issue 69 | autumn 2026

healthcare manager

Alder Hey's Kate Warriner

The UK's top digital leader tells Healthcare Manager why tech is a people business

Out of sight, out of mind?

What's gone wrong with England's maternity services? A special report

This must be the place

How will Andy Burnham's power shift to regions and cities play out in the NHS?

Hard labour

Plaid Cymru's uphill slog to turn around the NHS in Wales

mip The union for senior health & care managers

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healthcare manager

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This summer, I was pleased to travel up to Liverpool to meet Kate Warriner, digital chief at Alder Hey Children's Hospital, voted the UK's top digital leader by industry peers last year (*see page 11*).

Fifteen years ago, the idea of an NHS leader winning such an accolade would have been laughable. But today, several NHS trusts are seen as tech pioneers—and not just in healthcare ciricles—driven by a new generation of leaders who talk more about empowering people and transforming services than hardware and software.

But these star performers aside, progress across the NHS is patchy. Digital maturity varies wildly between trusts, the regulatory landscape, especially for AI, is hopelessly confused (*see page 7*), collaboration is piecemeal and funding is scarce and hard to access. There are plenty of national ambitions—the Ten Year Plan is packed with digital goodies—but no real sense of a national strategy.

And now the NHS is throwing away expertise it needs to realise those ambitions. We're still gathering intelligence on the impact of England's job cuts, but early signs are that we've lost significant numbers of digital and data staff, especially from ICBs. That's crazy. These staff were doing vital work, including crunching the numbers on which ICBs' new role as planners and 'strategic commissioners' will depend, and supporting over-stretched GP practices with digital transformation. They'll be hard to replace.

The success of tech-savvy NHS organisations like Alder Hey shows the opportunity we're wasting here. We need to nurture the digital talent we have and recruit more, so NHS organisations can develop solutions and collaborate with the tech industry from a position of strength, not desperation. We need clear national standards for AI governance and clinical safety. And we need a serious plan for collaborative investment in digital—not pots of money here and there—so we can find out what works and spread it everywhere.

Remember, there was no delivery chapter in the Ten Year Plan—and it shows. //

Craig Ryan, Editor
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heads**up**

analysis & opinion

features

regulars

healthcare manager

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Managers in Partnership (MiP) is the trade union organisation representing health and social care managers in the UK. 020 3437 1473 // miphealth.org.uk // info@miphealth.org.uk // BlueSky:@MiPhealth // LinkedIn: Managers in Partnership

headsup

News you may have missed plus what to look out for

MiP Reps Day returns to Birmingham in November

ETHAN THOMPSON @UNSPLASH.COM

MiP's annual event for workplace representatives, Reps Day, returns to Birmingham on 17-18 November. It's an opportunity to meet fellow reps from across the country for a day of learning, networking and supporting the union's policy and campaign development.

The event begins with dinner and a drinks reception—a chance to catch up with colleagues and make new connections, and for your union to thank you for your incredible work during another turbulent year in the NHS. The following day features a programme of workshops, interactive sessions and briefings—a full agenda will be sent to attendees before the day.

All travel and expenses are fully covered by MiP. For more information and to book your place contact MiP's national organiser, Rosie Kirk: R.Kirk@miphealth.org.uk.

Spaces are limited, so book your place today!

noticeboard

2 October 2026

MiP webinar: Challenging the myth of an over-managed NHS

Online, 12.30–1.30pm

In partnership with the Health Foundation and York University, this MiP webinar explores the real contribution managers make to improving services, supporting staff and delivering change. Hear the evidence, share your experiences and join the disussion.

crowdcast.io/c/mip-nhs-mangement-research

24-26 October 2026

UNISON Disabled Members Conference

Brighton Centre

See the UNISON website for details.

unison.org.uk/events/2026-ndmc

3-4 November 2026

Welsh Confed 2026

Cardiff City Stadium

Welsh NHS leaders meet at a crunch moment for the health service following the historic change of government at Cardiff Bay. And there's obviously plenty to talk about (see page 18) as the conference has been expanded to two days. All the usual speakers, workshops and networking events, plus dinner and a drinks reception at the Coal Exchange Hotel.

thenhsalliance.org/training-and-events/welshconfed26

13-15 November 2026

UNISON National LGBT+ conference

Belfast

See UNISON website for details.

unison.org.uk/events/2026-lgbt-plus-conference

17 November 2026

King's Fund Annual Conference

King's Fund, central London

Themed 'Good health for all', this year's conference takes the long view, exploring what health and care services could look like in 2040 and how to get there. "There's a growing consensus that the current model cannot continue as it is," say the organisers. Among the speakers chewing over this are health department perm sec Samantha Jones, NHS medical director Frankie Swords and Matthew Hood, a senior advisor to health secretary Yvette Cooper.

kingsfund.org.uk/events/annual-conference

17-18 November 2026

MiP Reps Day

Birmingham

Annual meet-up for MiP's workplace reps with dinner and a drinks reception the night before. See above for details.

Contact Rosie Kirk (R.Kirk@miphealth.org.uk) to book your place

KEEP THE DATE

21-22 January 2027: NHS Alliance Non-Executive Directors Induction, online (thenhsalliance.org/training-and-events/non-executive-director-induction-january-2027)

9 February 2027: NHS Employers conference: Reward that works: valuing the NHS workforce, Leeds (nhsemployers.org/rewardthatworks)

13 April 2026: King's Fund Annual Leadership and Workforce Summit 2027, central London (kingsfund.org.uk/events/annual-leadership-workforce-summit)

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

MiP joins march at Tolpuddle Festival

Trade unionists from across the UK came together in July for the annual Tolpuddle Festival, with MiP joining the march through the Dorset village under its own banner for the first time.

The festival celebrates the 'Tolpuddle Martyrs'—six agricultural workers who were sentenced to seven years' transportation to Australia in 1834 for forming a union to fight against wage cuts. Their harsh treatment sparked widespread protests, including a mass demonstration in London involving tens of thousands of trade unionists. Their eventual pardons made them enduring symbols of the trade union movement.

Warwick Heale, MiP rep at Devon ICB, led the MiP contingent, alongside colleagues from UNISON and dozens of other unions.

Warwick described it as a "great day of unity and a celebration of the union movement", with inspirational talks from union leaders, stalls and music, bringing trade unionists together from across the country.

MiP thanks everyone who took part. If you would like to join next year's festival, please get in touch: info@miphealth.org.uk.

STOP PRESS: NHS SCOTLAND

Local health boards to be axed in shake-up of Scottish NHS

The Scottish Government has announced plans to radically restructure the NHS, replacing Scotland's 14 territorial health boards with two new 'Strategic Health Boards' covering the west and east of the country.

The shake-up was announced by first minister John Swinney on 2 September, with ministers describing the changes as the most significant structural reform of NHS Scotland since devolution in 1999.

The government claims the new structure will simplify the NHS, reduce duplication and make accountability clearer, while improving access to care and tackling inequalities created by existing health board boundaries. Swinney said there would be no compulsory redundancies among NHS staff as a result of the reforms.

The plans—announced without any consultation with health unions—also include further reforms to Scotland's special health boards, which provide national services such as ambulances, training and public health, alongside wider changes to public services and social care.

Scottish first minister John Swinney

At the time of going to press, there were few details about how the reforms will work and ministers had not disclosed how many NHS jobs could be affected or how much money the reforms are expected to save.

Commenting on the announcement, MiP's national officer for Scotland, Claire Pullar, said: "There are still many questions about how the changes will be implemented and what they will mean for staff, services and patients. Cutting jobs or reducing management capacity cannot be allowed to become a substitute for delivering more efficient public services."

The union called on the Scottish Government to learn lessons from the ongoing NHS reorganisation in England and engage early with staff and unions, "to avoid repeating the same mistakes".

NHS reforms in England had "created significant disruption for services and the people managing them due to a lack of meaningful consultation, poor communication and cutting headcount before service design", Pullar said.

MiP will support members individually and collectively throughout the reorganisation in Scotland. Check the MiP website regularly for the latest developments: miphealth.org.

Unions call for action over "scandalous" partial retirement rules

Hundreds of NHS workers who took partial retirement could see their redundancy payments reduced due to obscure rules which unions have described as "outdated" and a "scandal".

UNISON and MiP have called on the government to give unions and NHS employers a mandate to negotiate changes to Agenda for Change rules which reduce reckonable service for partially retired staff.

One NHS worker, who wished to remain anonymous, described feeling "sick" when they realised the implications. After 35 years' NHS service, they had opted for partial retirement in 2024. It was only when placed at risk of redundancy that they discovered the clause in the NHS Agenda for Change handbook which reduces their reckonable service—and hence their potential redundancy payment.

"If I'd known what I know now, I would have never taken partial retirement," the worker said.

UNISON deputy head of health Alan Lofthouse said a resolution was particularly urgent when the NHS is the midst of cutting tens of thousands of jobs.

"We need to protect people facing redundancy from being shortchanged."—UNISON deputy head of health Alan Lofthouse

"Older workers took advantage of pension flexibilities that they thought would protect their terms and conditions and let them continue to work in the NHS," he said. "Now, they're starting to realise that there's a huge impact on redundancy payments when they face losing their jobs.

"It's important to protect flexible retirement options as they provide a great way to reduce hours and bring pension into payment," added Lofthouse. "But we need to protect those who face redundancy from being shortchanged after giving so many years' service to the NHS."

Get the latest advice on partial retirement from the UNISON website: mip.social/pr-advice.

Very senior managers

Further delays to exec pay rises "completely unacceptable", says MiP

Board level NHS managers in England are still waiting for this year's pay rise, due in April, after NHS England ordered trusts to withhold awards until it had completed a review of its oversight framework for NHS trusts and ICBs.

MiP said the continuing delay to the 3% rise, recommended by the Senior Salaries Review Body (SSRB) and accepted by the government in May, was "completely unacceptable". The award covers very senior managers (VSMs) working in trusts and ICBs, and executive senior managers (ESMs) working for NHS England.

MiP chief executive Jon Restell said the union "welcomed the government opening the pay round much earlier than previous years, but it means nothing if the award isn't paid on time. The SSRB is already accepting evidence for next year's award while this one remains outstanding—it's completely unacceptable."

