issue 63 | spring 2025

healthcare manager

INNOV-NATION

CAN THE NHS SPEARHEAD THE UK'S HEALTHCARE TECH REVOLUTION? A SPECIAL REPORT

THE PROS AND CONS OF REGULATION

BARRING, VOLUNTARY REGISTRATION OR A GMC FOR MANAGERS? WE WEIGH UP THE OPTIONS

THE INSPECTOR FALLS

WHAT WENT WRONG AT THE CQC AND HOW CAN WE PUT IT RIGHT?

mip managers in partnership

The union for senior health & care managers

There's more to life than work

That's why UNISON Living is here to help you get the most from your own time too.

Maybe you want to head off to the sunshine on a budget, or perhaps upgrade your car and you want a good deal.

Whatever your need, UNISON Living can connect you with a trusted partner.

We've used the huge power of our 1.3 million members to secure some of the best deals exclusively for you.

Take a look at benefits.unison.org.uk

Or call UNISON Direct on 0800 0 857 857

You'll see how your UNISON membership can benefit your everyday life too.

UNISON Living

healthcare manager

Published by:
Managers in Partnership,
Centenary House,
93-95 Borough High St,
London, SE1 1NL

The prime minister calls it "the biggest reimagining of our NHS since its birth", but all we really know about the government's ten year plan is that thousands of skilled and dedicated people working for NHS England and ICBs must lose their jobs to make it work (see pages 6-7). So let's see it then: if you're going to sack people, it's a basic courtesy to tell them why.

Maybe a system that's supposed to be decentralising doesn't need two 'centres'. Maybe NHS England's work could be better done nationally by the Department of Health and Social Care (DHSC), or locally by ICBs, primary care networks or trusts themselves. Fine. Let's hear that thinking.

Otherwise, this just looks like another bodged cost-cutting exercise dressed up as 'reform'. The only thinking I can discern is: *NHS England is so 2013. We don't know what it's for. Let's cut it in half. No, damn it, let's scrap it altogether!* This 'cut first, think later' approach only adds to fears that the ten year plan will be little more than a stack of targets and a reassertion of central control by politicians. That isn't much of a "reimagining".

The last thing we need is another botched or half-finished reform. The three key relationships in the English NHS—between the DHSC and NHS England, NHS England and ICBs, and ICBs and trusts—are all dysfunctional, mainly because the bodies involved are all products of long-dead or unfinished reforms. They were set up with different purposes and face in different directions. They struggle along together largely thanks to the efforts and patience of the people working in them.

A genuine reimagining would mean working out what the different bits of the NHS are for and how they can work harmoniously together. Then we could really see what costs we can afford to cut. Yes, that's really hard and probably involves deferred political gratification. But patients, taxpayers and all those dedicated staff struggling to make the NHS work better deserve nothing less. //

Craig Ryan, Editor
c.ryan@miphealth.org.uk

headsup

analysis & opinion

features

regulars

healthcare manager

issue 63 | spring 2025

ISSN 1759-9784

Design & Production: lexographic.co.uk

Contributors: Sue Carter, Nigel Edwards, Rhys McKenzie, Alison Moore, Jon Restell, Craig Ryan, Jo Seery.

Opinions expressed are those of the contributors and not necessarily those of *Healthcare Manager* or MiP.

Printed by Kind (kindagency.uk) on uncoated FSC-approved paper with vegetable-based inks. Please recycle when you're done.

Cover image: Alex Knight, Unsplash

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 // Twitter: @MiPhealth // Linked In: Managers in Partnership

headsup

News you may have missed plus what to look out for

Thousands of jobs at risk in "chaotic and hurtful" NHS shake-up—pages 3, 6 & 7

noticeboard

3 April 2025

MiP London Spring Social

MiP head office, 95 Borough High Street, London SE1 1NL

Drinks, nibbles and chat for MiP members in London, celebrating MiP's upcoming 20th birthday. Free, but you need to book.

mip.social/spring-social

7-9 April 2025

UNISON Healthcare Group Conference

ACC Liverpool

Annual motion-based conference for UNISON health branches (including MiP).

unison.org.uk/events/2025-health-care-sg-conference/

11 April 2025

MiP London Reps Network

Online, 12-1pm

Monthly online get-together for MiP reps at workplaces in London. Further meetings scheduled for 9 May and 13 June.

For more info email MiP's London organiser Jordan Creed: j.creed@miphealth.org.uk

11-13 April

TUC Black Workers Conference

Congress Centre, 28 Great Russell St, London WC1

mip.social/tuc-bwc

23 April 2025

NHS Confed Mental Health Network Conference

University of Leeds

Conference bringing together leaders from the mental health, learning disability and autism sectors. Speakers include health minister Baroness Merron and ten year plan supremo Sally Warren.

nhsconfed.org/events/mental-health-network-annual-conference-and-exhibition-2025

15 May 2025

FDA Annual Delegate Conference

Central London

Annual motion-based conference of MiP's sister union, representing senior civil servants, with guest speakers.

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

3-4 June 2025

TUC Disabled Workers Conference

Bournemouth International Conference Centre

tuc.org.uk/events/tuc-disabled-workers-conference-2025

11-12 June 2025

NHS ConfedExpo

Manchester Central

Annual meet-up for health and care leaders, policy makers and professionals, with keynote speakers, panel discussions and interactive workshops.

nhsconfed.org/events/nhs-confedexpo-2025

KEEP THE DATE

7-10 September 2025: TUC Congress, Brighton: tuc.org.uk/events/tuc-congress-2025

5-6 November 2025: King's Fund annual conference, London (kingsfund.org.uk/events/annual-conference)

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

Primary care

GPs to go digital from October in billion pound funding deal

GPs in England have agreed to mandatory online service requirements as part of a contract deal which is set to boost GP funding by £969 million—around 7%—in the next financial year.

In the first negotiated GP contract for four years, the British Medical Association, the GPs' trade union, has agreed that all GP surgeries will offer online tools for routine appointments, medication inquiries and admin requests by October. In return, the government has agreed an increase of £889 million in core GP funding, with an additional £80 million to compensate GPs for consulting with hospital specialists before referring patients for treatment.

The deal, which brings to an end the BMA's eight-month dispute with the government, is conditional on ministers committing to negotiations on a completely new GP contract to be introduced by 2029.

Katie Bramall-Stainer, chair of the BMA's GP committee *(below)*, said: "The government must now recognise the imperative to deliver a new contract within the current parliament for meaningful reform and vital investment. Only then can we keep the front door of our NHS open, provide timely patient care, and alleviate pressure across our entire health service."

Welcoming the deal, health secretary Wes Streeting said it was "the first step to fixing the front door to the NHS, bringing back the family doctor, and ending the 8am scramble."

Finance

Capital raids banned in bid to raise NHS investment

NHS trusts and ICBs in England have been banned from raiding capital budgets to fund pay increases and other day-to-day spending as new fiscal rules announced by the Treasury in the October Budget begin to bite.

FABRIKA CR

The Treasury confirmed in December that raids on NHS capital budgets ran contrary to the government's fiscal rules—which require day-to-day spending to be balanced with revenues—and would be banned under new budgeting guidance.

Also in December, the Department of Health and Social Care finance chief, Andy Brittan, told the Commons Public Accounts Committee that capital raids had "immediately ended" following the Budget.

In its evidence to the NHS pay review bodies for 2025, the government confirmed that NHS employers will be prevented from raiding capital budgets to fund staff pay increases. "The government has changed the fiscal rules to remove the incentive to make these kinds of switches, and will be changing the consolidated budgeting guidance to explicitly rule them out," the evidence said.

Despite criticism by Lord Darzi in his state of the NHS report last year and from Labour's health team in opposition, the practice of raiding capital budget continued after the election, with two capital "surrenders" totalling £876 million to fund extra tech and pay costs during the current financial year.

Overtime boost to part-time staff pensions

Some part-time NHS staff are set to receive a pensions boost under new pension scheme rules proposed by the Department of Health and Social Care (DHSC).

From April 2025, members of the 2015 NHS Pension Scheme can choose to have all overtime hours worked between 2015 and 2024—up to a maximum of 37.5 hours per week—counted towards their pension, as long as they pay the contributions due on those earnings.

Rule changes in April 2024 removed an anomaly under which members of the 2015 scheme—unlike colleagues in the 1995 and 2008 schemes—could not count additional hours towards their pensions, but the new rules were not applied retrospectively until now.

Guidance published by the DHSC says employers must notify affected staff by October this year, providing details of the impact on their pensionable service and the contributions they would have to pay, and allow scheme members three months to make a decision.

NHS shake-up

STOP PRESS: Ministers accused of "contemptuous attitude" to staff as ICBs face 50% cuts

As this issue of *Healthcare Manager* went to press, the government announced that England's 42 integrated care boards (ICBs) would have their running costs cut by 50% by the end of 2025. The move came as part of a frenzied re-organisation of the NHS in England, which also saw the abolition of NHS England and massive cuts in central staffing (see page 6).

Details remained sketchy at the time of going to press, but it's understood that the cuts will focus on reducing ICB management costs and that the Treasury will cover the cost of redundancies, which are considered likely.

Responding to the announcement, MiP chief executive Jon Restell said: "This is a chaotic way to run the NHS. One day there's a 50% cut to NHS England, the next there's a 50% cut to local ICBs and the day after we hear about the abolition of NHS England. This approach demonstrates a contemptuous attitude to real people who work hard to improve access to services, cut waiting lists, improve productivity and safeguard the public."

He added: "The prime minister says he's fixing the Lansley mess, but he risks repeating the mistakes that held the NHS back for a decade. Destabilisation on this scale will affect delivery of government priorities and the public will feel that.

"The government urgently needs to tell the country its plan to get the NHS back on its feet and how it will support managers to do that. Duplication is a red herring. The NHS needs to know what will be done and what will not be done in the future, as a result of these changes," he added

Earlier in March, ICBs had warned by by incoming NHS England chief executive Jim Mackey that he was considering a "fundamental reset" of the NHS financial regime in response to a looming £6.6 billion deficit in ICB finances. But the cuts announced a week later went much further than expected.

In its planning guidance for 2025-6, published at the end of January, NHS England had instructed ICBs to reduce core costs by a further 1% next year and improve productivity by 4%—as well as concentrate funding on "frontline" staff.

NHS England also said it would give ICBs more control over how they spend their money, promising to "transfer a higher proportion of funding than ever before directly to local systems and minimise ring-fencing, allowing local leaders maximum flexibility to plan better and more efficient services."

