NHS Providers

Briefing

December 2019

A PLACE TO WORK

System approaches to workforce challenges in the NHS

Key messages

- In many sustainability and transformation partnerships (STPs) and integrated care systems (ICSs), strong relationships are borne out of the recognition of shared motivation to improve patient care, grow the workforce and make best use of resources in a challenging financial climate. System leaders taking forward this work describe coming together around a shared aim, and recognising that organisations have commonalities which leaders can rally around to develop joined-up workforce solutions – across recruitment and retention, training, and skills gaps.
- System working can help address workforce challenges but this will require a significant shift in how the NHS operates, transforming culture to make close working and cross-boundary relationships part of the day-to-day business of frontline staff, as well as getting leaders from across the system together to engage in joint strategic planning.
- By definition, system working involves the input of organisations beyond the NHS alone. Primary care, social care, the voluntary sector and wider system partners such as emergency services all play a key role. There is an opportunity to use workforce initiatives as a driver of cross-boundary working in order to facilitate integrated care and put in place care pathways that provide people with a streamlined journey through services.
- With over 100,000 vacancies in the NHS there is a pressing need for systems to think differently about how they attract people to work in the local health and care sector. System working offers an opportunity to move beyond disparate and competitive recruitment initiatives and address the wider workforce needs by offering people varied, flexible careers within a place.
- As part of the drive to offer staff incentives to stay in the system, trusts are seeking to collaborate with local partners to make it easier for staff to move between organisations. Initiatives like rotation agreements and staff 'passports' have the dual benefit of creating a varied developmental employment offer for staff who might otherwise look outside of the system for new opportunities, and creating a more efficient mechanism for filling vacancies where they arise.
- Our workforce has a substantial role to play in driving the progress of system working. How we work with our valued workforce to enable closer relationships between trusts and other health and care organisations, and how we support staff throughout periods of change and transformation, will be an important determinant of how systems work in collaboration to tackle workforce pressures and drive integrated care.

1 Introduction

The NHS is moving towards collaborative working in systems, with trusts, primary care, local authorities, emergency services and the voluntary, community and social enterprise (VCSE) sector coming together to improve the health of the population and join up care.

As part of the wider move towards collaboration in local systems, the national bodies are also developing a new operating model, with a view to increasing workforce devolution to regions, ICSs and local organisations, using the ICS maturity matrix to benchmark workforce planning capabilities and determine where workforce planning should be undertaken at a devolved level.

However, all of this is taking place in the context of increasingly severe pressures across the NHS and care sector. 2018/19 Q4 performance figures showed a £700m deterioration in the underlying provider sector deficit in a year.[1] Demand for services is increasing, with a 5.4% rise in emergency admissions from 2017/18, and the provider sector has missed the A&E four-hour waiting standard in every month since July 2015.[2] The NHS is seeing more patients than ever, but demand now substantially outstrips supply. Social care and public health also face severe pressures due to reductions in local government funding, coupled with rapidly increasing needs among the older and disabled population. Rising levels of unmet social care need has contributed to the increase in demand for NHS services as vulnerable people turn to the NHS for support and spend longer in hospital waiting for care packages to be put in place at home.

The NHS and its workforce are consequently under increasing strain. Although the overall size of the workforce is growing, there are around100,000 reported vacancies in the NHS, almost 40,000 of which are nursing vacancies.[3] The NHS people plan aims to tackle workforce challenges by making the NHS a better place to work, encouraging new staff to train and work in the NHS, and improve retention and staff wellbeing. While the pledges within the people plan to grow the workforce are welcome, there is a pressing need to support the existing workforce, and to ensure staff are deployed as effectively as possible across a population to deliver those commitments.

This briefing aims to explore how trusts are working with their staff and with local partners to enable the health and care workforce to adapt to new ways of collaborative working in systems, and to support the aim of integrated, joined up care. It contains a number of case studies based on interviews with trusts, STPs and ICSs and local authorities, which explore new, devolved ways of organising and planning for workforce needs, and of deploying, recruiting and retaining staff in a system context. We would like to thank all of the interviewees who contributed to this publication for sharing their learning and insights to date.