Under current guidance, executives working for organisations placed in segment five of NHS England's national oversight framework are not eligible for annual pay awards, unless they have been working there for less than two years.

NHS England has written to trusts and ICBs advising them to withhold the pay uplift until it has confirmed organisations' rankings in the oversight framework and ministers have decided whether to extend the pay freeze to executives working for organisations in segments three and four.

"MiP is strongly against withholding awards based on organisational performance and completely opposed to extending this to more managers. This position has been made clear to the department and NHS England," said Restell.

The union has also requested guidance from NHS England on how organsiations should use money earmarked by the SSRB for 'pay flexibilities' —essentially dealing with overlaps between pay bands which mean some senior managers are paid less than more junior colleagues. The union has also requested a revision of ICBs pay ranges to reflect managers' new responsibilities following recent the job cuts and mergers.

"Senior managers are working hard to keep the NHS running in a highly pressurised environment, made much worse by the government's reorganisation and cuts to management capacity," Restell added. "They should not be left waiting indefinitely for a pay award they are already due."

Health department revolving door spins again as Cooper takes over

Yvette Cooper and four other new ministers—clockwise from top Diana Johnson, public health; Alison McGovern, social care; James Frith, innovation; Chris McDonald, science.

Former foreign secretary Yvette Cooper became the UK's eighth health secretary in five years as she replaced James Murray in Andy Burnham's new look Labour government. Cooper, 57, is one of five new faces at the Department of Health and Social Care (DHSC), with only MiP member and former NHS manager Karin Smyth and the women's health minister, Baroness Merron, surviving from the Starmer government team.

Murray's two-month spell as health secretary is the second shortest in history, exceeding only Thérèse Coffey's 49 days in charge in 2022. Murray returns to his former haunt at the Treasury as financial secretary.

Cooper, MP for Pontefract and Castleford since 1997, is one of the government's most experienced hands. She was a junior health minister from 1999 to 2002, and has served in several senior cabinet positions under Tony Blair, Gordon Brown and Keir Starmer.

In a podcast interview with former chancellor George Osborne shortly after her appointment, Cooper admitted she had been sceptical about abolishing NHS England, but has now changed her mind. "You've got this entire parallel structure and these non-functioning relationships between the Department of Health and NHS England," she said. In her first policy change, Cooper announced on 1 September that she was reversing Wes Streeting's plans to remove local council representation from Integrated Care Boards.

Cooper is joined at DHSC by Dame Diana Johnson, a former official with MiP's sister union, the FDA, as public health minister, former local government minister Alison McGovern, who takes charge of social care, and former Cabinet Office minister James Frith, who gets the 'health innovation' brief. Stockton MP Chris McDonald also joins the DHSC as minister for science, innovation and investment in a joint appointment with the business and trade department. Smyth retains her existing responsibilities for NHS secondary care.

NHS leaders should be accountable for past failings, Mackey says

NHS England chief vSir Jim Mackey

NHS England wants to change contracts for board level managers so they can be held accountable for actions in previous jobs, chief executive Sir Jim Mackey has said. The move follows the disclosure by Donna Ockenden, chair of the Nottingham maternity services inquiry, that some former executives had refused to give evidence to the inquiry.

NHS England is already working on the contractual changes, Mackey told a conference run by the IPPR think tank in June. "Everybody needs to be accountable for their actions," he said. "We're looking at changes we can make to leaders' contracts. A lot of people often leave and then it's very difficult to hold them accountable for what happened on their watch."

Donna Ockenden, chair of the Nottingham maternity services inquiry

Ockenden said 29 former staff at Nottingham University Hospitals, including some senior leaders, declined to give evidence, leaving gaps in the inquiry's understanding of the failings in the hospital's maternity services.

Responding to Mackey's comments, MiP chief executive Jon Restell said: "Accountability is an essential part of being an NHS manager and nobody is above scrutiny when things have gone seriously wrong, even if it's in the past. But trust is low in the system and it's important to know why some people declined to appear. It should not simply be assumed that they were trying to dodge accountability."

The proposed contract changes raised significant questions, Restell warned. "How will contactual changes bind staff who have left the NHS? What professional advice and access to records will be available to former staff during inquiries into historic matters?"

Federated Data Platform

New doubts over Palantir contract as Treasury finds costs outstrip benefits

The controversial Federated Data Platform (FDP) is set to cost the NHS more than it saves, with benefits far below those claimed by NHS England, according to new forecasts by the Treasury's capital spending watchdog. The new forecast comes as ministers ponder activating a break clause in the government's £330-million contract with the lead supplier, US tech giant Palantir.

A report from the Treasury-based National Infrastructure and Service Transformation Authority (NISTA) forecast 'lifetime' benefits from the FDP at £808 million, compared to the £2.5 billion claimed by NHS England last year. At the same time, the increased bill for "scaling up" FDP deployment has seen lifetime costs grow from £1.04 to £1.08 billion, NISTA estimated.

Last year, NHS England claimed NISTA's forecasts did not yet take into account the benefits of the "wider transformation work" that would "empower NHS organisations to drive efficiency and change ways of working". But the Treasury's new forecast showed only a modest rise in benefits over last year's estimate of £777 million.

NHS England did not comment publicly on the latest Treasury findings but in

Backing managers at the TUC

MiP is calling for a halt to NHS management cuts and a credible plan to develop management and leadership in the health service in a motion to the Trade Union Congress in Brighton this September.

MiP rep Saj Ahmad

The motion, to be moved by MiP rep Saj Ahmad, recognises that good management is fundamental to efficiency and patient safety, and that NHS managers "are working people in their own right" who, as part of an organised workforce, "strengthen partnership working and industrial relations" in the NHS.

The motion also warns that the ongoing NHS reforms and disproportionate cuts to management risk undermining the NHS's ability to deliver reform and provide safe services.

Read MiP's TUC motion in full at mip.social/mip-tuc-26.

NHS trusts

Blackpool managers face pay cuts as cash squeeze on trusts tightens

MiP has criticised proposals by Blackpool Victoria Hospital to cut managers' pay as part of a £500,000 restructuring of the trust's management jobs.

Managers in Bands 6, 7 and 8 have been told that their jobs are being reviewed as part of a 30-day consultation on proposals to move some posts down by one pay grade and remove all non-clinical roles at band 8A.

The plans have prompted concern among MiP members at Blackpool, who say morale is already extremely low following a period of significant financial and operational pressure.

The trust says the changes are needed to "strengthen accountability, improve decision-making and make sure our services are aligned to the way patients receive their care", adding that only a small number of the 144 roles under review would be affected.

But MiP chief executive Jon

70023VENUS2009ON FLICKR.COM

Restell warned the savings would come at a high price. "Forcing staff to take pay cuts is no way to balance the books. It harms morale at a time of extraordinary financial and operational pressure, risks undermining the trust's ability to deliver safe services and puts further pressure on already stretched clinical teams, he said.

"Moving jobs to a lower pay band does not make the responsibilities disappear," he added. "The trust needs to be clear about what work will continue and what work will stop."

With trusts under intense pressure to reduce spending, MiP has warned that management cuts are "going under the radar", with providers across England planing to axe at least 21,000 posts by 2028.

"These cuts in hospitals are going through with little to no scrutiny, but could have disastrous consequences for local services," Restell said. "Weakening hospital management shifts operational duties onto already stretched clinical teams—taking them away from treating patients."

He warned that combined with cuts to ICBs and the abolition of NHS England, the reduction of management capacity in the NHS "will only lead to less efficient services and greater burnout of clinical staff".

He added: "If the government wants to improve services for patients, it needs a credible, fully resourced plan for NHS management at all levels and to stop treating managers as a cost to be cut."

a bulletin to staff, chief data officer Ayub Bhayat insisted the figures "significantly undervalued" the FDP's lifetime benefits.

In June, the government's Office for Statistics Regulation (OSR) launched an investigation into NHS England's claims about the FDP, following a series of complaints about potentially misleading statements, including claims that the platform had enabled 110,000 additional NHS operations. "Some of the correspondence we received also raised concerns about the possibility of a culture within NHS England which suppressed criticism of the role or impact of the FDP," said the OSR.

The FDP is a decentralised platform designed to enable data held by different NHS organisations to be linked together and accessed using a single authorised login. It also offers a suite of applications for analysing data and managing key tasks such as waiting list prioritisation and dischage planning.

The project, which runs until 2032, has been hit by a series of controversies surrounding Palantir, including unauthorised access to NHS patient data by the firm's staff, its involvement in human rights violations in the US and Gaza and political attacks on the NHS by the firm's co-founder Peter Thiel.

While 170 trusts have signed up to the FDP, only 139 have gone "live"—52 of which have yet to use a single FDP application. A significant minority of trusts, as well as Greater Manchester ICB, have refused to use the FDP, citing data security concerns, a lack of public trust and low national uptake of FDP tools. Many 'opt-out' organisations have also claimed the FDP offers data tools which are inferior to those they already have.

CORY DOCTOROW

AI regulation

Safety watchdog launches probe into AI scribes as regulator scraps controls

England's main patient safety watchdog has launched an inquiry into the use of ambient voice technology (AVT) in NHS hospitals, warning the patient safety risks were "not fully understood". The probe was announced the week after the UK medical devices regulator scrapped controls on most AVT systems.

Commonly known as 'AI scribes', AVT listens into consultations and meetings and automatically generates clinical notes, letters and summaries. Many NHS trusts, including Alder Hey Children's Hospital (*see page 11*), already have live AVT systems.

Announcing the inquiry in August, the independent Health Service Safety Investigations Body (HSSIB) warned that "adoption of AVT is accelerating while the safety implications are not fully understood. National literature and implementation activity has focused more strongly on efficiency benefits than on patient safety risk." Hospital procedures for recognising and reporting safety risks "are not yet mature enough to provide confidence that emerging risks are being identified," the watchdog added.

"If an AI-generated summary omits clinically relevant information or introduces errors, the consequences can extend far beyond simple note-taking."