Executive pay

Board level pay regime not "fit for purpose", MiP tells review body

MiP has called on the government to update both the very senior manager and executive and senior manager (VSM/ESM) pay frameworks to make them "fit for purpose" and tackle a growing reluctance among NHS managers to take on board-level jobs.

In its evidence to the Senior Salaries Review Body (SSRB), which makes recommendations on executive pay in England, MiP said "pay overlaps" with Agenda for Change (AfC) grades are worsening, discouraging senior staff from taking on executive roles.

Band 8D staff at the top of their band are now paid slightly more than executives at the bottom of ESM Band 1, the union said, while the overlap with Band 9 AfC staff is even worse: Band 9s can command a higher salary than even the 'operational max' of ESM Band 1. This is before taking into account High Cost Area Supplements (HCAS), which are only available to AfC staff.

The pay overlap is further exacerbated, MiP warned, for staff with on-call duties, for which AfC staff receive additional payments not available to executive managers. This means the pay overlap in practice is likely to be much higher than the pay ranges suggest, the union said.

"The current VSM and ESM pay frameworks are simply not fit for purpose," said MiP chief executive Jon Restell. "Only with fair and transparent pay frameworks can the NHS recruit and retain the right staff for these highly demanding and pressurised senior roles."

It was vital, Restell added, for the government "to adequately address the pay overlap issue for senior staff in providers" when an updated pay framework for VSMs is published later this year. Restell urged the Department for Health and Social Care to undertake a similar review of the pay framework for ESMs working for NHS England, where there were similar pay overlaps with AfC staff.

"Only with fair and transparent pay frameworks can the NHS recruit and retain the right staff for these highly demanding and pressurised senior roles."

During its consultations on pay with board-level members, one ESM told MiP that they had been forced to take a pay cut after promotion due to the loss of HCAS payments—something they were unaware of before starting the job.

Annual pay awards were not enough to address these problems, the union said. Action to reform the outdated executive pay frameworks was essential because the pay ranges are not updated in line with annual pay awards, as they are for AfC grades. Many senior staff receive only non-consolidated awards because a pay rise would put their salary above the "exception zone" for their respective band.

To inform its evidence, MiP surveyed a group of members in senior AfC jobs who said they were currently open to, or had previously considered, applying for board-level roles.

73% of respondents said they were "worried" by the demands of working at board level, while 69% said they believed executive jobs carry more risk than any other role in the NHS. Less than half (44%) said that executive jobs were paid well enough to justify the higher demands and responsibility. This is likely to mean fewer Band 8 and 9 staff applying for more senior roles, the union told the review body.

Read MiP's evidence to the SSRB on our website: mip.social/ssrb-2025

NHS Scotland

Frustration grows as Scottish government delays pay talks

JULIE BROADFOOT

"No more excuses"— Matt McLaughlin, UNISON Scotland's co-lead for health

UNISON Scotland has written to Scottish health secretary Neil Gray demanding immediate talks on NHS pay and raising the possibility of strike action if adequate progress isn't made by April.

Gray had refused to open negotiations on the 2025-26 pay round, for which pay awards are due from 1 April, until the Scottish Government's budget had been approved by parliament—a process that was completed on 25 February. NHS staff are growing increasingly impatient, the

Agenda for Change

Government calls on review body to limit NHS pay rises to 2.8% in England

SANKAI

Pay rises for NHS staff in England should be restricted to 2.8% this year, the government has told the NHS Pay Review Body, which recommends pay levels for Agenda for Change (AfC) staff in England, Wales and Northern Ireland.

In its evidence to the review body, the government claimed 2.8% was the maximum that could be afforded and any higher award would have to be funded out of NHS organisations' existing budgets. Although annual pay awards are due to be paid from 1 April, the review body's recommendations are not expected until later this year.

The government has also delayed work to tackle long-standing structural problems with the AfC pay system until the second half of the year, despite committing to hold talks on reform when it accepted the review body's recommendation for a 5.5% rise last year. Any changes to salary structures this year would have to be funded from the 2.8% pot, taking money away from headline awards, the government said.

MiP chief executive Jon Restell said the health secretary had "broken trust and hindered morale" by reneging on his commitment hold talks on pay reform. "MiP has long campaigned for action on the many structural issues with Agenda for Change arising from years of inconsistent pay awards, including pay compression between Bands 7 and 8 and the lack of incentive for promotion at higher bands," he explained.

"For the NHS to recruit and retain the workforce needed to deliver the high quality of care expected of it, talks on pay reform must begin now," he added.

MiP and UNISON have called on the government to scrap the review body process and hold direct negotiations with NHS unions. "The pay review body process is from a bygone era and should be axed," said UNISON head of health Helga Pile. "A modern NHS needs 21st century pay practices to keep and recruit the staff required to deal with the multiple crises it currently faces."

As part of the unions' 'Time for Talks' campaign, thousands of UNISON and MiP members have already written to their local MPs, calling for direct talks and highlighting the importance of dealing with NHS pay quickly if the government wants to improve staff morale, retain expertise and tackle waiting lists. UNISON has also lodged letters of objection with every NHS employer in England.

The NHS Pay Review Body also covers Wales and Northern Ireland (but not Scotland—see below), although the devolved administrations make their own decisions on NHS pay. Both the Welsh government and the Northern Ireland executive are expected to wait for the review body's report before making decisions on pay for 2025-26.

union warned, as well as frustrated that a previously agreed one-hour reduction in the working week has been delayed until April 2026.

"The health secretary must come to the table with a credible pay offer without further delay, as anger is growing amongst NHS staff, said Matt McLaughlin, UNISON Scotland's co-lead for health.

"The government says it values NHS workers. But once again ministers are late starting pay talks and have already ditched an agreement to reduce the working week this year. Unless talks start soon, UNISON will have no choice but to start a consultative strike ballot," he added.

With Scottish budget process complete, "Neil Gray has no more excuses," McLaughlin warned. "If the health secretary fails to deliver on pay... any remaining staff goodwill will quickly evaporate, making NHS reform more difficult."

PA IMAGES / ALAMY STOCK PHOTO

Health secretary Neil Gray delayed pay talks until the government's budget was approved.

Up to half of NHS England jobs could go in "chaotic" reorganisation of NHS centre

Penny Dash takes over as chair of NHS England...

...and co-leads the "transformation board" with Alan Milburn.

MiP has criticised as "chaotic" and "hurtful" the announcement by NHS England that up to half its staff could lose their jobs as part of a radical revamp of the NHS 'centre', under which NHS England will be abolished and its functions taken over by the Department of Health and Social Care (DHSC).

Outgoing chief executive Amanda Pritchard announced on 10 March—three days before the abolition announcement—that plans "for radical reform of the size and functions" of NHS England "could see the size of the centre decrease by around half". The potential 7,000 job losses go much further than the 15% cuts announced in January, work on which has been paused pending the much larger cuts, Pritchard said.

"The chaotic nature of these announcements, coming so soon after the previously announced cuts, will have a destabilising effect on the workforce of both NHS England and the department," warned MiP chief executive Jon Restell. "The approach is deeply hurtful and disrespectful to people who get out of bed in the morning wanting to improve the NHS and patient care."

At the time of going to press, it was still unclear whether both NHS England and the DHSC would each be required to reduce their workforce by 50% or whether the figure referred to the two organisations as a whole. In the past two years, NHS England has seen its workforce cut by around 5,000 posts, while the DHSC has shed more than 800 jobs.

NHS England and the DHSC will set up a formal "transformation board", which will be co-chaired by incoming NHS England chair Penny Dash and former health secretary Alan Milburn, a non-executive member of the DHSC board. NHS England has frozen all existing vacancies and the organisation will only recruit new staff in 'exceptional circumstances', Pritchard said.

> *"MiP members are not opposed to reform but blunt headcount reductions to save money in the short term is not a credible reform agenda."*
> — MiP's Jon Restell

MiP called on ministers to set out a "serious" NHS reform agenda before announcing job cuts or staffing changes. "Our members are not opposed to reform but blunt headcount reductions to save money in the short term is not a credible reform agenda," said Restell. "The government should prioritise establishing clear structures, retaining skills and keeping up morale as it prepares to publish its ten year plan later this spring."

He added: "The NHS needs management more than ever as it struggles to get waiting lists down and healthy patients out of hospitals. You can't cut your way to an efficient NHS. Rushing through cuts at this time will only cause further damage to a health system going through one of the most challenging periods in its history."

Amanda Pritchard leaves in April as Wes Streeting plans to scrap NHS En

Pritchard and other senior figures quit as Streeting moves to scrap "biggest quango in the world"

Former Newcastle trust boss Sir Jim Mackey takes over as NHS England "transitional" chief executive from April.

A major shake-up of the commanding heights of the NHS in England is underway, prompting the resignation of NHS England chief executive Amanda Pritchard and the appointment of Newcastle Hospitals boss Sir Jim Mackey as "transition" leader of the arm's-length body as it prepares for merger with the Department of Health and Social Care (DHSC).

Mackey, an experienced and well-regarded hospital leader will formally take over from Pritchard at the start of April, and could stay in post for up to two years. "It will be an honour to lead the service... as we radically reshape the role of NHS England and work with the government to build an NHS that is fit for the future," Mackey said.

The looming abolition of NHS England, described by health secretary Wes Streeting as "the biggest quango in the world", prompted a flurry of other resignations from NHS England's nine-strong executive board. Chief finance officer Julian Kelly, chief operating officer Dame Emily Lawson and chief delivery officer Steve Russell all announced their departures within two weeks of Pritchard's resignation on 25 February. NHS England medical director Sir Steve Powis had already announced that he planned to step down this summer.

"It will be an honour to lead the service... as we radically reshape the role of NHS England."

Pritchard led NHS England for four turbulent years during which she steered the service through the latter stages of the Covid crisis and worked with six different health secretaries.

In a message to NHS England staff, Pritchard said the government's upcoming ten year plan and "radical reform" of NHS England were "a step change" which "would be best served by new leadership in NHS England".

"It has been an enormous privilege to help lead the NHS in England," she added. "I take immense pride from how the NHS responded to a once-in-a-century pandemic, delivered the vaccine programme, and has turned the corner on recovery—with A&E waiting times, elective and cancer performance, productivity and NHS staff survey results all now improving."