1 https://nhsproviders.org/media/644130/2019-06-13-q4-otdb-final.pdf

2 https://www.kingsfund.org.uk/projects/urgent-emergency-care/urgent-and-emergency-care-mythbusters

3 https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

2 A legal view

HEMPSONS

NHS Providers legal partner, Hempsons, give their perspective on the impact of system working on the NHS workforce, and shed light on the legal considerations trusts and other system partners should give to system working.

These case studies illustrate a range of ways in which trusts and their partners can move towards a more integrated and collaborative system of working. As well as the cultural and engagement issues referred to in the case studies, there are legal challenges associated with the move to new ways of working.

Some of these challenges arise out the structure of the NHS – system-wide organisations such as STPs and ICSs have no legal identity. They cannot directly employ staff and so other workable arrangements need to be found, whether that is using a 'host' employer or otherwise. Some of the challenges are more traditional and common across all sectors – the need to change terms and conditions, make redundancies, manage secondments etc.

This is an overview of the main employment law challenges facing organisations attempting to implement better system working of the sort set out in the case studies.

Changing terms and conditions

Existing employment contracts may have a degree of flexibility built into them and employers should always review existing flexibilities before considering changing them. Changing terms and conditions of employment except by agreement is not to be undertaken lightly given the potential for litigation challenge and risk. In order to make binding changes to employment contract terms employers have three options:

- obtain the **express agreement** (ideally in writing) **of the employee** to the change
- reach agreement on a collective basis with a recognised trade union
- **impose the change** unilaterally (if the employee does not object this would amount to an acceptance of the change)
- **dismiss and re-engage** (offer continued employment on the new contractual terms).

In cases where an employer proposes to dismiss 20 or more employees within any 90-day period, there is an obligation to consult collectively with appropriate representatives (for NHS employers that would usually be recognised trade unions) and this would apply if an employer chose to dismiss and re-engage employees.

If an employer fails to adequately consult with appropriate representatives, they can face claims for a 'protective award' of up to 90 days' pay for each affected employee.

Changing terms and conditions after a TUPE (transfer of undertakings [protection of employment] regulations 2006) transfer can be difficult to do lawfully. 'Harmonisation' of terms and conditions, which is often desirable from an employer's perspective, goes against the purpose of TUPE and is often the subject of challenge (both internally and through litigation).

2

TUPE

Where responsibility for providing a service transfers from one provider to another there is the likelihood that a transfer under TUPE takes place.

The purpose of TUPE is to protect employees against unlawful changes to their terms and conditions and against dismissal connected to a transfer.

A move towards more collaborative, systems working can, sometimes inadvertently, create TUPE transfers of employees. A clear understanding of when collaboratively working might lead to a TUPE transfer is essential if employers are to avoid litigation from affected employees. One of the key questions to ask when working more collaboratively is "*Who is now responsible for providing this service?*". If responsibility is going to change, employers should consider whether there is going to be a TUPE transfer.

There are practical ways of managing transfers to deliver the required outcome, but employers can only protect themselves (and employees) if they know that there may, technically, be a TUPE transfer and plan for it.

There are information and consultation obligations on employers, so it is crucial that these are planned for and implemented properly. The financial consequences of non-compliance with the information and consultation obligations can be very serious. Similarly, as with the failure to consult about collective redundancies, tribunals can award protective awards to affected employees of up to 13 weeks' pay per employee.

Employers should be particularly aware of the potential TUPE implications where they move to a 'host' employer, shared employment model or where multi-disciplinary teams from several employers are created.

Changing terms and conditions, when connected with a TUPE transfer, can be particularly difficult with few lawful exceptions for employers. Employers are always wise to seek legal advice before they undertake such changes.

Secondments

Often there may be a need to temporarily transfer an employee into a new work environment and a secondment arrangement might be the best way to do that effectively.