—Dr Anne Kinderlerer, digital health lead, Royal College of Physicians


ROYAL COLLEGE OF PHYSICIANS

In July, the Medicines and Healthcare Products Regulatory Agency (MHRA) announced that most forms of AVT would no longer be classed as medical devices. Previously, all AVT systems were designated Class I medical devices, requiring suppliers to self-certify compliance with safety standards and flag safety concerns—a light-touch regulatory regime which had been criticised by some clinical and tech industry leaders.

Under the new rules, only AVT systems which support diagnosis or recommend treatments, or act without clinical intervention will be classified as medical devices.

Dr Anne Kinderlerer, digital health lead at the Royal College of Physicians warned deregulation of AVT "risks creating gaps in oversight... when these tools have the potential to influence decisions about patient care. If an AI-generated summary omits clinically relevant information or introduces errors, the consequences can extend far beyond simple note-taking." The decision also "risks a much larger correction further down the line", she added.

In the wake of the MHRA's decision, NHS England removed the requirement for AVT systems to hold Class I accreditation to be listed on its registry of approved AVT software. In a statement, NHS England made clear that primary responsibility for ensuring that AVT systems are safe now rests with boards and executive teams: "Individual NHS organisations remain responsible for ensuring that it is deployed safely and appropriately in their settings, with staff using it in accordance with local clinical, professional and governance requirements."

Devolution: Closer, Disorder or Vanishing Point?

Andy Burnham's new government is all about devolution, with ministers keen to apply the 'Manchester model' to the NHS across England. But with the centralising Health Bill still going through parliament, the government has been left facing both ways.

A change of government always brings the prospect of change for the NHS. Andy Burnham's arrival in No 10 caught no one by surprise, but with no leadership election campaign and no manifesto of his own, there's still a lot we don't know about how he will govern.

Burnham has said he will broadly stick with the 2024 Labour manifesto that delivered Keir Starmer's huge majority and won't bend ex-chancellor Rachel Reeves's self-imposed fiscal rules on spending or taxation. That may change of course, but we will likely need to wait until the autumn budget to learn if there will be any major shifts in government spending.

In the meantime, the prime minister's early focus has been on constitutional reform. If there's one thing synonymous with brand-Burnham, it's devolution. The former mayor of Greater Manchester (GM) has spent more than a decade arguing England is too centralised and decisions about public services should sit closer to the communities they serve. Now as prime minister, he has started to set out his plans to realise this.

For the NHS, this could mean yet another significant change in how services are planned, commissioned and managed.

From Manchester to No 10 and back again

The direction of travel was made abundantly clear with one of Burnham's first acts as prime minister: opening No 10 North in Manchester, tasked with driving Burnham's decentralisation agenda. The prime minister's new northern seat isn't subtle with its symbolism, but it does signal Burnham's intent to shift power from Whitehall to the cities and regions of England.

This work was already well underway before Burnham's arrival, with the English Devolution and Community Empowerment Act becoming law in April. This act creates a framework for setting up strategic authorities across England. These authorities will bring together constituent councils as well as stakeholders from public services. With initial powers over regional strategy, transport and economic development they could become increasingly powerful bodies as devolution is extended.

There will be three tiers of strategic authority. Foundation authorities will cover areas without a directly elected mayor and will initially have more limited powers. Mayoral authorities will have broader devolved powers, while established mayoral authorities will receive the greatest level of devolution, including an 'integrated settlement' allowing government money to be spent more flexibly across the region.

Burnham is already accelerating this approach, committing each part of England to be covered by a strategic authority by 2028. If local council leaders cannot agree on forming one, the government will have powers to create one for them.

Most notable for the NHS is the prime minister's additional commitment to

> "The prime minister's new northern seat isn't subtle with symbolism, but it does signal Burnham's intent to shift power from Whitehall to the cities and regions of England.

align public service boundaries, with ICBs now told their boundaries must match the strategic authority's by 2029.

The commitment to align public service boundaries with local and regional government makes sense in principle. But it will ring alarm bells for NHS staff. Public service boundaries have developed independently for years, leaving an inconsistent web of geographies across the country. Greater Manchester is the clearest example of a strategic authority that lines up with its ICB. South Yorkshire and West Yorkshire's boundaries also closely align with local NHS geography.

Elsewhere though, the picture is much less tidy. NHS boundaries can encompass several local authorities, while emerging strategic authorities may cover different combinations of councils. Some areas are still working out what their future devolution landscape will look like.

After being told to cut their running costs in half, ICBs have spent the last year

Rhys McKenzie is MiP's communications officer.

MEDIA CITY, SALFORD

JONNY GLOS @ UNSPLASH.COM

merging, forming clusters and shedding staff in the thousands. Now they face the prospect of having to reorganise again, causing further uncertainty and disruption for staff. With many strategic authorities not yet established, some ICBs are effectively being asked to plan around boundaries that do not even exist.

The Manchester model

If the NHS is to be mandated to reorganise again, then the prime minister and new health secretary Yvette Cooper need to convince the public and NHS staff that it will bring tangible benefits to how the NHS is run and how services are delivered.

So far, we don't know how far this government intends to devolve health and care to regional and local government. The obvious case study is GM. The 2015 deal was the first of its kind in England and remains the most developed example of regional health and care devolution.

The agreement brought together the Greater Manchester Combined Authority, NHS England, 12 Clinical Commissioning Groups, 15 NHS providers and the ten councils covering the city-region. Together, they took collective responsibility for health and care spending across the region, pooling existing budgets into a combined total of around £6 billion. This was augmented by an additional £450 million transformation fund provided by NHS England and the Department of Health and Social Care.

This was not a transfer of the NHS to the mayor or the combined authority. NHS organisations retained their statutory responsibilities and remained subject to national NHS standards. GM's own evaluation subsequently described the arrangement as closer to delegation than devolution. But the deal gave the region greater freedom over how health budgets were spent and what was prioritised.

The GM experience was an important influence on the thinking behind Integrated Care Systems and ICBs. The important difference is that ICSs brought political and other public sector partners into an NHS structure, rather than creating a regional political structure around the NHS.

GM places the NHS within a broader regional political structure. The argument is that this gives local democratic accountability while creating greater potential to connect health and care with wider policy areas, including housing, transport, employment and skills, than is possible in the current ICS landscape.

While the Burnham government's devolution plans point towards stronger regional leadership and greater local control, the Health Bill is doing the opposite.

As we set out in the last issue (mip.social/hcm68-bill), the Health Bill in its current form concentrates more power in Whitehall. It gives ministers significant new powers over ICBs and NHS organisations, including powers to direct local bodies and intervene more directly in their governance.

The question is: how devolved can a health system be if central government retains the power to appoint and dismiss NHS board members, direct local organisations and exercise significant oversight over individual trusts?

GM shows that devolution is about more than giving a mayor a seat on an NHS board. Pooling funding and giving local organisations greater control over how it's spent means decisions can be better shaped by local need.

If that is the model Burnham wants to take national, the Health Bill will need to do more than simply reorganise NHS structures. Otherwise, there is a danger of creating a system where responsibility is devolved but power remains centralised.

Getting devolution right

Burnham will have a tough task getting health devolution right. The NHS has already been through a prolonged period of instability, and managers and staff will not welcome another round of reorganisation for its own sake.

Patients and the public want to see services improve—and quickly. Present and future mayors will want meaningful powers if they are to be held accountable for improving health in their regions.

The challenge for Burnham is to make devolution more than a change to the map. It needs to give local leaders the powers, resources and management capacity required to deliver better services.

And that means learning the lesson that applies to every reorganisation of the NHS: structures are only as good as the people and organisations expected to make them work. //

Our message to ministers: let's find some common ground

What do politicians want from the NHS? We don't ask this question much in my world of trade unions and representative bodies. We spend the lion's share of our time advocating—normally rightly—for our members and reacting—normally critically—to government decisions. Both jobs need doing. And the core messages from the NHS tribes don't change much: leave the NHS alone, employ more NHS workers (and pay them more), give the NHS more money.

These messages are well-grounded and mostly reflect public opinion. But politicians hear them endlessly and are apt to tune them out. They see their job as balancing the vested interests of different groups, trying to buy space and time for themselves to get on with the real job of reform and delivering improvements that they hope the public will feel by election time. They don't see, or soon give up seeing, our members as potential partners in a shared enterprise of reform and improvement.

As committed public servants, occupationally wired for reform and improvement, this attitude from government ministers causes despair among MiP members. Other parties are available, of course, with other policies—who knows what Reform is cooking up for the NHS?—but Labour is the party in power right now and they are 'the party of the NHS'. So, if not now, when?

What should be a chance to forge a partnership between a Labour government and NHS managers feels more like two ships passing in the night—with the crews heckling one another. MiP, for example, has found itself, amid another unpromised mahoosive restructuring and redundancy programme, campaigning to make planning management capacity a legal duty in the Health Bill. And pushing back when ministers seek political safety in the traditional Punch and Judy show of 'useless bureaucrats' and 'protect the frontline'. (If NHS managers are a 'vested interest', they are a ludicrously unsuccessful one.)

Is it too late to forge the partnership MiP members want to see? Very possibly. But it would be wrong not to try. What is it that politicians want that offers the common ground on which partnerships are built? Here are my thoughts.

> **"What should be a chance to forge a partnership between a Labour government and NHS managers feels more like two ships passing in the night—with the crews heckling one another.**

Politicians want to put the politics back into the NHS. While not expecting to hear bedpans dropping, elected officials are right to want to take back control of policy and direction. They also want to devolve power closer to communities. The challenge is making the new national centre stay in its lane of setting strategy, holding the NHS to account for outcomes and doing what only the centre can do—giving places the freedom to deliver without being micromanaged on inputs.

Politicians want value for money. For nearly two decades there has been little or no economic growth to generate more money for public services—and government now has new spending priorities such as defence and the cost of living. The relative protection of the NHS budget, resented across other parts of government, is no longer a given. The challenge is to build the systems and management capacity to deliver much better NHS productivity and to amplify the welcome trend towards streamlining approval processes, protecting capital funding and multi-year planning and budgeting.

Politicians want reform and improvement. The public criticise management—how NHS resources are organised and allocated—because they know it's important. Professionalising and regulating management, something generally welcomed by MiP members, is a (relatively small) part of the answer. The challenge is taking management as a systemic function seriously, planning and resourcing it and removing the obstacles getting in the way of managers doing their jobs.