Responding to Pritchard's resignation, MiP chief executive Jon Restell said she had "calmly led the NHS through one of the most difficult periods in its history, showing great commitment in a tough job".

Streeting confirmed in an email to staff on 13 March that NHS England and his department would "increasingly merge functions, ultimately leading to NHS England being fully integrated into the department". Work on the merger is set to begin immediately and could take up to two years, although no timetable has yet been set for formal abolition of NHS England, which requires fresh legislation by parliament.

Streeting had previously dismissed the idea of abolishing NHS England as a "distraction". But in his email he said "frustrations" with the "fragmented system" shared with him by NHS England and DHSC staff had changed his mind. "It doesn't make sense to have two organistions fulfilling the same role," he said.

Restell said that, as "one of the world's largest and most complex organisations", the NHS "needs a strong centre to work well". He added: "Structures are not set in stone, but form must follow function and this principle must also apply to NHS England. Transition needs to be well led and executed."

MiP has called on ministers to clearly spell out the roles and responsibilities of each part of the NHS and allow organisations "to evolve to deliver". Restell added: "Tearing it up and starting again every few years leads to a self-defeating loss of focus and of skill, smothering productivity and change in the NHS."

ngland.

PA IMAGES / ALAMY STOCK PHOTO

Strange ways, here we come

Creating a 'neighbourhood NHS' will demand a different mindset, unfamiliar ways of working and difficult decisions on finances and staffing. Middle managers as well as senior leaders will play a big part in making it happen, says *Nigel Edwards*.

MICHAEL TUSZYNSKI/UNSPLASH

Since the publication in 2022 of Claire Fuller's stocktake report on integrating primary care, we have seen growing interest in creating teams around neighbourhoods in the NHS. This interest was given more impetus after the 2024 election when health secretary Wes Streeting set out his vision for the development of a neighbourhood health service in England.

NHS England's 2025-26 planning guidance includes a substantial section on developing the neighbourhood model. As well as improving services for patients and reducing inequalities, this will create both challenges and opportunities for health and care managers in the next few years.

Balancing system and organisational goals

The development of integrated teams and place-based partnerships will create systems that can be held to account for health outcomes and in some cases wider objectives related to the government's key missions. The challenge with this has always been reconciling the objectives and finances of individual organisations with the wider goals of improving health, investing in prevention and shifting care from hospital into the community.

The current performance regime reinforces the natural tendency for managers to focus on local and organisational goals, which for board members are a key element of their role and identity. Leading organisations through this will be a challenge. In particular, acute providers will need to release resources—staff and in some cases money—to support the wider development of the system. This might be in the form of lower spending growth, which is easier than releasing cash, but it's still hard, particularly where organisations are already in deficit.

Changing and improving services

The development of multidisciplinary teams based around primary care has significant implications for how staff are deployed and services are designed. For community staff, working with defined teams may require changes to how they work and who they work with. For example, complex processes for referral and triage, rigid caseload models and the operation of lots of siloed teams are not compatible with an approach based on teamwork.

Breaking down the barriers, simplifying processes and removing some of the administrative burden associated with these ways of working will require time and improvement methods that not everyone knows about.

For acute providers there is a requirement to work with the system to standardise the response to urgent care demand and to develop new ways for specialists to work with neighbourhoods. All of this requires an ability to work across boundaries, think about the objectives of the system and not just those of the organisation, and a more patient and population focused approach than has often been the case in previous reforms.

Working with other agencies

Improving health and wellbeing and reducing inequalities will increase the need to work across organisational boundaries even further. The social determinants of ill-health and inequalities do not directly relate to services provided by the NHS, and leaders in the system will need to become much more effective at working with other agencies and communities more generally to make

Nigel Edwards is a senior advisor with public sector consultancy PPL and the National Association of Primary Care, and a former chief executive of the Nuffield Trust. His report for the NHS Confed, Working Better Together in Neighbourhoods *is available from mip.social/neighbourhoods.*

a difference in this area.

The risks are that neighbourhood health is seen as an NHS strategy, not one shared by local government and other agencies, or that the NHS is seen as trying to take over responsibilities that belong to others. Again, this is a challenge requiring diplomacy and interpersonal skills.

Working with communities

One opportunity that neighbourhood working provides is the ability to work with communities to tackle the issues that statutory services can't reach. Many very deprived communities have an ambivalent relationship to these services or at the very least find that they do not offer services in ways that they can easily use.

Many of the needs of these communities are complex and only some can be met by the NHS. One answer to this has been the development of local community action—often using the principles of 'asset-based' community development. In contrast to the approach and mindset commonly found in statutory services, these models ask what assets and strengths the community has rather than focussing on all its problems. Services operating on asset-based models demand a different approach from managers:

- They are very local and so operate on a scale that can be very small; statutory services can find managing multiple small interfaces difficult.
- They do not fit well into standard approaches to commissioning and procurement. Not only are they too small to jump through the bureaucratic hoops but the point of these models is that the solutions and actions need to be determined by the community not a commissioner.
- The impulse to control what they do or to force them into an NHS template must be resisted. The NHS needs to let go of elements of performance management and control, enter into longer term contracts and funding arrangements, and tolerate work that is less ordered and consistent.

Relationships matter

While formal processes and governance have their place, they are generally not what creates success with neighbourhood working. They are necessary but not sufficient. Experience in developing multidisciplinary working shows that a number of other components need to be in place.

1. A limited number of clear objectives
2. Clear roles and responsibilities
3. High-quality and frequent communication and interdependent working
4. Reflexivity, where the team comes together regularly to reflect on their practice, how they work as a team, their relationship with other teams and how these can be improved
5. The proactive identification and resolution of conflict

These elements help to create an environment of 'psychological safety' in which staff can voice concerns, try out ideas and talk about things that have not gone well. This is also closely associated with high levels of team effectiveness, innovation, productivity and care quality. In addition, mentoring, peer support and feedback on progress are needed to help with the continual development of the team and sustaining progress. These approaches also mean that team members need to understand each other's roles and capabilities, which also helps to improve cross-referral and problem solving.

Many of the changes require an approach that is less hierarchical than many people have been used to and calls for more working across organisational boundaries. In some cases, it is also messier and more organic. Other elements of the change will require process design, improvement and change management skills which are not always available. They also demand patience, which the system tends to be short of.

The role of managers at all levels in supporting these changes is vital. This is particularly true for mid-level managers and team leaders. The NHS has a tendency to focus on top leaders but this is a multi-level leadership challenge and middle-managers are a key part of managing these complex changes. //

Maximally destabilising, minimally useful

Managers are the most change-minded workers in the NHS. They engage with reform seriously, instinctively accepting that structure and function must evolve, and embrace innovation—even as they routinely experience the downside of change. It's why I admire them so much. But I can't say that the chaotic announcement of a further (possible) 50% cut to the centre of England's NHS — and now, we hear, to ICBs too — is anything other than a big, risky mistake: maximally destabilising, minimally useful.

The long drawn-out reorganisation of NHS England has been painful for staff. The workforce was cut by more than 30%. In January, NHS England said another 15% of posts would go. And, within weeks, 15% becomes 50% and then, three days later, outright abolition. Staff have never been shown a North Star that justifies the pain. The government and the employer have struggled to explain how job cuts will help patients and the public or what work will cease. 'Reform' has come to mean nothing more than a cut.

People working for NHS England find his approach disrespectful and hurtful. They get out of bed because they want to do a good job for the public—to improve the NHS and patient care. But their skill, hard work and dedication has been reduced to a cost to cut.

The figure of 50% is clear and will stick in the mind. But any reasonable questions about it can only be answered with "don't know". How long will this take? "Don't know". Which organisations are in scope? "Don't know". What functions will cease? "Don't know". What functions will go elsewhere? "Don't know". Does capacity exist elsewhere? "Don't know". What will be the resource envelope for the future? "Don't know". How will the new structure support delivery? "Don't know". How will it help deliver the ten year plan? "Don't know". What is the ten year plan? "Don't know". We don't know anything—and yet somehow we know we need a cut of 50%.

This is maximally destabilising. People we desperately need to keep will leave; those working on government priorities like waiting lists will be distracted by anxiety about their jobs, families and mortgages. Vacancy freezes will hamper effectiveness. Diversity, skills and capacity will be lost before the government's transformation board has even thought about what it wants.

> *This approach is disrespectful and hurtful. NHS England staff get out of bed because they want to do a good job for the public—to improve the NHS and patient care. But their skill, hard work and dedication has been reduced to a cost to cut.*

For nine out of ten Britons, the NHS is a top two issue. Support for the NHS model is just as high. Yet satisfaction with the NHS has never been lower. The government has made the NHS one of its missions and given it more money than other public services. The political risk here is huge: the government must deliver better NHS performance before the next election.

Achieving that will rely on managers. As the Institute of Fiscal Studies concluded recently, better productivity—in the absence of any other improvements—can only be put down to managers' focused efforts across the system. Supporting management effort should be the name of the game. As Lord Darzi rightly said, the NHS has spent a decade trying to restore the clear management line destroyed by the Lansley disaster.

To that end, we need a strong centre supporting strong local systems. Politicians *should* be put back into the management line—it was always stupid to think the NHS could be 'independent' of ministers. But my strong advice to the big beasts in DHSC and NHS England is do this without a playground-inspired turf war; you must all hang together or, assuredly, you will all hang separately.

The transformation board needs to put the percentage cut to one side—harder to do now it's out there—and work out what the NHS needs to do centrally, regionally and locally. Work out the strategy, wait for the plan and the money, and then design the structures, processes and incentives to deliver it. That may mean a centre 50% smaller—or it may not. But do the work the public and the hard-working healthcare professionals in NHS England need done.

We should all want to avoid this policy becoming a DOGE-style disaster. It's still possible to get back on track if NHS England's new leadership team openly works to re-engage its own staff and the wider system. MiP is ready to help and work in partnership.

MARTA SHER

Regulating the managers: more questions than answers

The Labour's government's plans for regulating NHS managers are still shrouded in mystery, and the three options on the table each have their pros and cons. *Rhys McKenzie* weighs up the choices and gauges the views of MiP members on the best way forward.

Ever since the then shadow health secretary Wes Streeting announced in 2023 that Labour would seek to regulate NHS managers if in power, managers have waited patiently for the party and now the government to show their hand.

While there didn't seem to be much opposition to the principle of regulating managers, questions were asked about the aims of the policy. Was it about professionalising a skilled element of the NHS workforce, bringing them in line with their clinical colleagues? Was it about rebuilding public confidence in managers after years of derision from politicians? Or was it

simply a political move to give the perception that Labour would be 'tough on managers'?