As long as the employee, the employer and the new 'host' organisation are agreed that it is a good idea the practical implementation is usually not difficult but it is important that all parties understand how the arrangement will work not just when it is going well but also when things go wrong (e.g. disciplinary or capability concerns, liability for claims etc).

2

Staff 'passport' arrangements

Several of the case studies rely upon increased uniformity (or at least a high degree of equivalence) between NHS organisations regarding their recruitment processes so that employees can move without too much friction between employers. There may also be a desire to ensure that terms and conditions and job descriptions are standardised across groups of employers.

Moves within the NHS are, in theory at least, easier because of the national framework of terms and conditions for NHS employees. There are, however, difficulties in some cases where there has been local variation and, though express terms and conditions may be the same, policies and procedures can vary significantly across the NHS.

The position is more complicated when employees from other sectors are added into the mix. In some cases, attempting to move towards commons terms and conditions and common policies/procedures can fall foul of TUPE protection and/or amount to an unlawful dismissal.

Again, there are practical ways to move to a more harmonised, system-wide offer but this may take time to do without significant challenge.

Information governance

Most system-wide, integrated models require the effective sharing of employee data. An important consideration can often be how to manage this without breaching data protection obligations. Hempsons recommend that all involved make it a priority to agree how employee data is to be handled safely and ensure that this is set out in a clear agreement to avoid inadvertent breaches of the general data protection regulations.

In summary

These case studies illustrate some of the ways that NHS organisations are working more in collaboration. There are clearly great benefits arising from these new ways of working. However, employers should take advice before entering into these new arrangements and ensure they have full knowledge of the potential legal pitfalls that can create problems for the future. There are good, practical solutions to most of these challenges as long as employers recognise the challenges and work to create solutions that minimise the risks.

Collaborative strategy and leadership

3

Developing a shared vision for the workforce

In many STPs/ICSs, strong relationships and collaborative working are borne out of the recognition of shared goals and motivations to improve patient care and experience, grow the workforce to meet the population's needs, and make best use of resources in a challenging financial climate. System leaders describe coming together around a shared aim, and recognising that despite different cultures and leadership, organisations across the system have commonalities which leaders can rally around to develop joined up workforce solutions which work for all system partners – across recruitment and retention, training, staff pipelines and skills gaps.

This should be underpinned by meaningful engagement with those who have a part to play in identifying and meeting the workforce needs of the system. This may involve trusts forming a coalition of partners to agree priorities and actions for the system, and may be supported by pooled resources, including training budgets.

CASE STUDY

Greater Manchester Health and Social Care Partnership

Following Greater Manchester's devolution deal, ambitious plans were developed to transform the Greater Manchester health and care system, focused around integration and moving more care out of hospital and into the community. Workforce transformation was identified as a key enabler for delivering these ambitions. The Greater Manchester Health and Social Care Partnership (GMHSCP) developed the health and social care workforce strategy in 2017, designed to address workforce issues across the ten localities in Greater Manchester, with the aim of achieving a resilient workforce that feels sufficiently motivated, supported, empowered and equipped to deliver safe and effective services, drive improvements and positively influence the health and wellbeing of the population.

The strategy identified four priority areas, including:

- talent development and system leadership, ensuring the system attracts and develops people and has the right kind of leadership across health and care
- growing their own, widening access to a range of roles by investing in training and development, employing apprentices and supporting work placements
- employment offer, promoting the region as an attractive place to work in health and social care
- filling difficult gaps in the workforce and addressing long term skills and role shortages through integrated and flexible ways of working.

The Greater Manchester workforce collaborative was created to support the delivery of the strategy. A core team has been established made up of colleagues from across GMHSCP and Health Education England (HEE), who alongside a steering group of key partners, work together to deliver the strategy. HEE and GMHSCP have agreed a memorandum

of understanding (MOU) to coordinate allocation of HEE resources to meet local needs, enabling the workforce collaborative to allocate £1.6m to initiatives associated with the delivery of the workforce strategy.