I believe there is common ground. Yvette Cooper has signalled a focus on outcomes and a disdain for 'macho' reform centred on restructuring. With the backing of a new prime minister, she has the opportunity to make common cause with NHS managers. It won't be easy, given where we are, but it must be worth a try. //

For more, watch Jon Restell's appearance at the Commons Health Bill committee on 16 June: mip.social/bill-comm (starts at 17:49).

"Innovation is all about people and relationships… the technology should never come first"

In a remarkable coup for the NHS, Alder Hey Hospital's Kate Warriner has been voted the UK's top digital chief by tech industry leaders. She tells Craig Ryan about what made the Liverpool kids' hospital a technology powerhouse and why innovation and transformation is more about human beings than machines.

Kate Warriner's first NHS job, while still studying music at Liverpool University, was a part-time gig as a ward clerk, "getting lots of paper case notes", she recalls. "The irony of starting there when you're in a digital leadership role!". Twenty-five years later, as Alder Hey's chief transformation and digital officer, leading innovations like electronic patient records, digital patient portals and AI scribes, she's one of a new generation of tech leaders who are dragging the NHS—kicking and screaming, sometimes—into the digital age.

And Warriner has good claim to be the tech leaders' tech leader. Last year, she was named top digital leader in the prestigious UK CIO 100 awards—the IT industry 'Oscars'—ahead of counterparts from Bentley, Lloyd's Bank and Chelsea Football Club, among many others in a largely private sector (and male) dominated field.

It's a big personal accolade but one she modestly prefers to see it as recognition for how Alder Hey works with its patients and clinicians to advance digital technology (much more about that later). "The NHS is notoriously always behind the rest if the world on [digital], but Alder Hey's board has always backed digital, backed innovation, and to see that recognised by my profession and through the industry is something we're really proud of," she says.

But it's also quite a coup for the NHS, a sign of the service's growing digital maturity and the backing given to the digital leadership profession in recent years. Most NHS organisations now have a chief digital or information officer, like Warriner, with a seat on the board and a remit that often goes way beyond traditional IT management to encompass innovation of all kinds.

Her job has "evolved quite significantly" since she joined Alder Hey in 2019, Warriner says, and the addition of 'transformation' to her job title three years ago was more than symbolic. "I think the board and the chief executive realised that… digital underpins all of the transformation of our services," she explains. She now has board-level responsibility for transformation and innovation across the trust, including overseeing Alder Hey Innovation, a multidisciplinary

collaborative hub with a mission to explore the frontiers of paediatric care.

Warriner describes herself as a "natural people person", and she certainly speaks human—not always the first language for tech leaders of the past. She barely mentions hardware or software during our talk and not a single piece of tech jargon passes her lips. Today's digital leadership is "all about relationships and about people, underpinned by great technology. But the technology should never come first," she says.

She likens technology to a "fourth utility", part of the organisation's wiring and "embedded in everything we do". Under the trust's multidisciplinary approach, digital expertise and project skills are distributed across the organisation rather confined to a few boffins locked up in an IT department.

She's keen to showcase the trust's "CXIOs"—clinical leaders given dedicated time to spend on digital projects, AI and service innovation. "[They] work in and amongst our services on the ground, spotting things that could improve how we operate and people's lives, then working as the voice of those [services] within our leadership team," she explains.

In turn, digital staff are "embedded" within clinical teams through a "clinical shadowing programme", she adds. "We've got a number of [digital] colleagues who are attached to different clinical services... They'll go out and understand where support might be needed or what new things they might want to try."

Alder Hey Innovation extends this collaboration beyond the trust, working with tech firms, other NHS bodies, patients and academics—and getting clinicians engaged early with innovation. Recently, the hub helped to develop an AI tool for predicting missed appointments, a remote monitoring tool for childhood obesity care and a device for collecting urine specimens from pre-continent children.

> **"We all bring different strengths. But we're only as good as the sum of all the talents of the partners working collaboratively together.**

Alder Hey is a strikingly modern hospital in the Knotty Ash area of Liverpool, three miles from the city centre and across the road from Liverpool Heart and Chest Hospital, where Warriner doubled up as chief digital officer until 2024. Originally a Victorian workhouse, Alder Hey became a children's hospital in 1914. In 1944, the hospital tested penicillin on a child for the first time, saving the child from pneumonia.

The hospital moved to nearby Springfield Park in 2015 and now sits at the heart of the trust's leafy 'Children's Health Campus', which also comprises a mental health centre, the research-orientated Institute in the Park, a bereavement care facility and, nearing completion when I visited in July, a state-of-the-art neonatal intensive care unit.

Alder Hey is a big trust, with 270 beds, employing over 4,000 staff and providing care to almost half a million children every year. It's one of only eight trusts selected to get extra financial freedoms under the government's 'advanced foundation trust' programme. The atmosphere is bright and buzzy but welcoming—about as far from its workhouse roots as you can get.

The trust's children's and young people's forum "worked really closely with the architects to make this place almost not feel like a hospital and feel friendly for children and young people," says Warriner. The forum meets weekly and its 120 members "have a really loud and important voice in the shape and design of everything we do," she explains.

That very much includes the trust's many digital projects. "They want us to bring them the future," says Warriner. "They want us to be at the cutting edge of technology, and they're really open

What's in the box?

Alder Hey's AI strategy sets out a series of "strategic initiatives" which aim to deliver on the programmes four big objectives: more personalised care, empowering staff, improving outcomes and transforming diagnostics.

Young people centred care

- Virtual assistants to guide children and families through the care pathway
- Predictive models to detect paediatric conditions early and recommend timely interventions

Empowering staff

- Ambient Voice Technology ('AI scribes') for consultations and meetings (already being deployed)
- 'AI Assistants' for day-to-day tasks, including automated scheduling, intelligent ordering and task management

AI-driven decision support for clinicians

- Building an Alder Hey large language model (LLM), using the trust's "data assets"
- Using AI tools on top of electronic patient records

Transforming outcomes

- Speeding up care using AI tools to identify inefficiencies and improve patient flow
- Developing machine learning models to use real-time health data to spot signs of deterioration and complication, enabling targeted early intervention
- Gathering patient-reported outcome information using AI tools and chatbots
- Remote monitoring for children with chronic conditions

Transforming diagnostics

- Developing and implementing reliable and accurate AI-driven medical imaging systems
- Identifying rare diseases using AI tools to analyse electronic health records
- Using AI tools in genomic medicine to support early diagnosis and develop tailored treatment plans
- Using data from wearable devices, such as smart watches and biosensors, to enable continuous monitoring of children's vital signs
- Testing the capability of AI in diagnosing neurodevelopmental conditions and congenital heart disease

Read the Alder Hey AI Strategy in full at mip.social/alderhey-ai.

and honest with us around that." One of the forum's first messages, she recalls, was "why do you keep sending us paper? Stop sending us paper!"

Easier said than done, as everyone in the NHS knows. But with the launch of 'Alder Connect' in April, paper is finally on the way out at Alder Hey. The online patient portal will let parents manage their child's care in one place, gradually replacing traditional patient letters. Developed with tech firm Blinx as part of wider system work with Cheshire and Merseyside ICB, it's a tangible product of the trust's collaborative approach.

Collaboration can be difficult to get going in an NHS in which competitive instincts have been encouraged for decades, but seems well-embedded at Alder Hey. Cheshire and Merseyside has a single digital plan, with the CIO at each NHS organisation taking the lead in a different area. Warriner is responsible for the AI programme across the patch, which includes 16 trusts and over 300 GP practices.

The trust recently forged an international partnership—alongside five other NHS trusts—with the SickKids hospital in Toronto, a pioneer in using AI in paediatric care (see opposite), and Warriner hosted a delegation from the Canadian hospital the week before our meeting. "Some of the work they've done over there, and some of the expertise we already have in the UK, is really helping us to push the boundaries with AI and paediatric healthcare," she says.

Alder Hey also leads on the Paediatric Open Innovation Zone, a £10 million programme of collaboration with local innovators which forms part of the Liverpool city-region's economic development plan. As well as pioneering new technology to improve children's health in Liverpool, the project hopes to create "high quality" jobs in a city hit hard by deindustrialisation.

It's a rich network of mutually-beneficial connections, a million miles away from both the siloed, hierarchical NHS of the 1970s or the 'let's pretend' market model introduced in the 1990s. "We all bring different strengths. But we're only as good as the sum of all of the talents of the partners working collaboratively together," explains Warriner.

Another group, the Digital, Data and AI Collaborative—described as "a multi-disciplinary powerhouse" by the UKCIO 100 judges—produced the trust's AI strategy, published in summer 2025 and widely seen as a benchmark within the NHS. While briefly sketching out an "imagined future" where robot nurses, AI companions and "smart pyjamas" transform the hospital experience "into a thrilling augmented reality adventure", the 12-page strategy mostly eschews the platitudes and vague promises that characterise most NHS strategies. Instead, there are clear, succinct objectives, and a series of practical initiatives (see opposite) with milestones up to 2030. The bottom line, the trust hopes, is a 25% fall in clinician burnout and a 15-20% reduction in waiting lists.

"We really thought hard about whether we needed an AI strategy," says Warriner, "but we felt there was so much going on that it would be good to have something that corralled it all together strategically." The "thread running though" the strategy, she says, is "how AI can empower people"—children and families, Alder Hey staff and the trust's many partners.

She's particularly enthusiastic about the trust's recent rollout of ambient voice technology (AVT)—AI-powered software which listens to consultations and produces draft clinical notes and letters. It's one of the biggest AVT

deployments yet in the NHS and about 95% of the trust's outpatient letters are produced using the new technology.

"Have you seen it work? I think you've got to see it to believe it, because sometimes it's like there's a magician in the room," Warriner says. "We felt a real moral obligation when we saw the ambient voice technology. I've never seen people want something so quickly."

Those 2030 milestones look tough, but Warriner says she's optimistic both because of Alder Hey's forward-looking investment plan (with additional funding from the Alder Hey charity, which helped to pay for the AVT rollout), and because the trust has built the "strong foundations" on which effective AI deployment depends: rigorous standards for clinical safety, information governance and cyber security, a "thoughtful" education programme for staff, and "open and honest" engagement with patients and families.