A year and a half later, MiP are still unsure what the government hopes to achieve by regulating managers—a view reflected throughout the health system. But we do now at least have some idea about the regulatory models being considered by ministers.

The Department for Health and Social Care (DHSC) has sought views on three different methods of regulating NHS managers in England: a statutory barring scheme, a voluntary register and full statutory regulation. Each model will impact managers differently, and comes with its own potential risks and benefits.

"MiP members say any new regulatory model must be independent. Our members do not believe that existing organisations like the CQC or NHS England could regulate fairly."

MiP asked our members for their views on each regulatory model and on regulation more generally. The 790 responses to this consultation have heavily informed our response to the government. Here are the key themes of our evidence.

Support in principle—but what's it for?

Most MiP members support the principle of regulating managers and that support has grown since November 2023, when we first asked for views on regulation. More than 80% of members also feel there's a need to improve management behaviours, culture and standards.

Opinion is split on whether regulation would help here. Around half of our members see regulation as a way to raise these standards, by increasing accountability and promoting ethical leadership. The other half are not convinced and, while some may still support regulation, they don't necessarily see it as the way to improve standards.

The government has stated its "overarching aim" for regulating NHS managers is "ensuring patient safety", but two-thirds of our members are not convinced that regulation would lead to a safer NHS.

Members who don't support regulation highlight the potential bureaucratic burden it will put on managers, costs to the individual and the taxpayer, and the potential impact on recruitment and retention as reasons to tread carefully.

'Chilling effect'

MiP members warn of the potential "chilling effect" of a poorly implemented system of regulation, with around a quarter of respondents saying regulation would make them more likely to leave the NHS. Over a third also said it would make them less likely to seek promotion to more senior roles, making recruitment to already hard-to-fill vacancies even more challenging.

Concerns were also raised that regulation could affect ethnic minorities disproportionately and heighten the risk of bias and discrimination.

For regulation to work, our members said there was a need for training and support, continuous professional development, and a fair and inclusive regulatory process.

MiP members are also clear that any new regulatory model must be truly independent to be effective. Our members are not satisfied that existing organisations like the CQC or NHS England could regulate fairly or independently. Only one in five believed an existing body could fulfil the role, with the vast majority believing a new body is needed—a view that MiP shares.

How would 'statutory barring' work?

With a statutory barring system, the regulating authority maintains a list of people who have been found unsuitable to practise a particular profession, such as NHS management. This means that it would be illegal for an NHS employer (and possibly other organisations delivering NHS services) to appoint any individual on that list to a management post.

An individual may be barred for committing a criminal offence or serious misconduct. Examples of existing statutory barring mechanisms include the Teaching Regulation Agency (which operates the barring list for teachers) and the Companies House list of disqualified directors.

A statutory barring system for NHS managers would mean introducing a national code of conduct for managers or leaders, and setting up a new national body with the legal responsibility to consider serious complaints made about individual professionals.

Statutory barring systems are usually taxpayer funded and would be unlikely to involve any costs for individual managers.

Duty of candour

Alongside professional regulation, the government is also considering strengthening the legal duties of candour for individual NHS leaders. This may involve holding NHS leaders personally accountable for ensuring the existing statutory duty of candour for NHS organisations is correctly followed, as well as leaders having further duties to record, consider and respond to any concerns raised about patient safety.

MiP and our members believe these duties should be extended. It is already an expectation of senior NHS leaders and formalising this position would offer greater clarity.

'Registration means care home managers are in a respected position'

The Care Quality Commission (CQC) already operates a statutory professional registration scheme for care home managers. All care homes, whether they're run by private companies, charities or local authorities, must have at least one registered manager.

To register, would-be care home managers must show the CQC that they are of "good character" and are "able to properly perform tasks that are intrinsic to their role". There are no set requirements for formal qualifications, but managers must demonstrate that they have the "qualifications, competence, skills and experience" to do the job.

After a career as an NHS manager, MiP National Committee member Sarah Carter now manages a 50-bed care home in the east of England. Her registration process lasted several months and involved an enhanced DBS check, verification of her experience and references, and a "fit and proper person" interview with the CQC.

"They check everything, right back to your very first job when you were sixteen," she says. "They look at your relevant qualifications and experience and whether you've worked with the CQC before. They want to get a whole picture of you."

While professional registration for NHS managers "shouldn't be looked at lightly," Sarah says, it does offer one big advantage. "As a registered manager, it doesn't matter whether you're clinically registered or not... Registered care home managers are in a respected position because of the hoops you have to jump through to prove you're a fit and proper person to do the job," she says. **CR**

No outstanding candidate

MiP members were split on which of the three regulatory models put forward by government would work best. Due to the lack of clarity on what the government hopes to achieve with regulation, it's difficult to determine the most effective and proportionate regulatory model.

In our survey, there was a very slim preference for the statutory barring system, with just over half of our members believing it would be effective. A statutory barring mechanism would also be the most fair, proportionate and independent model of the three proposed by the government, according to respondents, although only half had confidence in this.

Interestingly, there was more support for full blown statutory regulation than a voluntary register. While members acknowledged that a voluntary register would be simpler to implement, they were not convinced it would be effective. Those in favour of a professional register felt making it a statutory requirement made more sense, as it would bring managers in line with clinical colleagues and would do more to professionalise management than a voluntary register.

Start at the top and work down

MiP members believe that whatever form of regulation is introduced it should apply to staff working to the whole NHS, including arm's-length-bodies, as well as CQC-registered bodies, social care providers and private companies delivering NHS services.

For regulation to be fair it must be consistently applied throughout the system. MiP thinks it would be unwise to create a two-tiered system, where managers in certain organisations are regulated while others are not. Practically, this could prevent talent moving between different healthcare organisations due to differences in regulatory requirements.

There was agreement that regulation should apply to senior leaders, including chairs, non-executive directors and senior managers in strategic roles. Many of our members also made the case that, if regulation was about professionalising managers, it should be extended down to mid-level managers—roughly those on Agenda for Change Band 8A and above. Some suggested it should apply to all NHS staff with any management responsibility, regardless of their grade.

While extending the regulatory framework beyond senior leaders would be desirable for professionalisation, MiP is concerned about the additional burden it could place on other managers at this time. As the government's intentions are not entirely clear, we would urge caution on extending the scope too far, at least initially, until we learn more about the scheme and how it will work.

A phased approach

MiP members are also clear that any new regulatory model must be phased in. It's important to get this right and a phased approach, with extensive review and assessment periods, will give regulation the best chance of succeeding. This should involve introducing the regulatory framework for the most senior managers first, reviewing its implementation and extending it downwards if appropriate.

Managers should be held accountable, but they must be held to account for the decisions they actually take or influence. Once regulation is introduced it will be extremely difficult to roll back—for better or worse. By starting small and extending it when we are clear about what behaviours and competencies we are regulating against, managers will have more confidence that the system works.

MiP's position

On the options put forward by government, MiP believe that a statutory barring system for the most senior managers would make a good starting point. This would be the least intrusive form of regulation and easiest to get off the ground.

Full statutory regulation would be more costly, both to the taxpayer and the individual, and

How would a professional register work?

A professional register is a list of individuals who have demonstrated the relevant skills and competencies to practise a certain profession. These could be demonstrated through completing certain training and/or qualifications as well as through relevant experience. The register would be independently quality assured by a regulatory or professional body and would be publicly available.

NHS managers would be required to meet a set of agreed professional standards in order to join the register.

Voluntary schemes

With a voluntary scheme, managers would not be legally required to join the register to practise their profession. However, a voluntary scheme can become mandatory in practice if employers generally prefer to appoint people who are on the register.

A voluntary register would likely require some form of revalidation—a periodic re-assessment of registrants to make sure they still to meet the requirements for registration. Individuals could be struck off the register if they fail to meet the professional standards.

The initial set up of a voluntary register would probably be taxpayer funded, with registrants then required to pay annual fees to maintain their registrations.

Full statutory regulation

Full statutory regulation operates in a similar way to a voluntary register, but joining the register is a legal obligation for anyone practising the profession.

NHS managers would have to register with a regulatory body and hold an approved set of qualifications to show they are fit to practise their profession. This would put managers within a similar regulatory system as doctors and nurses.

Formal entry qualifications for NHS management and courses to deliver them would have to be devised. Statutory regulation would also require periodic revalidation. Managers on the statutory register could be struck off if they fail to meet the professional standards, meaning they would be unable to hold a management job in the NHS until they have rejoined.

As with the voluntary scheme, the taxpayer would fund the setting up of a statutory register, but individual registrants would be required to pay an annual fee to keep their registration.

consideration would have to be given to how managers demonstrate their competence. This would likely have to be done through a formal qualification. Introducing a qualification which captures the breadth of management roles seems technically unfeasible—at least in the short term. We also need to consider how much time and money can realistically be released to retrain potentially tens of thousands of managers in the coming years. MiP does not think this would be the best use of already-stretched resources.

MiP also has concerns that formal training requirements may unintentionally create an artificial barrier to entry. NHS managers come from all walks of life and this diversity is a strength. Formal qualifications could make it much harder for staff from under-represented and disadvantaged backgrounds to make their career in the NHS. We want to encourage people from all backgrounds to apply their skills in NHS management roles. Formal qualification requirements may have the opposite effect.

MiP members, however, are more supportive of the idea. If qualifications are properly funded and additional resources are put into training managers and supporting their professional development, then our members would be more supportive of formal management qualifications. We don't think it should be off the table, but we don't believe the government should be starting from here.

While a barring system would only have a limited effect on professionalising managers, it could provide a good platform to build from, ensuring any further moves to regulate and professionalise—such as formal qualifications or a professional register—would be more likely to succeed.

MiP supports efforts to professionalise managers through better training, support and ongoing professional development. This would

not only raise standards, it would recognise NHS management as a skilled profession and help improve public attitudes to non-clinical leaders.

However, the way the government has framed regulation still makes it seem more like a punishment than a vehicle for support and development. Once there is a clearer picture on how regulation will be taken forward, MiP hopes the government will understand the importance of framing it in a positive light with a genuine view to raising the standards of a skilled profession.

