowledge platform used by some individual NHS doctors, from the UK and European markets may have sharpened the MHRA's apparent concerns about over-regulation. Officially, the platform's American owners blamed the European Union's AI Act for creating "regulatory uncertainty", but industry insiders believe the firm was unwilling to comply with UK and EU regulations requiring tools that support diagnosis to be registered and validated as medical devices.

hard evidence that "they impact on patient outcomes or staff workload, on health economics or inequalities. And demonstrating cost savings, she adds, "is very difficult".

Leeds digital chief Paul Jones is sceptical about the need for new governance and regulatory frameworks specifically for AI. Clinicians have been finding new ways to treat patients "for donkey's years", he says, and the trust has well-established processes for ensuring new clinical procedures and treatments are safe, consistent and backed by evidence. "Why are we treating AI as something different? Just because it runs on a computer?" he asks.

Jones explains that the AI clinical governance team at Leeds reports into the trust's quality committee—a clinical route to assurance which builds on existing governance structures. "It's not a digital thing," he says. He accepts "people have worries about AI" but the answer isn't "to start from scratch", he insists, but "to start from the things we've got."

To succeed with any new technology, we need to harness the power while taming the risks—something NHS

managers "do day-in, day-out", says MiP National Committee member Felix Peckitt. "Being able to clearly specify a problem and the steps needed to resolve it is a core managerial competency—and also something that gets really good results with AI."

It's a huge challenge that managers, and MiP as their union, need to get to grips with. Managers are used to operating "in a highly regulated environment where the stakes are high", Peckitt explains, and their skills in critical thinking, delegation and risk management, together with an understanding of accountability and governance, mean they're "ideally placed" to take professional responsibility for the safe and effective implementation of AI.

Professional registration, already being introduced at the most senior levels, will be another advantage, Peckitt reckons. Without an "infrastructure of professional registration it could be really difficult to implement AI safely—you can't be struck off for being a rogue software engineer," he says. "And professional registration as a manager is one of the few marks of accountability which can't be replaced by AI." //



# Autism: unlocking hidden brilliance



**Neurodiversity coach and healthcare trainer  
Victoria English offers a practical guide to  
supporting autistic colleagues in the NHS.**

**T**he NHS can be a chaotic and demanding place to work, especially for neurodivergent staff, whose brains process, store and interpret information differently to the neurotypical majority. Many autistic professionals face daily workplace hurdles that silently damage their health, cause severe exhaustion and limit their career progression.

Research consistently shows that employers and managers need a better, more practical understanding of autism to reduce discrimination and ensure autistic professionals feel supported and safe. Supporting autistic staff isn't about rewriting national policy—line managers can dramatically improve team wellbeing and retention by working collaboratively with autistic colleagues to identify simple shifts in everyday workplace practices.

## Beyond the stereotype

Autistic staff make a vital contribution to our healthcare system, but face significant barriers at all levels, from entry-level administrative jobs to senior clinical consultants. In my work as a neurodiversity coach, employees frequently tell me about the immense energy it takes to manage everyday workplace friction. This friction rarely stems from the core work itself, which

they often love and excel at, but from misunderstandings, sensory overload, unannounced changes to routines and navigating the ambiguous 'hidden rules' of an organisation.

Earlier this year, I spent seven days on a busy, noisy and brightly lit hospital ward supporting my 90-year-old father. Being AuDHD (autistic and ADHD) and dyspraxic myself, I found the constant sensory stimulation—buzzing alarms, harsh fluorescent lighting, overlapping conversations and constant shift handovers—overwhelming. It wasn't until I returned home that I realised how much it had affected my nervous system and left me physically drained. It made me wonder how autistic colleagues who actually work in this high-pressure environment manage on a day-to-day basis.

Before addressing the challenges, it's important to understand the strengths that autistic healthcare professionals bring to work, and how neurodiversity can be a major advantage in patient care.

## Understanding the 'spiky profile'

There is a golden rule in neurodiversity: when you have met one person with autism, you have met one person with autism. Like everyone, each autistic employee has a completely unique cognitive profile.