Does she think AI requires different governance and safeguarding arrangements to previous innovations? "You have to have the same suite of standards that you'd always expect, regardless of the technology," she says. "You have to ensure that you meet all your safety standards, all the data protection standards and all the key things that keep you safe, effective and ethical."

But she adds: "What's perhaps different with AI is the scale of the opportunity and the speed it's moving at—and the speed [required] to scale it in an agile way. That's different to electronic patient records, for example." But as the technology develops, she suggests it will be impossible to separate AI from any "core" change in the way services operate—"the AI is embedded within it, so ultimately they will end up hand in glove together."

Alder Hey's young patient cohort is probably less resistant to AI than others, but building trust is still vital and depends as much on good relationships as regulation and governance, she says: "It's about how you implement change, being open and talking to people, listening to their concerns, responding to that, and changing if you need to change."

It's another illustration of what Warriner says is the biggest lesson of her career: "not to focus on the technology, but to focus on the people, and really spend time with the people we're here to serve. I've seen over the years, that if you don't do that, you don't get the success."

Leadership, she adds, "is all about relationships and people, being true to your values, being kind and bringing hope and energy to people."

It's a management ethos that has brought Warriner to the top of her profession. So, as Britain's top CIO, is she not seriously tempted by the big bucks that would surely be on offer in industry?

She smiles, slowly shaking her head. The NHS is "a genuine passion", she insists. "My mum and auntie are both nurses, so the NHS has always been part of my DNA." Walking around the hospital's different departments, as she does every fortnight, "it's so rewarding to see the difference we make to people's lives," she says.

Warriner is still a musician and chairs a local community orchestra. She describes how, every Christmas, she brings a group of musicians into Alder Hey: "To be able to go around playing the saxophone with a group of mates to children who are in hospital on Christmas Day, to see the joy that brings, is just amazing. You wouldn't get that if you were to go and earn the big bucks somewhere else." //

Canadian Club: Alder Hey's partnership with SickKids

Alder Hey has joined five other NHS hospitals in a formal partnership with the Hospital for Sick Children in Toronto (known as 'SickKids') to share expertise and develop AI solutions to tackle the some of the thorniest problems in children's healthcare. SickKids (sickkids.ca) houses Canada's largest paediatric research institute and is widely seen as a global pioneer of healthcare AI.

Warriner travelled to Toronto in February to meet the SickKids AI (SKAI) team and see the hospital's extensive AI programme in action. The partnership means Alder Hey's clinicians and digital staff will be able to learn alongside the Canadian team and get hands-on experience using some of solutions developed by SKAI.

The partnership with "the number one hospital in the world", will "accelerate how we apply AI to improve patient flow, support our clinical teams and ultimately deliver even better care for children and young people," Warriner says.

The SKAI service has three components: an in-house team supporting AI deployment, a discovery-focused research arm and a community-building element to promote AI literacy and knowledge sharing. Recent innovations and research at SickKids includes:

- A machine learning model using pharmacogenomic testing to more precisely match medication to a patient's condition and genetic make-up
- A machine learning model to predict which cancer patients are at risk of chemotherapy-induced vomiting, enabling early intervention
- Research into using AI to develop drugs that target disease-causing genes
- A platform that enables machine learning models to be trained, validated and safely deployed without exchanging raw patient data
- Research into how clinicians' decision making and effectiveness are affected by using AI models

The other five trusts joining the partnership are Guy's and St Thomas', Great Ormond Street, Bristol Royal Children's Hospital, Cambridgeshire and Peterborough, and Sheffield Children's Hospital.

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Maternity... out of sight & out of mind?

NHS maternity services have been subjected to a steady stream of inquiries for more than a decade—including two this summer—but the same failings keep coming to light. Is maternity uniquely hard to manage or does the crisis signal wider defects in hospital services? Alison Moore reports.

What's gone wrong with maternity, and how can it be put right? That's the question many NHS managers and boards will be asking after a series of maternity service scandals and two damning reports delivered earlier this summer.

In one sense, what's gone wrong is now clear. In multiple inquiries, from Morecambe Bay in 2015 to Nottingham University Hospitals this summer, similar themes have been laid bare.

Poor inter-professional working, a failure to listen to mothers and families, a lack of compassion, boards unaware of what was happening on the ground, and a push for women to have 'normal' births beyond the point at which intervention was needed are all common failings identified in successive reports.

But behind those are deeper questions about the working culture in maternity services and how to change it, how trust boards can understand the issues and act accordingly, and about the role of regulation and how it can aid improvement.

Despite this, many NHS trusts see the recommendations as largely about other trusts. Until the Amos maternity and neonatal 'rapid review' reported this summer, previous maternity investigations concerned a particular trust and its failings. While all trusts were expected to implement some recommendations, for most, their services were not under scrutiny. "When I look back ten years, it was Morecambe Bay this and Morecambe Bay that," says one manager with extensive experience in maternity. "But the issues are systemic. They are not limited to one trust."

'Disgruntled' and separate

There is also a question mark over where maternity services sit within trusts. A Health Services Safety Investigation Branch (HSSIB) exploratory review into maternity last year said: "We heard that often maternity services are 'disgruntled' and not treated as part of a trust, but also that maternity services do not wish to be treated as part of trust services."

Bill Kirkup, who authored reports on maternity services at Morecambe Bay and

East Kent University Hospitals, agrees maternity is treated a little differently. "That's probably not from managers but I think it's from fellow clinicians," he says. "The nearest example may be psychiatry [which] is regarded as different and dealing with a different client group, and staffed by people who are different."

Clinicians know how rapidly a pregnant woman's condition can change and escalate into something serious requiring urgent attention, he says. When a maternity patient is admitted to a surgical or medical bed elsewhere in the hospital, staff "can't wait to get her off the ward. Other clinicians have lost touch [with] and any interest in maternity, and they don't really feel a kinship with it."

Maternity is also unusual in having two professions—midwifery and obstetrics—taking the lead, leading to sometimes confused lines of accountability. Midwifery has traditionally been overseen by the chief nursing officer, who is unlikely to have midwifery experience and, until recently, most trusts didn't have a director of midwifery. Similarly, many chief medical officers will have limited experience of obstetrics.

Maternity does need to work closely with other services, says Dr Jenny Barber, vice president for clinical quality at the Royal College of Obstetricians and Gynaecologists, and good care is dependent on communications and collaboration across departments.

But in some cases this isn't happening. In her report on Nottingham's maternity services (mip.social/ockenden), Donna Ockenden highlighted that anaesthetic governance sits outside the maternity governance framework—despite the key role anaesthetists have in many births. This meant, for example, that anaesthetists were not informed about the outcomes of rapid reviews of adverse events, potentially limiting their learning.

Changing demands

Maternity units are also dealing with a rapidly changing clientele: more older mothers and more women with pre-existing health conditions, who are likely to need more care during birth and beyond. "What does this mean in terms of staff, length of stay, bed numbers? How is this big shift being understood in terms of service capacity?" asks Sarah Scobie, deputy director of research at the Nuffield Trust.

In 1970, Caesareans accounted for only 4% of births, rising to around 20% by the early 2000s. Today, the Caesarean rate—elective and emergency—is 46%, and only 43% of pregnant women give birth vaginally without the use of instruments.

Barber points to the rising workloads, staffing gaps and the estates, theatre and equipment issues which plague many maternity departments. The government needs to fully fund the national action plan—prompted by the Amos review—which is expected around Christmas, she says. But there will also be a challenge for boards.

"The demands on their maternity services are changing, and boards and NHS managers need to ensure they have the right number and mix of multidisciplinary staff, and understand rota gaps across the multidisciplinary team, training capacity, educational supervision and succession planning," she adds.

NHS leaders should also use more local data to understand the needs of their local populations and how it impacts on maternity service demand, she says.

A gigantic chequerboard

It would be very hard now for a board to claim it was not kept informed about its maternity service. In a noticeable change in recent years, most boards now regularly review data and qualitative reports on maternity services, which often run into dozens of pages. They are also required to sign off on submissions to NHS Resolution for the maternity clinical negligence scheme. Rebates on this—which depend on meeting certain quality measures—can be worth seven figure sums to some trusts.

But is this plethora of information making much difference? Arguably, boards at some of the 12 trusts examined by Baroness Amos had access to plenty of information but had not publicly acknowledged—or possibly realised—there were serious failings in their services. It was often pressure from bereaved parents or highly critical CQC inspection reports which 'revealed' their problems.

One NHS manager with experience of maternity is doubtful that the level of data boards are seeing is actually helpful. Boards may need more distilled information, they suggest. And meeting so many recommendations can lead to service improvement becoming a tick-box process.

Kirkup, who was a trust non-executive director for a time, says: "I can remember being confronted with pages and pages filled with a gigantic chequerboard of green, amber, red and blue points... they are just impossible to interpret." Boards need clear data showing what the problems are and what is causing them, he adds.

This has started to happen with the maternity outcomes signal system (MOSS), which was developed by NHS England in response to the East Kent Hospitals review and went live last year. Trusts now get warnings when certain indicators rise above what would be expected. It is, of course, up to them whether anything happens in response, or whether adverse signals are 'explained away'.

Unfortunately, there's plenty of evidence that trusts have taken little action when given information about

problems with maternity services in the past. Kirkup—who called for the development of MOSS in his report on East Kent and supports the initiative—says: "I think it's lack of attention. We saw that in East Kent, where things were going wrong for a prolonged period of time but they did not know what to do.

"I think that is partly a product of 'we don't quite understand this unit.' If that happened in a surgical unit that would have been different," he adds.

'Overwhelming' demands

Boards are coming under pressure to increase scrutiny, with NHS England chief executive Sir Jim Mackey recently sending trusts a list of ten demands, including improved triage, joint board-level accountability between chief medical and chief nursing officers for maternity and neonatal care, and 24/7 responsiveness with safe service arrangements.

But many managers already feel overwhelmed with new demands and recommendations, an issue highlighted in the Amos review. "We consistently heard from senior leaders in trusts that the number of recommendations directed at maternity and neonatal services [is] overwhelming and take time to implement," it said.