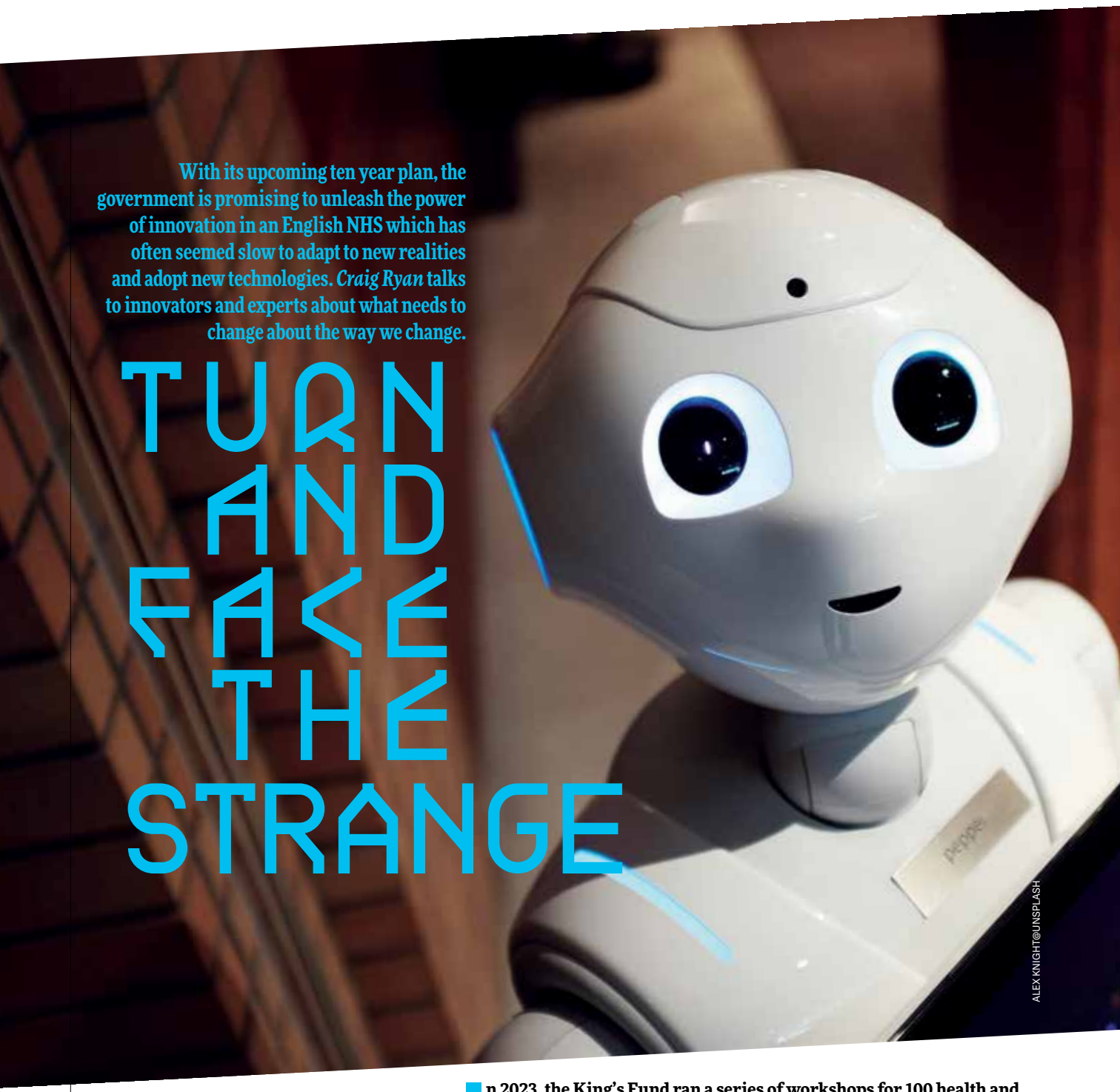
Looking ahead, we now need to think about how professional standards for NHS managers could be set and reviewed and how any regulatory framework would be evaluated, modified and extended. MiP believes that the government should ensure that standard setting and the regulatory framework are reviewed independently. In line with the practice of other healthcare professional regulators, standard setting should involve representatives of managers, employers and the public. The timetable and criteria for reviewing the regulatory framework should also be published when regulation is introduced.

MiP will keep members updated on the government's plans to introduce management regulation as it progresses. Settle in—it seems this story still has a long way to run. //

Rhys McKenzie is MiP's communications officer. To give MiP your views on this issue email: info@miphealth.org.uk.

With its upcoming ten year plan, the government is promising to unleash the power of innovation in an English NHS which has often seemed slow to adapt to new realities and adopt new technologies. *Craig Ryan* talks to innovators and experts about what needs to change about the way we change.

TURN AND FACE THE STRANGE



ALEX KNIGHT@UNSPLASH

In 2023, the King's Fund ran a series of workshops for 100 health and care innovators, where they shared their experiences of trying to transform services in a system under severe pressure. Reflecting on the sessions, the Fund's digital technologies lead, Pritesh Mistry, wrote: "We noticed how quickly, and how often, frustrations bubbled to the surface. Our discussions would quickly turn from what is possible to the reality of how hard it is to innovate in the NHS and social care."

The think tank's report on the workshops describes innovators as "siloed", "unsupported" and "hindered" in a service where "there is no space to do things differently". It's no surprise, the report concludes, "that innovation happens in pockets and that the NHS and social care have a reputation of

DR BEA BAKSHI, C THE SIGNS

AN OBVIOUS PROBLEM WE NEEDED TO SOLVE UPSTREAM

Former GP Dr Bea Bakshi was inspired to create C the Signs—a digital tool that helps GPs spot the early signs of cancer—when she spent a hospital nightshift looking after a sick patient who turned out to have incurable pancreatic cancer which had tragically gone undetected. The patient's reaction was "stoic", she recalls, but his blunt question stayed with her: "Why was my cancer diagnosed so late?"

This experience was "harrowing for me", she says, "but it also seemed like an obvious problem we needed to solve upstream". Most cancers are diagnosed in primary care but, at 58%, early detection rates are poor and "we have few tools or technologies to help GPs with identification," she explains.

Once deployed in a GP practice, C the Signs integrates with electronic patient records and uses AI technology to spot patients at risk of cancer. "It processes all the information very quickly—in less than a minute," says Bakshi. "It predicts what type of cancer they may be at risk of and recommends the best pathway for them based on their risk and the availability of local services."

C the Signs is already being used in 1,400 surgeries, and early results are impressive—it has so far identified 40,000 patients across 50 cancer types, and areas using it have seen a 50% reduction in cancer diagnoses in A&E and a 50% improvement in diagnosis time. The software has 99% sensitivity to cancer, compared to 54% for a GP.

With results like that, why isn't everyone using it? Bakshi says most ICBs either don't have funding at all, or have ring-fenced money that can't be spent on primary care. "Primary care attracts less than 10% of NHS funding," she says. "We often judge hospitals by how well they manage the front door—the A&E department. But primary care is the front door for everything in healthcare, so why aren't we investing there?"

being slow to innovate".

In January, health secretary Wes Streeting promised his eagerly-awaited ten year plan will "empower NHS leaders to deliver the innovation and reform required to fix the NHS". Like a lot of criticisms of the NHS, the claim that it's hostile to innovation has a whiff of truth, but exaggeration and repetition has turned it into an unhelpful cliché. Everyone's clear that something has to change about the way the NHS does change, but a lot less clear about what needs fixing and how it's going to get fixed.

'FANTASTIC LAUNCHPAD'

"I would push back against the idea that the NHS is culturally hostile to innovation," says Tim Horton, the Health Foundation's assistant director of insight and analysis. "The NHS has been the birthplace of many celebrated innovations—MRI scanning, CT scans, hip replacements and ocular lens implants, to name a few. We see NHS teams coming forward with great ideas all the time. Instead, I'd say the challenge lies in scaling innovation across the system."

As these pages show, world-class innovation does happen in and around the NHS. But the experiences of most innovators we contacted tend to bear out the King's Fund's finding that "innovation happens, not because it is supported by the system but in spite of it, due to the energy and drive of enthusiastic individuals."

Dr Ross Harper, a neuroscientist and chief executive of Limbic, which has developed the only AI-powered mental health tool licensed as a medical device in the UK, insists that NHS trusts can be a "fantastic launchpad" for tech innovation. "Technology is really great at alleviating the supply-demand problems NHS trusts face, so when they have autonomy over how they solve pressing issues, that's a great test bed," he says.

Mental health trusts like Surrey and Borders, Essex and Lincolnshire, which pioneered use of Limbic as a digital front door to services, "didn't decide to use AI because it's cool", he says. "These really passionate, heart-in-the-right-place NHS services took a gamble on Limbic because they believed we could help solve their problems."

But—you knew one was coming—"the NHS is a very difficult customer for any company that needs commercial viability", Harper warns. Problems with scaling, funding and procurement could, he fears, lead to fledgling healthcare tech firms leaving the UK to grow up elsewhere. "They're not problems with anyone working in the NHS; they're system problems and they're very real," he says.

The fragmented NHS structure in England, with thousands of bodies potentially taking individual decisions on investment, transformation and procurement makes it hard to scale innovations even when they've proven effective.

"The challenge is that every ICB wants to run its own pilot rather than adopting proven innovations at scale. This slow diffusion curve makes NHS-wide adoption difficult," explains Dr Bea Bakshi, who developed 'C the Signs', an AI-powered tool that helps GPs spot patients at risk of cancer (see above).

She wants the NHS to put more resources into making sure that proven innovations like C the Signs are implemented effectively on the ground. "If GPs actually use it, cancer detection improves. If they don't then it's not a good investment for the NHS, ICBs or GP practices. Implementation science is key—not just innovation."

Dr Rishi Das Gupta is chief executive of the South London Health Innovation Network, which supports innovators and NHS organisations working together to transform services. He says it's much easier to scale innovation where services are standardised around a clearly-defined group of patients.

"If 80% of patients can benefit, I can expend the energy required to innovate and make the whole pathway better for those patients," he explains. He gives the example of hybrid closed loop technology for treating diabetes: "It's a good product, it actually changes lives. In one year we managed to get rollout to 70% of patients. It scaled really easily."

The big challenge now, he says, is doing that for generalist services, like integrated neighbourhood teams, community care and GPs, where "the change might benefit only 5% of patients and I might unravel a lot of other things by innovating."