A broad variety of stakeholders support the successful delivery of the strategy, including HR directors in trusts and local authorities, organisational development and equality and diversity colleagues, as well as professional networks, trade unions, education providers and the private sector. Enabled by strong governance of the GM health and social care strategic workforce collaborative board, key partners discuss and shape decisions to reach collaborative agreements, and through a variety of different forums engage with a diverse range of stakeholders including a trade union forum, an education transformation group as well as the steering group bringing together arm's length bodies and support organisations. Stakeholders come together twice a year to provide input and ideas for the future direction of workforce collaborative, looking to put in place plans to build on the outcomes already achieved beyond 2021.

GMHSCP faced the challenge of encouraging partner organisations to look beyond their own workforce challenges and take a collaborative approach to solving system-wide workforce issues. In May 2018 GMHSCP also launched the *Workforce futures centre*, an online platform which acts as a one-stop-shop for workforce teams across Greater Manchester to access resources and best practice to support the delivery of their local workforce plans.

Workforce planning in a place

This complex landscape of system working has implications for how trust leaders and their partners build workforce strategies and plan for the future. With a move towards collaboration, working across traditional organisational boundaries, and building relationships across sectors and organisations, people working in the NHS are increasingly being asked to work in a collaborative way. If systems are to join up to deliver on shared goals, it is no longer sufficient for individual organisations to work and plan in siloes, and there is increasing recognition of the value of carrying out this work at a local level to ensure the makeup of the workforce marries up with population health needs.

STPs and ICSs are likely to become pivotal in this process. The people plan raises questions about what elements of workforce planning and development should take place nationally, regionally or locally. However, as system partnerships mature, they will be expected to take on additional responsibility for workforce planning across a larger population and across organisational boundaries, with oversight from the new regional directors.

This is often more easily done on smaller footprints at the level of 'place' within an STP/ICS, in conversations between local leaders about skills mix and numbers. This is best supported by local level data, and a culture in which leaders and staff at the frontline have an understanding about where their challenges fit in with the wider system and how they can best support and develop their staff.

CASE STUDY

Northumberland System

The Northumberland 'place' is part of the North Cumbria and Northeast ICS spanning a very large area across the north of England. Its constituent players are active within the ICS, as well as in the ICP arrangements across North of Tyne and Gateshead.

At 'place' level, Northumberland operates a system transformation board, chaired by the chief executive of Northumbria Healthcare NHS Foundation Trust, and over the past ten months has established a number of workstreams, including a workforce stream to help partners understand the specific challenges for Northumberland and progress workforce transformation at a place level.

The leader of this workstream engaged with the respective leads of each clinical and care component and with those directors responsible for workforce in individual organisations (including local council, clinical commissioning group, acute, mental health and ambulance providers) to identify what can be valuably carried out at a place-based level, without replicating work done by the ICS or merely aggregating up the work of individual providers.

The review raised some consistent themes across the providers and the system. This included the need to design and develop future workforce across the Northumberland-specific clinical and care pathways. Alongside this, partners were keen to model demand and capacity across the place so as to effectively plan for future workforce needs, factoring in the impact of new roles.

The importance of this is reinforced by the commitment for primary care networks to employ additional roles including clinical pharmacists, paramedics, social prescribers and physiotherapists. This has generated a need to think carefully about required pipelines, ensuring a joined-up approach which enables the workforce to grow without destabilising the system. Equally, recognition of how creation of new roles in health can potentially destabilise home care, and the tendency for job creation opportunities linked to economic regeneration to result in domiciliary and residential care workers leaving the sector for more attractive jobs elsewhere is critical. Creation of accessible and attractive career pathways are essential.

Another area identified as benefitting from place-based emphasis is recruitment. ICS approaches have proved very successful for junior doctors and are being extended to nurse recruitment. Recruitment campaigning is as much about selling local lifestyle as it is the job: being able to showcase Northumberland as part of this helps greatly to differentiate us as a great place to work, live and train. Additional place-based campaigns, building on individual partner initiatives could offer tailored and flexible opportunities for attracting staff, their partners and families into the area.