The HSSIB report also highlighted the complex national infrastructure around maternity and neonatal care, and the large number of recommendations in recent years, many of which have seen only limited implementation.

And, while NHS England's ten-point plan has been welcomed by some, it was immediately followed by the requirement to report on 25 maternity "asks" by the end of September and again in December.

'It will come back again'

Some doubt the recent plethora of recommendations will do much to change the culture in maternity services, especially persistent reports of race discrimination and a lack of compassion. "We have not done much about underlying problems... we are looking at what happens at the surface. It is not the answer. It will come back again", warns Kirkup.

Managers face a challenge in understanding the cultures and sub-cultures within departments, he explains: "If you are working in a system which has all sorts of informal hierarchies, just putting something in at the top and trying to instil a different culture won't work."

One of the most shocking revelations in recent reports has been the practice of giving junior or inexperienced midwives difficult deliveries as a challenge. "That's a thing that someone sitting in a CEO's office is not going to be able to detect very easily," Kirkup says. "Finding out what's happening is going to need a wider process as no one is going to confess to behaving like this.

"If you are having just a single interview with people you are not going to find it out," he adds. "You need to go back and talk repeatedly to people and this is difficult with the way the NHS is operating," he says.

Changing culture is "a massive task, not just in maternity," one manager told me. "But fundamentally it's all about accountability. Maternity can seem pretty unmanageable but if you have the right structure in place, it is manageable."

But, in the face of what can feel like unrelenting criticism, maternity also needs to be an enjoyable place to work, they add. "I think on the whole it is, with lots and lots of positives."

Trying to change a culture where staff have become accustomed to working in a certain way, can be extremely hard, Kirkup warns, and a "hero leader" trying to make rapid changes may not be helpful and is unlikely to be sustainable. Nor are top down pronouncements—this sort of change needs to happen at the "sharp end", he says.

Systemic failings

It's a big challenge for managers, says independent consultant and former Nuffield Trust chief executive Nigel Edwards, as they must be willing to tackle some of the tough cultural issues, and what he describes as the "normalisation of deviance". Managers need to acknowledge these problems are systemic and don't just affect particular trusts, and ask whether they are complicit in the institutional resistance to accepting this, he explains.

But Edwards also questions whether general managers have the skills and knowledge to lead maternity services. "General management is an important skill, but if you're managing a complex clinical area you do need specialist skills," he says. "It's not enough to be a good manager, you do actually need to know something about what you are managing. You need to have the knowledge of what good looks like."

Ockenden's Nottingham report noted that the trust's chief executive took direct control of a maternity improvement plan in 2019, but the "feedback from senior stakeholders is that they did not have the expertise, experience or knowledge to effect the changes required".

But perhaps the most worrying question is whether these failings are unique to maternity services—there have been similar issues in other areas such as cardiac surgery, Edwards points out. Maternity failings could be more prominent because of the very high costs involved in cases which progress to clinical negligence claims, but other services can also feel distant from the main flow of a hospital and involve clinicians whose work is not easily understood by others. "Why do you think it is only maternity?" he asks. //

A mountain

The new Plaid Cymru government promised a fresh start for the NHS in Wales and ministers have hit the ground running. But setbacks on waiting lists and funding have made a tough job even tougher, and a radical rethink of the health and care system more urgent. Craig Ryan **reports.**

It's four months since Plaid Cymru took power at Cardiff Bay, promising a 100-day blitz of initiatives to transform the NHS in Wales. "So far, they seem to be on top of getting things done," says Helen Howson, director of the influential Bevan Commission think-tank based at Swansea University. "There was a lot of despondency before, the feeling that we were going round in circles. I'm not saying we won't be going round in circles again, but there's a new energy and a new enthusiasm."

New health secretary Mabon ap Gwynfor has been busy enough, announcing plans for a string of surgical hubs, beefed up partnership working with councils, better workforce planning and a mandatory annual funding shift from hospitals to primary care. There will also be a "root and branch" review of NHS performance and a new deputy minister for public health.

In its supplementary budget, the new government also promised to restore the outgoing Labour administration's targeted funding for cutting waiting lists, which expired in March, along with £25 million to jump-start surgical hubs and £20 million more in capital spending.

But as the 100 days expired in the dog days of August, Plaid's uphill slog had, if anything, got steeper. After falling for a year, waiting lists have surged again, A&E performance is going in the wrong direction and the troubled Betsi Cadwaladr health board in North Wales remains, well, troubled. Then, in July, came a harsh lesson in the realities of minority government: amid a row over education funding the Senedd blocked the supplementary budget, leaving the promised waiting list money on hold, at least until the autumn.

While none of this is Plaid's fault, ap Gwynfor's long list of promises—including a risky-looking pledge to "eliminate" two-year waits "within months"—have become even harder to deliver.

Wales had been making real progress in reducing waiting lists, explains Nesta Lloyd Jones, assistant director of the Welsh NHS Confederation. "Overall patient pathways have been reducing considerably and the number of people waiting longest for treatment has fallen dramatically from its peak," she says.

The sharp reversal since the funding stopped—including a 60% surge in two-year waits—"is not a coincidence" says Professor Jon Barry, consultant surgeon at Swansea Bay and director in Wales for the Royal College of Surgeons (RCS). Hospitals got extra funding to run clinics out of hours or on weekends, he explains "and I got through a lot of patients". But "chucking money in" is "not a durable solution... because if you keep working people harder and harder you get more burnout"—a problem already showing in RCS member surveys, he warns.

Barry, a member of the government's elective hubs taskforce, argues that hubs are a more sustainable solution than piling up surgical overtime or using expensive private hospitals. "A

DUNCAN STEPHEN

surgical hub means a separation of our emergency and elective streams," he explains. Hubs can be a department within an existing hospital, a separate facility on the same campus or a standalone unit—what's important, Barry says, is that "those beds are only there for elective patients—you have dedicated beds and a dedicated workforce."

Experience from England "shows that hubs work", Barry says. But while England has 125 and Northern Ireland six, Wales's only operational hub is an orthopaedic unit at Neath Port Talbot hospital; planned hubs at Llandudno and Llantrisant have been hit by delays. This "glacial pace... is a frustration for all of us", he says, especially as Wales has "enough infrastructure and the right workforce" to "deliver the hub model with what we've got".

Ministers want the hubs to become "centres of excellence" in areas like orthopaedics, ophthalmology, general surgery, ear, nose and throat, and gynaecology—"the biggest pinch points in terms of our waiting lists," says Barry. Location will be politically sensitive: north-south travel in Wales is notoriously difficult and there's unlikely to be enough money to replicate each hub in both halves of the country.

But hubs alone are not "a silver bullet", Lloyd Jones warns. "They must be supported by sufficient multidisciplinary workforce capacity, modern digital infrastructure and sufficient social care capacity to ensure strong patient flow across the wider health and care system."

That sounds expensive. It's the age-old public service dilemma: reforms which save money in the long run come at a short-term cost that 'here today, gone tomorrow' politicians are usually unwilling to pay.

"If there's no more money coming in, the only way can do this is to work differently," says Barry. That could mean concentrating emergency care on fewer sites, he suggests, giving the example of Royal Glamorgan Hospital and University Hospital Cardiff— just nine miles apart. "Hypothetically, you could take the emergency unit out of Royal Glamorgan and, overnight, you'd have a *de facto* surgical hub... Those beds would just serve the elective population. That doesn't cost as much money as a shiny new building on a mountainside in Wales."

Earlier this year, Howson had an NHS-funded knee operation carried out a private hospital. "I was in one day, had the op, and out the next," she recalls. "I asked my consultant how they could do six operations in a day when the NHS can only do two. He said, 'Some of it's money but mostly it's mindset. If two is the standard, why would you push yourself to do four or six?'"

As well as "getting the mindset right", surgical hubs "mustn't be isolated", Howson says, but "work together as part of a national co-ordinated system... But you also have to look at how to reduce flow into the system."

With that inflow increasing year on year, it's like to trying to drain a bath with the taps still running on full, Barry explains. "But there are other things we can do. We could get people in Wales to stop smoking, lose weight, exercise more, and we can frontload primary care to stop people needing to come to hospital".

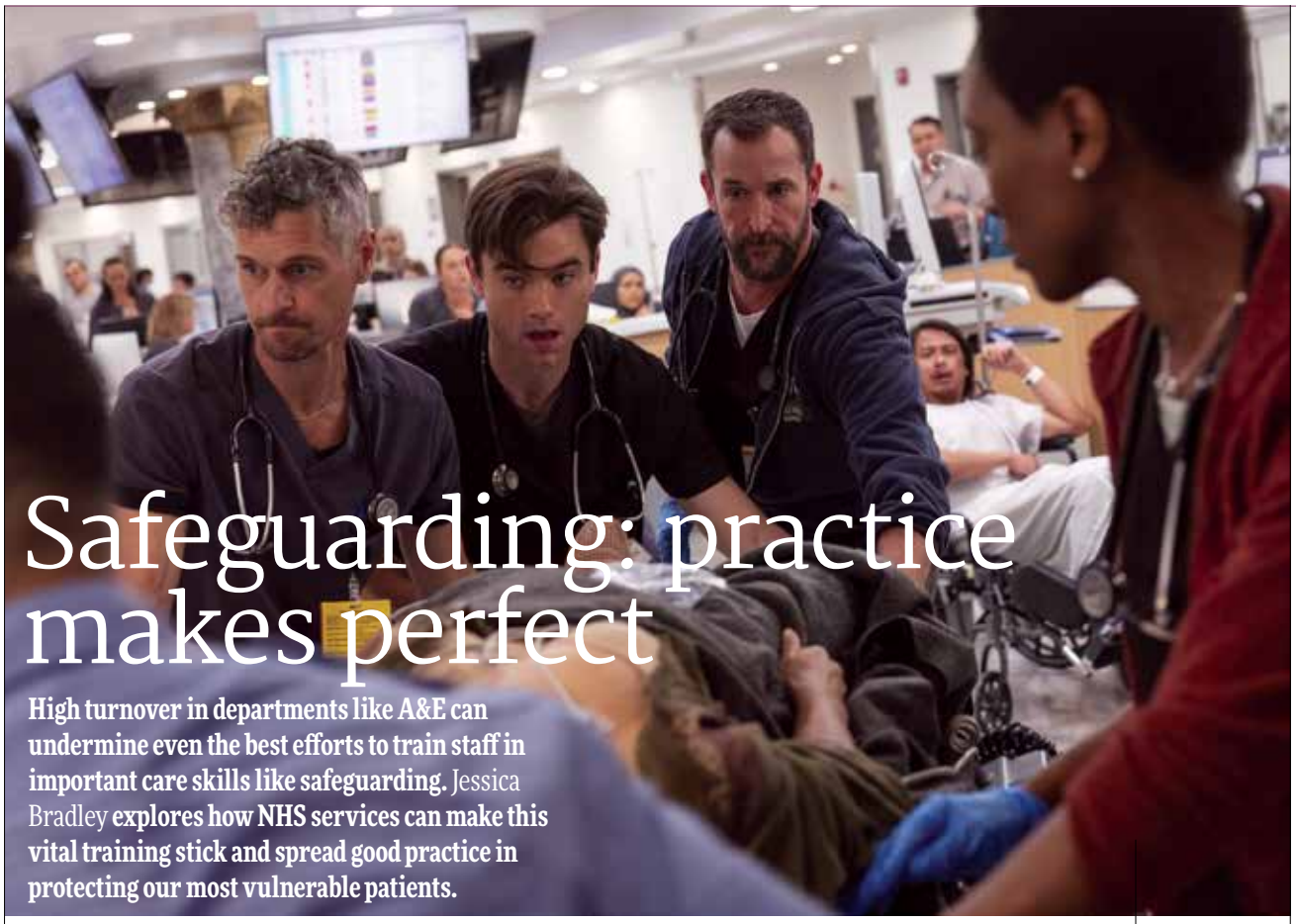
And a lot of people on waiting lists may not actually need an operation, he says. For example, in his own area of surgery, there's "good evidence" that patients with asymptomatic small inguinal hernias don't need an op, he explains. "They need reassurance and if anything changes, [to] come back and see us."