ANNA LISA MILLS, SMARTCARBON & NEWCASTLE HOSPITALS

I haven't come across as many barriers as you'd expect

"Find your allies—the people who can connect you to the right stakeholders," is the advice to innovators from Anna Lisa Mills, sustainability manager at Newcastle Hospitals and founder of SmartCarbon, a digital platform that helps organisations measure and reduce their carbon footprints. "Since joining the NHS five years ago, I haven't come across as many barriers as you'd expect," she says. "Okay, the bureaucracy's a pain, but the buy-in to sustainability is there."

A chartered environmentalist and lecturer at Northumbria University, Mills started the SmartCarbon business with support from the North East Local Enterprise Partnership, which provided funding for a pilot with the Newcastle trust.

SmartCarbon developed a bespoke version of the platform, which included hospital-specific metrics like anaesthetic gases. It's now used by 17 NHS trusts, as well as bakery chain Greggs, Newcastle United football club, Surrey county cricket club and Durham Cathedral. Mills's work with Newcastle Hospitals led to her joining the trust—after "completing lots of conflict of interest paperwork", she says— working three days a week while still serving as a director of SmartCarbon.

Decarbonising the supply chain is "the biggest sustainability challenge we face in the NHS", Mills explains. Instead of simply estimating them, Newcastle now supports suppliers to measure their own emissions, which are fed through to the trust's 'footprint plus' data.

Mills would like to see the ten year plan "treat the climate emergency as a health emergency". Pointing out that air pollution is now the fourth biggest killer in the UK, she says, "it's not a nice-to-have bolt-on, it's core to human health."

Maddening and irrational

All our innovators and experts agreed that the NHS framework for funding and supporting innovation needs an overhaul. "Money is released, but it goes into different pockets and budget holders are diffuse and obfuscated," says Limbic's Ross Harper. "Not even people within the system really know how to access that funding."

He recalls being told recently by one very senior NHS leader that trusts with funding to expand capacity often can't find new staff, but can't spend the money on time-saving tech solutions instead because it has been ring-fenced for staff costs. "We were being very respectful, but it was a maddening, irrational conversation; both parties recognised it was counterproductive, yet there was nothing we could do," Harper says.

Das Gupta reckons building a case for investing in innovation is harder in the UK than in any other major health system. "I can't build a multi-year business case because I don't have a multi-year financial settlement from the government," he explains. NHS organisations are also not incentivised to grow through innovation, he says, because "the only benefit we can draw is the cost reduction. We don't assign monetary value to patient experience, staff experience, or learning and innovating in itself. We keep it narrowly to financial savings and that makes it harder."

He worries that this lack of return could encourage successful healthcare tech businesses to move abroad. The thing he most wants to see in the ten year plan is a change in the financial incentives "to allow organisations which innovate to retain some of the financial benefits that they generate for the system as a whole. That's the big one," he says.

Sad story

Innovators also point to other 'system' barriers to innovation, including ponderous decision-making, labyrinthine procurement processes and a risk-averse culture that penalises failure while insufficiently rewarding success. Government adviser Paul Corrigan recently described the NHS as "a pretty bad partner" for tech firms, because it didn't know what it wanted, bought what was offered rather than co-developing solutions, and took too long to approve contracts.

Professor Angie Doshani, consultant obstetrician at Leicester Hospitals, says rolling out JanamApp, a successful online tool she developed to support south Asian women through pregnancy (see below) has

REBECCA HOWARD, SHINY MIND

We waste so much money trying to implement things that don't work

"Where innovation sometimes goes wrong is that it isn't co-designed," explains Rebecca Howard, psychologist and founder of Shiny Mind, a digital mental health and wellbeing programme developed with the NHS. "I think we cut out co-design because it's expensive, but we waste so much money trying to implement something that doesn't work.

"Co-design with patients and clinicians is laborious, time-consuming, and you've got to absolutely be open to the fact that what you think is right could be complete rubbish," she adds.

Originally developed to support NHS staff, Shiny Mind is now being prescribed for patients with anxiety and depression by GPs in Bedford, Luton and Milton Keynes. "They had a group of passionate clinicians who had used Shiny Mind for their own mental health and could see it would support their patients," explains Howard.

Billed as "a hug in an app", Shiny Mind offers range of wellbeing tools and masterclasses as an alternative to conventional treatments like in-person therapy and medication. There are separate editions for patients and NHS staff, and a new version for nursing and midwifery students has just been launched.

After retraining as a psychotherapist, former marketing executive Howard became interested in how therapy could be used in "a preventative, proactive way" rather than waiting until "people are falling down". With initial funding from an angel investor network, the first version of Shiny Mind was co-created with staff at the NHS Walton Centre in Liverpool over the course of a year.

Although one-to-one therapy is still important—Howard still practices herself—"patients are more receptive to digital than we think they are. People increasingly want to access care in their own time and space," she says.

"been a challenge, not because people don't love it—they do—but because every trust does procurement differently, and there's no standard. When you you've cleared one hurdle, there's another. That's frustrating for me as an innovator."

She would like to see a "national pathway" for innovation adoption, with trusts modifying their own approaches to meet the national standard. "That would make life easier for innovators and for trusts," she says.

"It's a sad story," reflects Doshani—who still works in the NHS—that so many innovators feel they need to leave the NHS to develop their ideas to improve NHS services. "If the NHS wants to recognise innovation, they need to support the innovator," she says. "Having something with NHS support makes spread and scale so much easier. If you're already working in the NHS, why should you have to go outside and then try to get back inside?"

Innovators need "as much evidence as possible, even in the early days," advises psychologist Rebecca Howard, founder of the digital mental health and wellbeing platform ShinyMind (see page 17), because the NHS requires a "huge level of certainty to move forward with an innovation".

Co-design is key, she believes: too many innovations fail because they haven't been developed and tested with patients and staff. "But because the NHS doorway isn't particularly open or easy to access, innovators end up developing services without them being tested with the people that are going to use them," she says.

The tough regulatory framework in the NHS may look like another hurdle, but Limbic's Ross Harper says it can actually help innovators by weeding out the ineffective or quack solutions that damage trust. "Just deregulating doesn't necessarily mean you're going to see more innovation," he warns.

Tighter rules on what can be classed as a medical device in mental health, recently introduced by the MHRA, will help innovators by "bringing clarity and establishing hard lines," Harper says. "Innovation will be stifled far more by scandals and patient harm than regulation. I'm a huge advocate of AI in healthcare, but I'm terrified of an unregulated ecosystem allowing bad actors to have a go, cause a problem and set the field back."

VALUED PRIORITY

The Health Foundation's Tim Horton urges the NHS to shift some innovation funding towards "capacity building"—giving staff the training and time they need to refine and successfully implement innovations. "In many cases, just a small amount of additional investment—whether that's training, mentorship or change management resources—can make a huge difference," he says.

"If we truly want to embed innovation within the NHS, we need to signal that it's a valued priority," Horton adds. "That means recognising and rewarding efforts to implement new ideas, even when they don't immediately succeed."

And while a degree of pressure can be a spur to innovation, the day-to-day pressure on NHS services means "innovation tends to drop off because people simply don't have the bandwidth to engage with new ways of working," he warns.

Let's end on a note of optimism: the ten year plan is an opportunity to make the NHS a great place for innovation. None of the problems we've heard about should be too big to tackle in what Keir Starmer has called the "biggest reimagining of our the NHS since its birth".

"While the NHS is a very difficult customer, it's a nationally cohesive system with incredibly high-quality data reporting," says Harper. "We have institutions like Cambridge, University College London and Imperial College, that bring the world's best AI talent to the UK—where there's an amazing pool of data to support innovation and a willing sandbox to deploy new solutions.

"That's why I think the UK will be the launchpad for the most important healthcare AI company in the world. And the NHS will be a massive part of that," he says. "The challenge now is to make sure that company stays in the UK and doesn't commercialise somewhere else." //

ANGIE DOSHANI, JANAMAPP & LEICESTER HOSPITALS

WE STILL LIVE IN ISOLATED SILOS

"Understanding that you can learn from other specialties, from their errors or the good things they've done—that's where my innovation bug came from," says Professor Angie Doshani, consultant obstetrician at Leicester Hospitals and the brains behind JanamApp, a digital tool that supports South Asian women through pregnancy. "We still live in isolated silos," she adds. "There's so much amazing stuff happening around us, which we don't know about because we don't have those conversations."

Doshani, who still works full time in the NHS, set up a community interest company to manage the development of JanamApp. "This is not about making money," she says. "Everything we earn from licensing this app goes into development or community projects."

Janam means 'birth', and the app offers "culturally sensitive and linguistically appropriate" pregnancy and postnatal information in English and six South Asian languages. Trusts pay £5,000 for unlimited users—less than a pound per patient in Leicester, where the app was first launched. Hospitals in Derby, Burton and Chesterfield will launch the app this spring, and Manchester University trust is set to follow.

Early data shows improvements in staff efficiency, with less reliance on interpreters and shorter consultation times. Patient and staff satisfaction rates have improved, with 80% of patients saying they feel better informed after using the app.

"For me, it was all about patient empowerment," Doshani says. "If you've got the right information, you'll make the right choices, reduce anxiety and self-activate to look after yourself. It's an investment in the future."

HOUSE OF COMMONS/UK PARLIAMENT

The inspector falls: why the CQC needs a fresh start

After years of chaos, the Care Quality Commission urgently needs to rebuild trust and credibility with the public and the services it regulates. What needs to change and what are the priorities for new boss Sir Julian Hartley? *Alison Moore* reports.

Regulators are rarely popular but the Care Quality Commission (CQC) has few defenders left after several years of what looks like chaos and severe doubts over whether it has been fulfilling its key task—keeping the public safe.

The number of inspections carried out by the CQC has plummeted, it has massive IT problems, backlogs of registrations and notifications of concern to get through, and staff and stakeholder confidence is low (see page 20). One senior medical figure described it as "having lost its way".

So there was general applause when Sir Julian Hartley—then head of NHS Providers and a former trust chief executive—took on the job of leading the CQC in December. Former health secretary Jeremy Hunt said Hartley had "a pretty good handle" on the problems, while the NHS Confederation's Matthew Taylor says Hartley and other senior CQC executives "are being very measured and very reflective and open about the challenges that lie ahead and the changes they need to make to rebuilt trust".

But no one doubts the scale of the problems Hartley will face turning round an organisation without a chair—although former hospitals chief inspector Sir Mike Richards has recently been named as preferred candidate—and which urgently needed to recruit non-executives and permanent chief inspectors with real standing in the sectors it regulates.