System partners also identified the value of culture and relationships, with the need for all to gain a better understanding of the working context and challenges of partners.

Breaking down siloes through job shadowing, co-location of teams, regular face-to-face interactions and more joint training will help.

System leadership clearly signalling the importance of day-to-day system-wide working is seen as key, allowing teams to continue to progress transformation efforts even when the system comes under pressure. Creating cross-system teams focused on transformation, or dual roles with partners buying into their authority to lead collaborative working can facilitate this.

This engagement work has culminated in a report and nine themes and recommendations which will be used to develop a place-based workforce strategy and priority objectives:

- our future workforce should be designed and developed across our local (Northumberland) clinical and care pathways and organisations
- workforce modelling is needed at local system level to identify gaps now and in the future, and to model proposed new workforce solutions to address these
- work with local schools and other education providers is key to developing attractive career pathways and our well-qualified workforce of the future
- systematic, proactive system-wide work is needed in some specific areas to secure adequate local workforce supply and ensure service stability
- there is an important place for system-wide training schemes and support
- Northumberland-specific approaches to recruitment should be maximised
- consideration should be given to opportunities for increased shared back office functions
- development of system leadership which supports a cultural shift to embrace concepts of integration, care closer to home and realistic medicine is crucial
- our use of technology should be an enabler currently, but will also significantly alter our workforce of the future.

Building relationships across sectors

One of the fundamental drivers of system working is the role of individual relationships in enabling collaborative working. Trust leaders have expressed mixed views about the need for legislative change to enable system working, but consistently agree on the importance of building strong, local working relationships regardless of what is happening at a national level. Many systems are therefore working to break down the siloes between social care, primary care, the provider sector, commissioners and local government.

The workforce has a key role to play in this at all levels of leadership and frontline service delivery. While good working relationships at the top of organisations are important in building a culture where collaboration is the norm, connections need to be formed at every level, including at the frontline. Cultural norms, ways of working and different lexicons may vary across sectors, and, as such, new ways of collaborative working may take time to bed in. Leaders have a substantial role to play in granting the workforce permission to work in a different way, and promoting the benefits of working across boundaries. While funding

pressures across the board may encourage system partners to retreat into their siloes, some systems have used these pressures as a burning platform to work in a different way.

Systems that have built strong relationships are often those where close working precedes formal STPs, and relies on a mutual understanding of system partners' different ways of working, lines of accountability and challenges. Practical measures like co-location of teams and active efforts from leaders to build bridges often have a significant effect.

CASE STUDY

Mid Yorkshire Hospitals NHS Trust

Work to integrate services across Wakefield has been underway for a number of years under the *Connecting care* programme and when the system received vanguard pilot status, a number of initiatives were implemented which enabled them to test new models of care. The work has involved numerous system partners, including Mid Yorkshire Hospitals NHS Trust, the CCG, Wakefield metropolitan district council (Wakefield MDC), Wakefield district housing and the third sector.

Challenges across the whole system were identified, both in terms of delayed transfers of care, and levels of unmet need. Older people were visiting A&E with a variety of social needs, not necessarily social care needs, and some admissions to care homes were often a result of family carers not being identified and supported in time. Incompatible IT systems made it difficult for organisations to share information, meaning people had to tell their story multiple times. System partners convened the Wakefield Integrated Care Partnership board, where chief executives and directors of health, social care and third sector organisations in the system make decisions in collaboration with one another.

As part of the work, system partners have adopted multi-disciplinary team working, with teams co-located in two hubs and a satellite location. Staff work closely across organisations, and this has been done without changing employment terms and conditions to avoid distracting staff from the core aim of integrating care and generating an unwarranted focus on structures. A significant contributor to the success of the initiative has been drawing on the mutual mission of striving to provide the local Wakefield population with the best care possible at the right time, in the right way and in the right place. It has also been important to ensure staff have a good understanding of what colleagues across the system do and the challenges that they face.