Wales's older and sicker population means "we probably do need more resources", Howson says, but with John Healey unlikely to be sending bags of cash down the M4 anytime soon, "we ignore at our peril that 85% of health is created outside hospital—only 15% comes from fixing people once they're ill." She believes ministers are finally listening: ap Gwynfor "is really going in there on this," she says. "But, inevitably, it will take time."

Meanwhile, the Welsh NHS needs to get more efficient at what it does. Health boards have already made "substantial savings", says Lloyd Jones, particularly by reducing agency staffing, but NHS leaders are hampered by "short-term funding arrangements which make it harder to plan services effectively and invest in the transformative changes needed." Such changes will also need the kind of cross-party co-operation which was not much in evidence before the Senedd recess.

While no one has the stomach for an English-style re-organisation—"we would lose three years, wouldn't we? says Howson—there's a clear need to bring the NHS in Wales together, "to share our learning, our skills, our resources, at national level as well as local." For politicians, working through seven health boards, focused "on competition as much collaboration", can be "so, so frustrating", she explains.

"What we really need is clearer purpose, sharper accountability and stronger national coordination, as well as greater freedom for people and places to improve care," she adds. There should be enough there to keep Wales's new ministers busy for quite a while to come. //



THE PITT/HBO

Safeguarding: practice makes perfect

High turnover in departments like A&E can undermine even the best efforts to train staff in important care skills like safeguarding. Jessica Bradley **explores how NHS services can make this vital training stick and spread good practice in protecting our most vulnerable patients.**

A&E is notoriously one of the most challenging working environments in the NHS. The fast pace and high stakes are often accompanied by high staff turnover, and problems recruiting and retaining staff, often leading to over-reliance on locums.

In an environment like this, it's crucial for A&E departments to keep up to date with ongoing safeguarding training. But with such a transient workforce it's often difficult for staff to put what into practice what they've learned.

All medical staff are required to complete certain training modules every one to three years—depending on the nature of the training—to maintain their registration. But since May 2025, staff no longer have to repeat mandatory training when they move from one NHS organisation to another.

The compulsory training modules include conflict resolution, fire safety, infection prevention control, data security and safeguarding for adults and children. Safeguarding training is often a combination of e-learning and face-to-face work, and every NHS hospital runs safeguarding programmes that include female genital mutilation (FGM), domestic abuse, the Prevent counter-terrorism duty, domestic homicide reviews, and modern slavery and human trafficking.

A crucial opportunity

Hospitals do their best to make this training topical, relevant and interesting to keep people engaged, says Vijay Patel, head of safeguarding at the Social Care Institute for Excellence (SCIE), and a former NHS trust head of safeguarding. But, with safeguarding, training is only one part of the picture; it's the "spirit on the job" that's often more effective, he adds.

Domestic abuse is one of the most prevalent safeguarding issues within A&E, affecting one in five people at some point in their lives.

A&E can be a crucial opportunity to reach a survivor of domestic abuse, because it may be one of the rare occasions they are in front of professionals who can help without the perpetrator being present, explains Carrie Bower, practice development consultant trainer at SCIE.

To spot signs of domestic abuse, staff need the space and time to observe the behaviour of the patient and the

people accompanying them, and the know-how to create the right setting for the patient to feel safe enough to disclose that they're being abused, she says.

Curiosity and creativity

But, of course, three things most A&E departments lack are space, privacy and time. "You've got to strike while the iron is hot—but make the environment safe," Patel says. This often means having the confidence to think outside the box and find "creative" solutions and ways to speak to the patient alone. Good leadership helps, he adds, especially a supportive safeguarding lead who encourages staff to be curious rather than worrying about being blamed.

"In the NHS you're trained to follow processes, and in many cases they work, but not for all, and domestic abuse is especially challenging," Patel says. Many staff think they need specialist training to handle this, but often skills can be readily transferred from other roles: "It's the same skillset—being a detective, being curious and communicating well," he explains.

In an environment like A&E, it's also important to quickly build a sense of trust with the patient. "It doesn't have to be physical space—it can be look, feeling or touch, something that tells that person you're safe," says Bower. "There are subtle ways of doing it, even in a busy corridor," she says.

"Some professionals are good at this and some aren't, some have learnt and some can be taught," adds Patel. "So it's good to have role models, to see how other people do it."

Some experienced staff will also be aware that having these conversations with patients can open up a Pandora's Box. "Sometimes, the more knowledge staff have, particularly in relation to domestic abuse, the more reluctant they are to ask, because disclosure may increase risk, if there aren't any specialist services available," Bower explains. "Many specialist services are funded around particular demographics, with very few services for men and older adults," she adds.

Brilliant but overstretched

Most hospitals have "brilliant" safeguarding teams that A&E staff can contact, but they're often overstretched, says Patel. This is where Independent Domestic Violence Advisors (IDVAs) can help.

Healthcare IDVAs work with some community, hospital and midwifery services. Research shows their presence in hospitals encourages more survivors to ask staff for help. They are well connected to local domestic abuse services—important for helping survivors make an informed decision and have confidence in the response. Despite this, IDVAs are thin on the ground in the NHS—a 2021 Safer Lives survey found that only one in ten services had an IDVA based in a healthcare setting.

IDVAs based in hospitals can be particularly helpful in identifying older victims of domestic abuse in A&E departments, Bower adds. "Particularly in later life, someone could have been controlled for a long time by a perpetrator who becomes unwell and needs care and support.

"The power dynamic changes and control can actually intensify as the perpetrator feels they are losing control through their own ill-health", she adds.

NICE guidelines specify that medical staff should check patients feel safe at home—but mostly in higher risk settings, such as antenatal and postnatal appointments. But Bower argues that practitioners should be reaching out to everyone routinely and asking this—including older people. "There's a magic age where routine enquiries about domestic abuse start to drop off," she warns.

A moment of vulnerability

A&E also presents a good opportunity for staff to identity young people who are victims of violence. "In major trauma centres, there's a unique moment where the young person is reachable," says Sam Sweeney, who manages the 'Redthread' youth support service for national charity Catch 22. "This is a good opportunity to meet them in that moment of vulnerability, make sure they're okay and build a relationship with a view to [providing] support post-discharge in the community."

Redthread delivers training across many trauma and A&E hospitals in London—as well as one in the north of England—supporting young people who are victims of violence, and helping to drive changes within NHS trusts. Redthread training covers various safeguarding issues, including 'adultification' and challenging the unconscious bias towards young men. One of its aims is to challenge the assumptions about young people affected by violence and exploitation.

High staff turnover in A&E departments "is a big challenge for us," says Sweeney. "They often have new influxes of new trainee doctors and nurses, so we will target that group." This means being proactive with their presence in the hospitals, including joining morning huddles to introduce Redthread's advisers to new staff.

"Where we have high turnover, it's about having a good relationships with key clinicians who can advocate for us and champion us. We see real success where they put us at the top of the agenda," Sweeney says.

But visibility—and 'easy 'referral routes—only go so far. Identifying young people who are victims, or at serious risk of becoming victims, of violence requires professional curiosity, Sweeney says. "This means looking for what might be going on behind the medical presentation. Our training includes adolescent trauma, which helps clinicians to understand how trauma might affect young people's communication, behaviour and willingness to accept support." //

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

Neurodiversity discrimination—know your rights

Jo Seery explains the legal duties on employers to support neurodivergent staff in the workplace.

Recent analysis shows that employment tribunal cases involving a neurodivergent condition almost doubled between 2020 and 2025, but are still relatively rare compared to other types of cases (mip.social/nd-discrimination).

It's estimated that one in seven people in the UK are neurodivergent. Awareness has grown in recent years, but many neurodivergent workers continue to face barriers in the workplace. A 2026 ACAS survey found that employers were not providing effective support for neurodiverse workers.

What is neurodiversity?

The term 'neurodiversity' describes the natural variation in how people's brains work and process information. It recognises that differences in thinking, learning, communication and behaviour are part of normal human diversity rather than something to be 'fixed'. The term commonly covers conditions such as:

- Autism Spectrum Condition (ASC)
- Attention Deficit Hyperactivity Disorder (ADHD)
- Dyslexia
- Dyspraxia
- Dyscalculia
- Tourette's Syndrome

Every neurodivergent person is different and some people have more than one type of neurodivergence or an additional non-neurodivergent condition such as stress.