"If anyone can do it, he probably can," says MiP

What's gone wrong at the CQC?

A recent session of the Commons Health and Social Care Select Committee (HSCC) examining the operations of the CQC was an eyeopener—with the chair, Liberal Democrat MP Layla Moran, later saying she was "shocked" to hear how bad things were and that the CQC needed to "work at pace" to address its shortcomings.

Many of the committee's concerns were also highlighted in the reports on the CQC by Penny Dash and Sir Mike Richards last year; Dash's broader review of NHS regulatory bodies is still awaited.

The most striking revelation made to the HSCC was that 500 reports were stuck in the CQC's IT system and could not be retrieved. New CQC chief executive Sir Julian Hartley said this was causing staff "deep distress", that there had been inadequate engagement with staff before the rollout and a lack of willingness to listen to them when they reported problems. There was also a backlog of 5,000 'notifications of concern'.

The failed IT system was one part of a transformation programme which saw the introduction of a single assessment framework for both health and social care. The programme also combined three sector teams into one, which many NHS managers believe has reduced the CQC's level of expertise when assessing them. The transformation programme was panned by Richards in his report, which called for a "fundamental reset of the organisation".

The CQC board had taken some time to grasp the extent of the problems. Outgoing chair Ian Dilks admitted to the committee that there was "clearly a failing in the information that the executive team had". At the same time, the board was "thin", he said, with long delays to the approval of non-executives by the Department of Health and Social Care.

The number of inspections carried out by the CQC has fallen dramatically and it has increasingly focused on inspecting individual services rather than whole hospitals. As a result, inspection results are often out of date: the average hospital inspection is four years old and some hospitals have not been fully inspected for ten years.

As Sir Julian put it succinctly during the hearing: "We are not delivering for people."

chief executive Jon Restell. "It's a twofold problem—the place of the regulator within the system and also the fact that it's an organisation which is probably on its knees in terms of morale, sense of purpose, leadership culture and so on."

Sir Julian will need to balance the need to pacify external stakeholders with nurturing CQC staff and keeping them on board, he says. And there will be bumps in the road which could derail his plans: a scandal about safety or care quality somewhere in the NHS or social care is almost inevitable at some point—so Hartley will need to get his changes in place quickly.

Hunt says the appointment of chief inspectors, who lead the inspection teams for a particular sector, will be "the most important decision he will have to make.....you need someone who has credibility." The hospitals job, which in the past has been held by such heavyweight medics as Mike Richards himself and Professor Ted Baker, is likely to be crucial.

Although NHS England's patient safety lead, Professor Aidan Fowler has been appointed interim inspector of healthcare overall, the CQC is set to return to having separate chief inspectors for primary care, mental health, hospitals and social care. With so few inspections taking place, these senior figures will need to "get out there" and understand what is happening on the ground, adds one informed commentator.

Trusts want to feel they are being judged by a cadre of competent inspectors, Hunt says. He sees this as one of the CQC's key successes in its early years under David Prior and then David Behan, who built an inspection regime which didn't rely solely on data but also included dozens of inspectors going in and talking to people. "Numbers don't tell the whole picture, you need to actually go and see the place," Hunt explains.

This helped build confidence and secured the position of the CQC after it had been shaken by a number of scandals. "I absolutely think we can do the same again and I think Julian is on the right track," he says.

But any new model of inspection will also have be financially sustainable. One informed commentator says this could mean relying less heavily on inspections, which inevitably involve lots of staff time. The CQC could instead learn more from regulators in other sectors which are more data driven, they suggest.

Hartley has promised more co-production and closer working with providers but will need to avoid their involvement being seen as 'provider capture'. Whether the CQC's controversial 'single word' assessments will survive is unclear, although health secretary Wes Streeting is believed to want to keep them.

Ofsted, the schools inspectorate, has tried to move away from single word ratings following the suicide of a headteacher whose school was criticised, but its proposed solution has been panned by teachers' unions as "bewildering", with multiple ratings for different aspects of the school's role. Any changes to CQC's system may run the same risk of losing clarity in search of nuance.

Not all managers see the single word rating as an issue. One senior manager says they offer clarity and assurance to the public and how managers feel about them simply doesn't matter.

"'Inadequate' is for those who are really bad and don't have a plan to improve it. You can game the system. If you know what they're doing and what they're looking for. You can tick all the boxes," they said. "I like the concept of the CQC. Most of the people really unhappy about it are those who've had really bad inspections, but if you read through the inspection reports, you can

see they're not making it up!"

But another commentator with experience of CQC inspections questions how meaningful a one word assessment can be when a hospital has multiple sites and services. Even comprehensive inspections are unlikely to delve deep into every part of the trust, they warn.

"It would help if there was more focus on what actually benefits patients and users," says the NHS Confed's Matthew Taylor. Using data to spot problems in the early stages is helpful, he suggests, and was the idea behind the CQC's risk-based approach. But it's hard to do well. "CQC's data capabilities did not match this ambition," he adds.

Hartley will also need to rebuild the CQC from within. UNISON national officer Matthew Egan says that some CQC staff have been "traumatised" by events over the last few years, but he feels "cautiously optimistic", adding, "[Hartely] is making all the right noises about changing the culture and he has made an effort to listen to staff."

But Egan warns some issues may be harder to solve. CQC staff pay is tied to the civil service, where pay has been frozen for much of the last decade. This can be off-putting for experienced NHS staff considering a move to the regulator. Although staff shortages have eased recently, there are still teams which are struggling to recruit and retain staff, Egan says.

In last year's staff survey, the CQC fared particularly badly on the issue of whether staff felt they could speak up about problems at the organisation. "If the organisation had listened to front-line staff, we would not be in the mess we are now," Egan adds.

To give people a reason to stay at the CQC, Hartley will need to clearly signal that the organisation is changing and make staff feel they are helping the NHS to improve, suggests MiP's Jon Restell. "He needs to give people a message that it is tough now but it will get better," he says.

The CQC also faces wider questions about the purpose of regulation and whether too much is expected of it. One senior medic suggests the CQC has to "add value" but points to the difficulties organisations face in a pressurised system and the challenge of recognising that through inspection ratings.

"MiP are not hostile to regulation, but the way it's used can mean a disproportionate amount of energy gets tied up in it."

The remit of the CQC—which was formed by merging three existing regulators—has been extended to include both integrated care systems (ICSs) and local authority social care services (the latter are assessed with a percentage rating alongside scores for a series of quality statements). One moment the CQC can be assessing a private ambulance service or home care service with a handful of staff and the next a multi-site trust employing 20,000 people. But 85% of the organisations it assesses have less than 50 employees. Can a single organisation be agile enough to do all this and provide a consistent standard of assessment which holds across these different sectors?

Restell has doubts, pointing to the difference in scale between the organisations and also to the different risks. The risks in hospitals which have lots of data and few people working alone are quite different, he says, to those in "smaller services where staff may be struggling out of sight in care homes or small clinical settings".

The CQC's wide remit also raises concerns about a 'one size fits all' approach. Basic common tenets may be needed across the different inspection processes, but how inspections are then tailored to the circumstances of the organisations—and how they support positive change is crucial. However, splitting the CQC into different regulators or devising different regulation systems for different types of provider goes against the zeitgeist for more integrated care.

When to restart ICS inspections—paused since October last year following criticism of the inspection regime in the Dash report—is a decision for the Department of Health and Social Care. But the CQC will need to think about how it can add value, suggests Taylor: "Our perspective is don't rush it, get the trust inspections right first before assessing complex systems."

Jeremy Hunt sees supporting improvement as being at the core of the CQC's purpose, and argues that organisations with poorer ratings often do look to learn from others. He also sees regulation as one way to avoid micromanagement of the NHS from the centre.

One change which would be welcomed by MiP members, adds Restell, is to depersonalise the inspection process and make it less adversarial: inspectors need to make it clear that it's not a matter of blaming people, but of carrying out an objective assessment of quality while taking into account the systemic factors that affect quality. Hartley could take the lead in driving more "adult conversations" about inspections, he says.

More fundamentally, Restell questions whether regulation by the CQC and other bodies risks imposing too much strain on the NHS and its staff. It's just one pillar in a quality system which should also involve professionalism, he suggests.

"We have a belief in regulatory primacy over everything else," he says. "But there's a finite amount of resources any system can give over to regulation before it starts to affect quality. We need a model of safeguards which does not just rest on regulation."

He adds: "MiP are not hostile to regulation, but the way in which it is used means a disproportionate amount of energy gets tied up in regulatory activities."

Small changes around the margins, such as developing common datasets for all regulators—rather than each regulatory body demanding bespoke ones—could help, but he feels there are bigger issues.

"It would take a politician who is brave enough to say that we can't regulate everything to the same level of detail that we would like to have in an ideal world," he concludes. //

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

Bye your leave: understanding settlement agreements

Settlement agreements are commonly used in the NHS to end a manager's employment when there are no good reasons for dismissal. *Jo Seery* explains how they work and how they can be enforced.

What do mutually agreed resignation schemes (MARS), voluntary redundancy processes and without prejudice discussions about termination have in common? They all tend to lead to employers proposing 'settlement agreements' as a way of ending a manager's employment. Such agreements are commonplace and, usually, allow both sides to part on amicable terms.

What is a settlement agreement?

Formerly known as 'compromise agreements', a settlement agreement is a legally binding contract setting out agreed terms for ending an employment relationship or resolving a dispute. In return for signing one and waiving some of their statutory rights, the employee receives a compensatory lump sum—usually be more than they would get if they went to court.

Do they include gagging clauses?

Confidentiality clauses and non-derogatory clauses (commonly called 'gagging clauses') are a common feature of settlement agreements. While there is nothing illegal about these clauses, some employers have become much more cautious about using them. NHS guidance dating from May 2024 urges employers to proactively consider whether a confidentiality clause is needed and, if it is, that it should be tailored to the specific case and should go no further than necessary.

A confidentiality clause must never be used to try to prevent someone from making permitted disclosures ('whistleblowing') and such clauses will be unenforceable. It's also inappropriate to include confidentiality clauses in MARS agreements—the process should be open and transparent. Employers could find themselves subject to regulatory action (for example, a CQC well-led review) if they use settlement agreements inappropriately.