The system has implemented a virtual leadership team between Mid Yorkshire Hospitals NHS Trust community team and adult social care Wakefield MDC, working as if they are one organisation, and giving staff permission to work across boundaries. Co-location of teams has been an enabler of this as it facilitates face-to-face conversations and relationship building. The virtual leadership team aims to lead by example, and working closely as leaders in the system enables other staff to do the same.

The 'personal integrated care file' enables sharing of records, so that all partners involved in a person's care are working from the same basis, using the same electronic file to record information and make referrals, as well as follow up on outcomes.

Since the implementation of the system, all of the GP practices in Wakefield have joined the initiative and referrals are now received through one channel.

More system partners are expected to join the collaborative including Alzheimer's UK, West Yorkshire Fire and Rescue Service and Yorkshire Ambulance Service with a view to looking more widely to other organisations which support vulnerable people, at the prevention end of service delivery.

One of the challenges has been demonstrating impact and value for money. Evaluating the impact of work in community services is more challenging due to the lack of concrete activity data. However, emergency admissions have reduced in the context of a nationwide increase. An independent evaluation of an integrated community services programme gathered evidence that patients felt more positive about their care as a result.

System leaders feel that having been part of the vanguards programme has facilitated collaboration and formed a basis for future system work including broadening people's skill sets and the scope of people's roles. The trust and the local authority are now part of conversations about how primary care networks in the system should look, with a view to sharing expertise from its own model of care in connecting care.

Working with primary care networks

New and more integrated models of providing care present opportunities for realising the value of cross-sector working including between secondary and primary care. Trusts are pursuing a number of models to integrate services with primary care, including the development of primary care networks (PCNs), structural integration and partnerships with primary care at scale via federations and super partnerships.

Each of these models brings challenges and opportunities with regards to the local workforce. There are clear opportunities for multi disciplinary teams, more integrated care, and better use of NHS estate through the co-location of different services. There are also challenges to be overcome through close partnership working particularly to develop new career paths and to avoid any one service facing increased vacancies because partners are recruiting. This is a particular concern with regard to recruitment and retention of key roles as PCNs begin employing staff which have traditionally worked in trusts such as paramedics, physiotherapists and pharmacists, alongside social prescribing link workers and physicians' associates.

Many trusts are seeking to mitigate this risk, either through existing models or new ones. For example, ambulance trusts are seeking to promote the rotational model to develop their paramedic staff without sustaining a net loss to their workforce, while other trusts are lending their support to primary care networks to build a collaborative base for working in this new way.

CASE STUDY

Leeds Community Healthcare NHS Trust

Leeds Community Healthcare NHS Trust works closely with the Leeds GP Confederation, a membership organisation comprised of GP practices in Leeds and which exists for the benefit of its members, providing a unified voice for primary care in Leeds. The confederation and the trust share several roles, including the director of workforce, director of nursing, and medical director posts. This means that the post-holders for those roles sit on the boards of both organisations, facilitating joint working and the shift towards integrated care for the patients and communities of Leeds. In addition to this, the chief executives of the trust and the GP Confederation have a close working relationship and communicate regularly.

This joint working has been in development for several years, and before the NHS long term plan and the advent of PCNs, the Leeds GP Confederation and its predecessor organisations have been working alongside Leeds Community Healthcare Trust towards joint working and integrated care. The joint posts have been in operation for over a year to date.

The long term plan outlines plans for GP practices to join PCNs, which from July have had the opportunity to employ additional staff to support traditional primary care roles. These include community pharmacists, advanced paramedic practitioners, physiotherapists, and social prescribing link workers. It was evident from the work that the GP confederation undertook with PCNs that some needed support with the infrastructure necessary to employ staff – infrastructure which the Leeds Community Healthcare NHS Trust already had in place and could use to support PCNs.

The trust has made an offer to the PCNs in Leeds to be the employer of staff working for PCNs in these roles, handling HR functions such as payroll and employment contract – an employ and deploy offer. The PCNs will then determine how those staff will work and staff will be deployed and managed by PCNs locally and day-to-day, rather than the trust. This was agreed by the trust board within the context of the trust's long term vision to integrate care across primary and community services, contribute to joint working as well as ensuring the best use of resources.