How do equality laws cover neurodiversity?

Although many neurodiverse workers do not see themselves as having a disability they may be protected under the Equality Act 2010 if they meet the act's definition of disability.

Section 6 states that a person has a disability if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities, including participating fully and effectively in working life on an equal basis with other workers.

There is no requirement for a mental impairment to be clinically well recognised nor does a worker have to have a medical diagnosis—as long as there is evidence that a worker's neurodiversity has an impact on normal day-to-day activities they will generally be seen as meeting the definition.

What are the duties on employers?

Employers must not discriminate against workers whose neurodiversity meets the definition of disability, with respect to:

- recruitment and training arrangements
- working practices, such as working hours and the way tasks are undertaken
- terms and conditions of employment
- subjecting the worker to any other detriment

What forms might discrimination take?

Two forms of discrimination are particularly relevant for neurodivergent workers:

- **The right not to be discriminated against** for a reason arising from disability. This applies where the reason for the unfavourable treatment is not the neurodivergence itself but its effects. In *Jandu v Marks & Spencer* an employee succeeded in a claim when she was selected for redundancy because of making errors in her work and not completing work on time due to her dyslexia.
- **The right to reasonable adjustments,** where a 'provision, criterion or practice', a physical feature of the premises or a failure to provide an auxiliary aid puts disabled workers at a substantial disadvantage in comparison to non-disabled staff. In *South Staffordshire & Shropshire Healthcare NHS Foundation Trust v Billingsley* the employer was held to have failed to make a reasonable adjustment by requiring an autistic worker to communicate primarily verbally, and by failing to provide written information before and after meetings.

What defence do employers have?

It's important to know that an employer is not liable for discrimination arising from disability or failure to make reasonable adjustments unless they know or could reasonably be expected to know that the worker has a disability.

But the fact that a worker does not disclose their neurodivergence does not necessarily mean the employer is not liable. In *AECOM Ltd v Mallon*, the tribunal held the employer should have made further enquiries when a worker asked for adjustments to the online application process because of dyspraxia.

An employer also has a defence if they can show that the unfavourable treatment is 'justified'—i.e. is a proportionate means of achieving a legitimate aim. However, an employer who fails to make reasonable adjustments is unlikely to be able to show that the unfavourable treatment is justified. In the *Jandu* case (above) the tribunal found that discounting the disability-related effects when assessing the redundancy selection criteria would have been a reasonable adjustment.

Key takeaway

It's important to challenge employers who subject neurodiverse workers to unfavourable treatment based on stereotypical assumptions or who fail to make reasonable adjustments. The ACAS guidance on neurodiversity at work (acas.org.uk/neurodiversity-at-work) may be useful for MiP members and representatives alike. //

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

With 25 years' experience in workplace culture, leadership and transformation, Sophie Bryan is the founder of Ordinarily Different, which helps organisations create happier, healthier and higher-performing workplaces. Visit ordinarilydifferent.co.uk.

How to take back control of your inbox

Still buried under the post-holiday email avalanche? Follow these tips from workplace culture expert **Sophie Bryan** to cut your inbox down to size and save your attention for what really matters.

UNSPLASH.COM

Email is one of the most useful work tools, but one of the most relentless demands on our time. A recent study found that we spend 28% of our time dealing with an average of 121 emails every working day. Worse still, an overflowing inbox causes distraction, brain fatigue and that churning sense that there's always something else waiting for our attention.

Email overload is also a workplace culture issue. Every organisation has unwritten rules about email: how quickly we should respond, what constitutes 'urgent', who gets copied into what, and whether we're expected to show 'commitment' by being permanently responsive—evenings and weekends included.

Leaders own behaviour can inadvertently set those rules for everyone else. Managing email better isn't simply about having a tidier inbox. It's about being more intentional with our attention, and creating healthier expectations for the people around us. Here are ten ways to start.

1. Rethink 'Inbox Zero'

Inbox Zero doesn't mean maintaining a completely empty inbox. It's a decision-making tool. Every email gets one of four actions: Delete, Delegate, Defer or Do. The aim is to eliminate 'email procrastination'—those messages we repeatedly open, reread and leave sitting there, creating stressful mental clutter. Simply open it, decide where it sits, schedule the when, and move on.

2. Use the Eisenhower Matrix

Not everything urgent is important and not everything important is urgent. Often, we mix the two together. Decide what constitutes urgent and important, and prioritise your work based on that. Using the 4D's from Inbox Zero will help.

3. Apply the two-minute rule

If something takes less than two minutes, just do it. Small actions left unresolved quickly accumulate. Completing them immediately reduces inbox volume, cuts down on mental clutter and creates a sense of progress.

4. Set email office hours

Instead of dipping into email continuously, set specific times for dealing with it—perhaps late morning, after lunch and late afternoon. This reduces context switching, protects deeper work and challenges the belief that you must always be instantly available.

5. Make technology work harder

Use email rules, filters, flags and folders to control what actually reaches your main inbox. Newsletters, notifications, receipts and emails you're simply copied into can be automatically organised elsewhere.

6. Batch similar work

Process similar emails such as approvals, scheduling, administration or project updates together. Staying in one 'brain mode' speeds up decision-making. Even a focused ten-minute batch creates momentum and makes a large inbox feel more manageable.

7. Find Your 20%

According to the Pareto Principle, 20% of activity produces 80% of impact. Which emails move important work forward, influence decisions, strengthen key relationships or significantly impact others? Prioritise those. Not all emails deserve an equal share of your attention.

8. Adopt the one-touch principle

How often do you read an email, close it, then come back and read it again later? Wherever possible, open an email when you're ready to make a decision: Delete, Delegate, Defer or Do. One touch means fewer repeated decisions and a clearer mind.

9. Stop writing the same email

If you regularly send similar responses—confirmations, introductions, follow-ups or routine updates—create templates. Personalise messages to keep communication warm but stop wasting time writing the same content from scratch.

10. Create cognitive closure

Before you finish work, spend three minutes asking: What's left? What's essential? What can wait? Identify what needs your attention next, then consciously close the inbox. Unfortunately, emails are never finished but you can decide how much of your time, attention and energy to give them.

Remember, our individual habits become collective ones. When we set clear boundaries, reduce duplication, stop treating every message as urgent and resist being permanently responsive, we give others permission to do the same. These small, visible behaviours say, your time matters, your boundaries matter, and you don't have to be constantly available to be effective. //

To help you turn theory into practice, download your free email checklist from mip.social/emails.

meetyour**reps**:**Sam Shearman**

"Football coaching taught me about teamwork, strategy and how to adapt quickly"

Former football coach, digital manager and MiP rep Sam Shearman from Sussex and Surrey ICB talks to **Craig Ryan**.

"Who I am as a manager is down to my background in football coaching," says Sam Shearman, MiP rep and senior digital delivery manager at the recently-merged Surrey and Sussex ICB. "That's where I learned about managing individuals, what it means to be part of a team, and how to adapt quickly and to strategise."

Sam started playing football aged eight and went on to play for Brighton and Hove Albion before going into coaching. "I wanted to give something back. I couldn't just walk away from playing when my knees started hurting," she recalls. Coaching ten-year-olds on a Saturday morning "really changed the direction of my life," she says. "I was going out most Friday nights and I needed to be more responsible." After gaining her qualifications and coaching in New York for a year, she returned to Brighton to coach elite girls—including four who went on to play for England.

For several years, she juggled coaching with her NHS career, until the demands of the day job became too much. "It wasn't fair to mess the team about by being there one week and not the next," she says.

Sam joined the NHS in 2005, but her initial plans to become a paramedic came unstuck when she saw the ambulance crews in action. "I felt a bit overwhelmed with sadness," she recalls. "I thought, I probably won't be emotionally strong enough for this. I need to help people in a different way."

After spells in primary and secondary care, she joined Crawley, Horsham and Mid-Sussex CCG, now part of Surrey and Sussex ICB, where she leads a team of change managers supporting GP practices with digital transformation. "The most important thing for GPs is that technology works and is reliable," explains Sam, but the job is also about "showing practices how digital tools can make a difference to them and their patients".

Sam has seen the financial and workforce impact of the 50% cuts to ICB running costs. "It's left many colleagues facing a difficult and uncertain period, with people understandably concerned about their roles, their teams and their future," she explains. Sam's own team has been cut from 12 staff to two in just 18 months. "We will have to work much smarter and scale up services, but I'm concerned that relationships could be the trade off," she says.

> ***"I'm not someone who likes to wait for someone else to do it. I've got this fairness button, this sensitivity to injustice. So I thought I might use it."***

After training as an MiP rep last year, Sam was immediately pitched into supporting members through the merger, but took to it "like a duck to water", according to Tim Brooks, MiP's national officer for the area.

"I'm not someone who likes to wait for someone else to do it," says Sam. "I've got this fairness button, this sensitivity to injustice. So I thought I might use it." She quickly teamed up with Stephen Richards, MiP's newly-trained rep at Surrey, and recently became staff side chair for the merged ICB.

The "crazy" change process was "quite something to cut my teeth on", she says. "As staff side, we've asked detailed questions about the people impact assessment and equality information to understand how the proposals affect different groups and whether anyone could be disproportionately affected."

Sam also raised questions about the different approaches to post-filling arrangements taken by different parts of the organisation, including slotting-in, ring-fencing and expressions of interest. "As the process progresses, unions will continue to listen to members' experiences and raise any concerns through the appropriate channels," Sam says.

Sam also led negotiations on a new hybrid working policy, which introduces "sensible discussion and flexibility" into the ICB's 'two days in the office' rule, she explains, as well as changes to the expenses process that could help lower paid staff.

Sam has trained as an organisational development (OD) practitioner, which she sees as tying together what she's learned from football, her job and union work. "I've always managed individuals with a coaching mindset. I'm interested in developing people using OD principles to establish mutual expectations, clarify intended outcomes and build collaborative relationships. It all comes from wanting to make this a better place to work," she says.

"And I still love football," Sam adds. "I'll go back to it, I think, when it's not so crazy here." //

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

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