The best research points to what

psychologists call a 'spiky profile'. We often hear that schoolchildren are either generally good at everything or struggle across the board. A spiky profile refutes that assumption: an individual might possess exceptionally high capabilities in specific professional areas while needing structured support and minor adjustments in others. When managers take time to understand the unique individual sitting opposite them and learn to harness these cognitive spikes, the benefits to delivery and team performance are profound:

- 1 Meticulous attention to detail and accuracy:** A recent study involving 66 autistic adults identified this as a key workplace asset, especially valuable for clinical safety, drug documentation, infection control, clinical coding, risk registers and laboratory work. "Because of my very strong focus on small details, I'm able to provide a consistently high standard of work for my clients," one participant explained.
- 2 Advanced pattern recognition:** "I can see patterns in data to come up with better systems," said another professional in the study. Autistic clinicians excel at complex diagnoses, spotting subtle patient deterioration, identifying trends, analysing complaints and reviewing clinical incidents.
- 3 An honest voice:** Autistic staff often

have a deeply ingrained sense of fairness and an innate drive to speak up against unsafe practices. While a direct communication style can be misinterpreted by managers as a challenge, research shows that autistic staff are invaluable assets in maintaining rigorous ethical and safety standards.

**4 Deep focus and 'hyper-focus':** Complex clinical reasoning, data analysis and safeguarding require uninterrupted concentration. One clinician in the study described how they could "get in the zone" to solve complex logistical problems and spot systemic flaws that others had overlooked.

**5 Empathy through lived experience:** Having navigated a world not designed for them, autistic staff are uniquely positioned to help design accessible services, improve communication and reduce sensory barriers for neurodivergent patients.

### The Manager's Toolkit: 8 tips for a neuro-affirming team

Line managers are crucial to providing a psychologically safe, sensory-aware, predictable and clearly communicated team culture. There is one golden rule: staff should never be penalised or isolated for communicating differently.

Evidence shows that accommodations work best when treated as ordinary, good line management rather than special favours or exceptions. Here are eight practical, low-cost steps you can implement today:

**1 Give clear instructions and reduce ambiguity**—many of my clients are intensely frustrated by vague, open-ended or ambiguous directives. An example: a manager asks a clinic coordinator, "Can you sort out the clinic creep when you get a minute?" To a neurotypical colleague, this means pulling patient files for tomorrow. To an autistic one, it lacks scope, timing and priority, causing immediate anxiety. Avoid jargon and metaphors—don't assume staff will 'read between the lines'. Use concise, factual language and specify exact expectations: "Please print the patient histories for columns A and B by 2pm today."

## Further information and resources

**The National Autistic Society (NAS):** toolkits, employment training modules and best-practice guides on the Equality Act 2010. [autism.org.uk](http://autism.org.uk)

**Advisory, Conciliation and Arbitration Service (ACAS):** straightforward guidance for managers on neurodiversity adjustments, preventing workplace discrimination and structuring formal conversations. [acas.org.uk](http://acas.org.uk)

**NHS Employers:** dedicated neurodiversity spaces, case studies from trusts and frameworks for staff networks. [nhsemployers.org](http://nhsemployers.org)

**Access to Work:** Government grants scheme offering provide practical advice and funding for workplace adaptations, specialist software and tailored neurodiversity coaching. [gov.uk/access-to-work](http://gov.uk/access-to-work)

**2 Use written communication as well as verbal**—Verbal instructions given in a busy hallway during a shift handover can easily be lost or misheard.

Backing up verbal requests with written bullet points, checklists or meeting summaries gives colleagues time to process information at their own pace and relieves the burden on short-term memory.

**3 Actively reduce sensory overload**—Sensory overload drains the cognitive energy needed for patient care and safe decision-making: frontline clinicians routinely see this as their biggest hurdle. Work with your colleagues to make practical adjustments: noise-filtering earplugs in non-patient zones, different lighting, computer screen filters, permanent desks and a quiet decompression space for breaks.

**4 Plan changes and give advance notice**—Predictability reduces stress and prevents acute anxiety. Give as much notice as possible of changes in rotas, software or departmental structures, allowing autistic staff to prepare cognitively, practically and emotionally for the change.

**5 Invest in peer and team training**—The more your team understands neurodiversity, the less they will rely on unhelpful stereotypes. When managers understand the mechanisms of autism, they feel more confident in proactively approaching staff to

discuss their adjustments. Training dismantles fear.

**6 Use 'job crafting'**—Job crafting means subtly adjusting roles to match someone's unique skill spikes without lowering baseline standards. NHS Resolution states that reasonable adjustments are designed to ensure a neurodivergent person can work at the same high standard as their peers—it does not mean reducing standards or workloads.