Statutory requirements for settlement agreements

Section 203(3) of the Employment Rights Act 1996 (along with corresponding provisions in other laws) lay down that:

- ✔ The agreement must be in writing
- ✔ The agreement must relate to a "particular complaint" or "particular proceedings"
- ✔ The employee must have received legal advice from an independent adviser on the terms and effect of the proposed agreement and how it will affect their ability to pursue their rights in an employment tribunal
- ✔ The independent adviser must have insurance covering the risk of a claim against them by the employee in respect of their advice
- ✔ The agreement must identify the adviser
- ✔ The agreement must state that the statutory conditions regulating settlement agreements have been satisfied

The NHS guidance also makes clear that these agreements are not a substitute for tackling poor performance or dealing with disciplinary matters, particularly issues involving the quality and safety of patient services, or the care and wellbeing of staff.

What's in a settlement agreement?

While it's usual to hold without prejudice discussions and agree the terms in principle, it's only once a settlement agreement is signed by all parties and complies with the statutory requirements (see above), that the terms become legally enforceable. So it's crucial that all agreed payments are specified within the agreement, together with any other details like retention of property, agreed references, recoupment of training costs or writing off of relocation expenses. Promises made verbally or by email are not enforceable unless confirmed within the terms of the signed settlement agreement.

Breach of a settlement agreement

This occurs when one party fails to fulfil their legal obligations under the agreement. Common breaches include:

- » Payment breaches, such as employers not paying within the specified period or paying less than agreed
- » Confidentiality breaches, such as disclosing sensitive information about the employer—parties need to be particularly careful about comments made on social media
- » Non-compliance with agreed terms, such as failing to return property

Some agreements will include a specific clause on what happens in case of a breach. For example, the employee may have repay some or all of the agreed payment, depending on the extent of the breach. Any repayment must be a genuine estimate of the loss caused and not a financial penalty designed to deter a breach.

Another option is a breach of contract claim in the County or High Court. The usual remedy would be damages based on the actual loss caused by the breach, such as reputational harm or unpaid sums, for which evidence will be required.

Negotiations or mediation may be a better way to resolve the dispute in the first instance; for example, an agreement to remove a derogatory social media post coupled with a reminder of the obligations under the agreement. Payments due under the contract may also be withheld if, for example, the employee has breached the terms of the agreement.

Your MiP representative can provide invaluable support throughout the settlement agreement process, ensuring you fully understand your rights and the implications of signing the agreement. Contact *MemberAdvice@miphealth.org.uk* for advice. //

How to manage new tech with a spring in your step

COFOTOISME

Digital and business change veteran *Sue Carter* offers her tips on how to seize the opportunities offered by new technology for the benefit of your colleagues and patients.

New technology solutions are coming at us left, right and centre, particularly with the explosion in generative AI. This can be exciting and transformational, but also daunting and terrifying. So, how do you move forward? These ten tips will give you a roadmap for navigating the tech path ahead.

1. Understand your own understanding

Be honest with yourself about your own tech capability and level of comfort. What matters isn't your level of proficiency, but how you share, use and grow your knowledge. If you're a tech native, you can be an advocate in your workplace—but be wary of going too fast or ignoring sceptics. If you're digitally cautious, don't be afraid to ask questions and call on your experts. Don't try to 'fake it till you make it'.

2. Do the groundwork

Being curious and open about technology will always stand you in good stead. Take opportunities to learn through reading, podcasts and internal training. You don't need to be an expert but having a broad understanding of what's going on will put you at ease with workplace innovation. Use tech as much as you can in your everyday life. Getting to grips with technology is like any other skill: the more we do it, the better we get.

3. Understand the pain points

When considering new tech, identify your organisation's pain points. What's stopping your team from succeeding? What's hampering people's interactions or engagement? Ask questions, gather data and consider the evidence. Once you understand the pain points, you can find the right technology to resolve them.

4. Find your match

Finding the right tech solution can be daunting and frustrating. Turn your pain points into requirements and use these to narrow your options. When comparing products or services, a table with scores against your requirements for each one can be incredibly useful—give some requirements a higher weighting if they're more crucial. Be wary of over-engineering by choosing something that offers much more than you need.

5. Test and learn

This has been a tenet of tech change since the dawn of...well, tech. Start small, by trying out a few features and functions (testing); then gather feedback and data; then analyse those results and consider iterations (learning). Look for the positive and negative impacts, and be ready to flex according to the lessons you learn. Be prepared to fail. Every time you fail in tech you learn how to improve the experience.

6. Don't go too fast, too soon

It's easy to get carried away with everything new software promises. Technology adoption takes time; if you want it to stick and your team to embrace it, go at a speed that works for everyone. Go too fast and you may also miss problems and opportunities.

7. Collaborate, with transparency

Don't disappear into the technological dark room, only to emerge when the solution is ready. Involve everyone who might be touched by the change—leaders, the staff who will use the system, IT support and comms teams. Share your progress and learning, and be honest when things aren't going to plan.

8. Look out for scepticism and fear

As you research, test and deploy new tech, be aware that scepticism, fear and unease will be bubbling away somewhere in the team—and it might not be obvious. Look out for people who aren't fully on board, try to understand their challenges and provide reassurance. Often, people just want to be heard.

9. Identify and use your experts

As well as sceptics, there will be early adopters and tech enthusiasts who can't wait to get started. Seek out their advice and support. Can they help other colleagues? Or help you build your own understanding and skills? A note of caution: if you nominate 'digital champions', make sure they're good communicators who will encourage sharing and openness within the team.

10. Be curious, consistently

So we come full circle, because curiousity is your best friend in digital change. Don't bury your head in the sand and hope it will be OK. Keep testing, trying and learning. Make mistakes, ask questions and collaborate. It'll pay off in the end. //

Sue Carter is a former director at Yahoo! and BBC editor, who now supports people and organisations through technological and business change. For more info, visit suecarter-consult.mystrikingly.com or email suelcarter@gmail.com.

meetyour**reps**:**Sarah Carter**

As a care home manager, you can see the difference you're making to people's lives

MiP National Committee member Sarah Carter tells *Craig Ryan* about her rewarding switch from the NHS to social care and the "very special" role of managing a care home.

As a registered care home manager, "the buck stops with you", says Sarah Carter. "You're responsible for managing that service. You can't be everywhere all the time; you have to trust your team. So, the job comes with quite a lot of responsibility."

A former NHS manager, Sarah runs a 50-bed care home in the East of England. Registered with the Care Quality Commission (CQC) for both residential and nursing care, the home welcomes adults of any age, including those with learning disabilities and complex dementia needs.

Sarah began her career with the London Ambulance Service, where she immediately joined UNISON, transferring to MiP when she reached Band 8. "Managers need a different type of protection, and there are different reasons why you might need support and advice," she says. A National Committee rep since 2024, she hopes to give social care managers a stronger voice on the union's governing body.

Before taking voluntary redundancy from the NHS, Sarah worked as an urgent and emergency care manager for Norfolk and Waveney ICB. When managing patient discharge she often felt frustrated seeing ambulances still queuing outside hospitals because of a lack of available beds. "The decisions or actions you took never seemed to show up as a tangible difference at the front door or in the headlines," she says.

As a care home manager, every day is "different and challenging", she says, "but you can see how people's lives are affected positively by the work we do. When a resident wants a cup of tea and you give them a slice of cake too, it completely brightens their day. You really see the richness you bring to people's lives."

Working for a small, family-owned business also means "you're close to the decision makers because there isn't a massive hierarchy", Sarah says. "If I need something, I can talk to the finance director, say why I need it, how much it costs, these are the risks and benefits, and he can say yes or no. So in theory you can implement things really quickly."

While Sarah found her skills were readily transferable to social care, moving sectors wasn't completely straightforward. Unlike NHS managers (see page 11), care home managers must be registered with the CQC, a process that involves submitting a full career history and references for verification, an enhanced DBS check (as well as additional checks by the CQC for staff who aren't clinically registered) and a 'fit and proper person' interview. All this takes a minimum of 16 weeks.

> *// You're close to the decision makers because there isn't a massive hierarchy. If I need something, I can talk to the finance director... In theory, you can implement things really quickly. //*

"They check everything; they want to get a whole picture of you," she explains. "At the interview they ask about your experience, your knowledge of the regulations, and what it's like running the service. At the end, you get a lovely certificate from the CQC."

Keeping the home properly staffed is one of the biggest challenges Sarah faces in her new career. Many staff are on the minimum wage and small care businesses can't offer the same career opportunities as larger organisations, she explains.

"Finding people and keeping them is a challenge across all of social care," she says. "We've got rolling recruitment going all the time. I've been in my current role for nine months and I feel like I've interviewed somebody every week."

While better career progression might help, many of her team are "dedicated and passionate carers" and may not be interested in management roles, she says. "They're really happy caring for people and that's where they get their joy from."

At the same time, care homes struggle to increase salaries because of funding constraints. "The margins are very slim on local authority funded residents," she says. "The standard rates aren't really enough to look after somebody who needs washing and dressing, and maybe two people to assist them with everything, while you're laying on food, lighting and heating. That's a lot of cost."

With April's national insurance rise adding to rising costs, many care homes will be forced to balance the books by taking more privately-funded residents—"a huge challenge," Sarah says, because "you want to deliver high quality person-centred care for every single resident based on their needs, not on how much they pay for their beds." //

If you're interested in becoming a rep, contact MiP's national organiser, Katia Widlak: k.widlak@miphealth.org.uk.

Our pledge to you

THOMPSONS
SOLICITORS

STANDING UP FOR YOU

Thompsons Solicitors has been standing up for the injured and mistreated since Harry Thompson founded the firm in 1921. We have fought for millions of people, won countless landmark cases and secured key legal reforms.

We have more experience of winning personal injury and employment claims than any other firm – and we use that experience solely for the injured and mistreated.

Thompsons pledge that we will:

- work solely for the injured or mistreated
- refuse to represent insurance companies and employers
- invest our specialist expertise in each and every case
- fight for the maximum compensation in the shortest possible time.

The Spirit of Brotherhood by Bernard Meadows

www.thompsons.law.co.uk 0800 0 224 224 *Standing up for you*

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

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

Inspirational stories about real people

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

Recognition and support for the work managers do

Because managers do a great job in challenging circumstances they need recognition and support from their colleagues, politicians, the media and from the public.

Get involved today by scanning the QR code

Nominate an inspirational colleague, a manager or even yourself to be featured in the campaign. It's happening throughout the UK on social media and in the press.

Help us make change happen!

Jon Restell
Chief Executive, MiP

MANAGING our NHS