**7 Cultivate authentic psychological safety**—NHS Employers advises organisations to foster a psychologically safe workplace so neurodivergent staff feel empowered to speak up. In a toxic culture, a nurse who asks three questions to clarify a task will be snapped at; in a safe culture, their precision is valued. Staff must feel they can ask questions, request adjustments and voice concerns without being labelled "difficult," "rude" or "hypersensitive".

**8 Support peer networks and mentoring**—Isolation is a significant factor in professional burnout and resignation. Actively encourage staff to participate in neurodivergent staff networks and mentoring schemes. NHS Employers says these networks give staff mutual support and a collective voice to safely influence organisational practice.

### The ultimate payoff

We know far more about neurodiversity, reasonable adjustments and what makes people thrive at work than when I started supporting autistic people 29 years ago.

Leaders need to develop autism awareness, not to comply with HR policies, but to build genuine managerial confidence. When we listen actively, make practical adjustments and explicitly value different ways of thinking and speaking, staff can stop masking their true selves in silent exhaustion. By managing the environment rather than trying to fix the person, we unlock the brilliant contributions our autistic colleagues are waiting to make to the NHS, leading to better care for the patients we serve. //

To find out more about neurodiversity training, visit [victoriaenglishwellbeing.co.uk](http://victoriaenglishwellbeing.co.uk).

# Flexible and hybrid working: what are your rights?

Flexible and hybrid working are widespread in the NHS but employer attitudes vary and can change suddenly. Jo Seery explains your legal rights if you want to change the way you work.

**F**lexible and hybrid working are important for managers and their teams. According to a 2025 survey by the Chartered Institute of Personnel and Development, flexible working is “pivotal to the attraction and retention of talent”.

Under the Employment Rights Act 2025, employers will have to explain why it's reasonable to refuse a request for flexible working. In this article, we consider your statutory rights and what they mean in practice for hybrid working in the NHS.

## Your statutory rights

All employees have a day-one right to request flexible working for any reason under section 80F of the Employment Rights Act 1996. This could be a request to change your:

- » hours of work
- » the times you are required to work
- » your place of work (e.g. your home or any of the employer's workplaces)

This opens up a range of flexible working practices, including hybrid working. Your request must be in writing, state that it is a statutory request and include details of any previous requests. Two requests can be made in any twelve-month period.

Your employer must:

- » deal with your request in a reasonable manner
- » not refuse without consulting you
- » respond within two months (including any appeal) unless both parties have agreed to a longer period

The ACAS Code of Practice on flexible working requests ([mip.social/acas-fw](http://mip.social/acas-fw)) says employers should arrange a meeting without unreasonable delay and allow employ-

ees to be accompanied by a trade union rep.

## What if your request is refused?

The grounds for refusing a flexible working request can include any of these wide-ranging business reasons:

- » additional costs
- » detrimental effect on ability to meet customer demand
- » inability to reorganise work among existing staff or recruit additional staff
- » detrimental impact on quality or performance
- » insufficient work at the times you propose to work
- » planned structural changes

You can only bring a tribunal claim on the grounds that, in refusing your request, the employer:

- » failed to deal with it in a reasonable manner
- » refused without consulting you
- » failed to notify you of their decision within two months
- » rejected it for a reason other than one of the statutory grounds
- » based their decision on incorrect facts
- » treated your request as withdrawn without grounds to do so

In one tribunal case, the employer had changed its requirement for working in the office from two days a week to three. It refused one employee's request to keep working two days, based on evidence that his presence in the office would help improve ways of working, collaboration, problem solving and performance, and that accepting his request would have a detrimental impact on quality, performance and meeting customer demand. The tribunal accepted this was the factual basis for the refusal and rejected the employee's argu-

ment that his employer was simply applying a diktat from above.

## What about discrimination claims?

An employer refusing a hybrid working request could still face a claim for indirect discrimination. Requiring staff to work a certain number of days in the office is likely to amount to a 'provision, criterion or practice' putting women at a disadvantage because of caring responsibilities. The employer must then justify the refusal as a proportionate means of achieving a legitimate aim.

In one case, an employment tribunal rejected the employer's claim that data protection, health and safety, cost and the possibility of the employee being distracted by her children amounted justification for refusal. There had been no complaints when the employee had previously worked from home and evidence that productivity had improved.

In another case, where an employee's mental health impairment prevented her from leaving home, the tribunal held that the employer's failure to consider home working instead of dismissal was a failure to make a reasonable adjustment.

## What happens if your request is granted?

When granted, a statutory flexible working request will generally lead to a permanent change in your contract. But you can also agree a temporary change with your employer, for example to cover a short-term caring need or following bereavement. In such cases, you should agree with your employer in advance the duration of the temporary flexible working arrangement and that you will revert to your previous terms and conditions when it ends. //

*Legal Eye does not offer legal advice on individual cases. Members needing personal advice should contact MiP by emailing [MemberAdvice@miphealth.org.uk](mailto:MemberAdvice@miphealth.org.uk)*

# How to build your personal brand

Building a strong personal brand isn't about self-promotion, it's about who you are as a leader, what you care about and the impact you make at work. Executive coach Gillian Smith offers her tips to get you started.



**M**ost of us have a sense of how we want to show up at work and the impact we hope to have. But few of us take time to articulate it clearly. Being clear about this is being clear about your personal brand. Think about it as your 'leadership signature'.

A strong personal brand is something you uncover. It's already there in the way you make decisions, communicate, support others and show up under pressure. So how do you bring it into focus and then live it with intention? Here's how to get started.

## 1. Begin with the impression you want to leave

This simple question can unlock a surprising amount of insight: "When someone says your name when you're not in the room, what do you hope comes to mind?" Most people don't answer with job titles or achievements. They talk about qualities: warmth, clarity, fairness, courage. Or they describe impact: someone who brings calm, who lifts others up, who gets things done. These early clues point to the essence of your personal brand and the emotional footprint you leave.

## 2. Understand what personal brand is

Many leaders feel that the phrase "personal brand" sounds artificial or self-promotional. But in practice, it's what ties together who you are, what you care about and how you show up. It's the picture that emerges when people describe what it's like to work with you. Crucially, it's not about being liked by everyone or curating a perfect image. The strongest brands are lived, not performed, and they evolve with you. Start from where you are and build from what's already true.

## 3. Explore what you value

Values sit at the heart of your personal brand. They shape your decisions, boundaries, leadership style and the way you want others to experience you. Try listing five values that feel alive in your day-to-day work—the ones you notice when they're honoured or violated. Then narrow them down to the two or three that feel non-negotiable. These values are the principles that shape your signature.

## 4. Identify your natural strengths

Your strengths are the behaviours people already associate with you when you're at your best. Think about moments when you felt proud of how you showed up, or when someone thanked you for something that felt small to you but meaningful to them. These might include bringing calm to chaos, creating clarity from complexity, asking good questions, building trust or generating ideas. Strengths give your signature definition.

## 5. Bring your brand to life

A personal brand only becomes real when it's lived. Small, consistent actions are often the most powerful. If you value clarity, you might summarise decisions or check understanding. If you value fairness, you might invite quieter voices into the room. These micro-habits build trust. Communication is another key expression of your brand. Tone, pace, curiosity, and honesty all signal your values. When your words, tone and intentions match your values, people feel they're genuine and authentic. Behaviours are everyday ways your signature shows up.

## 6. Shape your 'leadership promise'

This is the experience you want others to have of you. It's your quiet commitment: "When you work with me, this is what you can count on." Prompts that might help you articulate this for yourself include:

- » I'm at my best when...
- » I want people to feel... after interacting with me.
- » The difference I want to make is...

The leadership promise is the mark you leave on others.

## 7. Navigate challenges with intention

No one lives their personal brand perfectly. Real-world pressures and organisational politics can pull you off-centre. The goal isn't perfection; it's awareness. Common challenges include balancing authenticity with organisational expectations, and slipping into impression management or reactive behaviours when under pressure. This is when your signature wobbles and you steady it by reconnecting with who you are and how you want to lead.

## 8. Treat your personal brand as a living practice

Your personal brand evolves as you evolve, deepening as your leadership deepens. As your career progresses, you gain more information about what energises you, what derails you and the conditions in which your best leadership shows up. Paying attention to these patterns helps your brand mature from something intuitive into something intentional, helping you to develop a clearer, steadier expression of who you are as a leader. //

# “Working in theatre taught me how to get strong characters to do things on time”

Chelsea and Westminster’s MiP rep talks to **Craig Ryan** about his unorthodox path into management and how he hopes to boost the union’s influence in NHS trusts as a new member of MiP National Committee.



**“I** often say this is an admin job that got out of control,” Chris Withers jokes, describing his accidental route into NHS management. After training at drama school, Chris worked in theatre for many years doing production management and lighting design for plays, musicals and pantomimes. He worked on Maggie Smith’s last live play and partied with Eastenders actress Charlie Brooks. “It was a pretty great career, actually,” he says. “The wages didn’t increase much but I worked with people whom I greatly admired.”

Then the pandemic struck. The theatres went dark. Chris fell through the cracks of the government’s various support schemes. “I got to a point of desperation, applying for entry level admin jobs all over the place and getting nowhere,” he recalls. It was a shout-out on his socials that led to some temp work at Whittington Hospital in London, and a handbrake turn into NHS management. Six years later, Chris is a deputy general manager at Chelsea and Westminster, one of the highest rated hospital trusts in England.

Within months of joining the Whittington he was project managing the £2 million expansion of its endoscopy service to help tackle the post-Covid backlog. “I always saw it as a bit of a cliché that theatre folk have good, transferable skills, but they thought my background in production management meant I might be able to do this,” he recalls.

“Soft skills” picked up in his theatre career helped make up for his lack of “technical knowledge” of the NHS, Chris says. “I know how to get strong characters to do things on time. I liken it to going to a regional theatre in the middle of nowhere with a grumpy crew who don’t want to be out of bed, and having to get a full-blown show on by five o’clock.”

Despite the perception of the NHS as “very bloated, slow and inefficient”—“I’ve worked in three trusts and there’s greater or lesser degrees of that in all of them”, he says—when the system has clear aims and proper funding, “things happen pretty quickly.” As well as the pandemic, he points to the first rollout of community diagnostic centres. At the Whittington, he says, “the whole thing was done from start to finish in nine months.”

Chris moved into operational management, then to the Royal Free where he managed liver services for three years. In February, he joined

Chelsea and Westminster, where he manages a range of specialist medical services across the trust’s two sites, as well as a cancer diagnostic service for non-specific symptoms.

While the Royal Free was “very challenged financially”, at Chelsea and Westminster challenge comes from “the high bar they’ve set for us” and “getting things done quickly enough”, Chris explains. “But I’m enjoying that a lot more than worrying about how the hell I’m going to meet this target with no resources.”

An Equity member in his theatre days, Chris first joined UNISON, then moved to MiP. “I’ve always believed in being a member of a union... but I thought it would be nicer to be part of a union that specifically represents what I’m doing,” he says.

After completing MiP’s reps training at the Royal Free, he joined the union’s National Committee, representing London, earlier this year. There can be “a lot of political dysfunction and factionalism” in union work “which I find frustrating”, he says. “But MiP’s National Committee is very mission focused. We raise different views on pretty much everything, but we talk things through and come to a consensus by the end.”

Chris is keen to boost MiP membership and activity in acute trusts, where the union’s presence isn’t as strong as in ICBs and system bodies. Trusts can still be “very hierarchical”, “workloads are intense” and “there’s definitely a slight cultural fear of putting your head above the parapet,” he says.

“I’ve observed that it only takes one senior person to have an unhealthy way of approaching things for that to filter through the system. Then there’s the pressure... The exec team are really on the details, so the minute something starts going off trajectory, they’re very much involved.”

A louder voice for trusts would also boost MiP’s campaigning work, he says, where he’d like the union to engage more with MPs and parliamentary committees, as well as ministers. “I think we see a lot of happens on the ground and how the national picture is affecting patients, both positively and negatively. So I think more of that voice would be useful.” //

**“MiP is very mission focused. We raise different views, but we talk things through and come to a consensus.”**

*If you’re interested in becoming a rep, contact MiP’s acting national organiser, Rosie Kirk: r.kirk@miphealth.org.uk.*

# Our pledge to you



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The Spirit of Brotherhood by Bernard Meadows



# Managers are vital to the NHS, but does anybody actually know why?

At MiP we're launching a campaign to change perceptions by showing how managers, right at the heart of the NHS team, are ideally placed to make it work and to **make it work better**.



## Inspirational stories about real people

We're doing this by launching a documentary style campaign based on interviewing inspirational managers and publishing their stories backed up with key statistics and evidence from independent research.



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Chief Executive, MiP



MANAGING our NHS