The GP confederation and the trust led a workshop with leads from a number of interested PCNs in the system to begin to develop a service level agreement (SLA) to define how the employ and deploy model would work. The funding for the new mandated roles was released at the end of July, and work is well underway to begin recruiting to the first tranche of staff, community pharmacists. To date, five PCNs have taken up the Leeds Community

Healthcare NHS Trust employment offer with several already having appointed to their community pharmacist roles. At the time of writing, the trust with those PCNs are about to sign the SLA. It is hoped that this arrangement will create leverage for much closer working.

With 99 GP practices in Leeds, and multiple GPs working in each, a great deal of engagement across the Leeds system has been undertaken to gain buy in from the practices to facilitate this collaboration. Engendering understanding between the trust and the GP confederation as the voice of primary care in Leeds has been key within the context of differences in priorities and culture, given that GP practices are small businesses and function differently to an NHS trust. This has involved engagement with staff across primary care, supported by the chief executives of both organisations to broker communication with the relevant staff and build a shared understanding and vision to work from. There is always more work to do in this area both locally within Leeds, as well as the potential for national-level enablers to be put in place to facilitate collaborative working, including addressing the conflict between system working and organisation-level accountability for performance and finances.

Collaborating to support recruitment and retention

4

Recruitment and retention of staff in the NHS is an increasingly pressing challenge, with around 100,000 advertised vacancies and an NHS-wide nursing vacancy rate of around 11%.[4] With demand increasingly outstripping supply, NHS staff are working harder than ever. This has begun to take its toll, with NHS staff survey results reflecting the level of strain the workforce is under, and staff wellbeing and engagement declining – 57% of staff said they have gone to work despite feeling too unwell to perform their duties, and over two thirds feel there are not enough staff at their organisation for them to do their job properly.[5]

The interim NHS people plan sets out a strategy to tackle these issues, from developing a 'new offer' for NHS staff, to bolstering continuing professional development (CPD) funding and increasing the supply of newly qualified staff through higher education and alternative training routes. The government announced in the recent spending round that nurses would receive £1000 each over the next three years for CPD. Additionally, local systems are beginning to collaborate on developing an offer for staff to encourage them to join and stay in the system – using system working as an opportunity to create a more varied offer for staff, as well as joining forces to attract people to the system.

Creating a system as a place to work

A traditional workforce model encourages staff to develop a sense of belonging to a single organisation. System working now asks staff to think in a different way. Given the behaviour and cultural change this demands, system leaders are working to ensure it is underpinned by a sense of security and support to build the skills and relationships needed to work in this way. To maintain morale and engagement, systems need to create an environment in which working for a system or place enables the same degree of engagement, satisfaction and feeling of belonging for the workforce that organisation-based working offers.

This includes fostering a culture in which system working is the norm and leading by example, with close collaboration among senior staff in the system. Some trusts are working with partners to align terms and conditions to reduce local competition and streamline recruitment processes to support future potential flexible working arrangements. Others are collaborating to develop an offer for staff which promotes their system as a good place to work, regardless of the organisation they are working within.

Organisations with severe workforce challenges may struggle to collaborate on recruitment when faced with an urgent need to address their own staff shortages. In an environment in which an overall shortage of staff leaves trusts competing for an insufficient number of people to fill a growing number of vacancies, trusts are increasingly seeking efficient ways to join resources, both to bolster the local campaign to bring people into the system, but also to underpin future flexibility in ways of working. It is also a conduit for organisations to build relationships around a shared aim to increase the size of the workforce.

4 https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey

5 https://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2018-Results

In areas where shortages are concentrated – particularly rural areas – it isn't enough to incentivise people to join a trust as an employee. Promoting the NHS as a good employer also needs to be underpinned by work to promote the local area as a good place to live. Initiatives to promote the system as a place to work can act as a draw to then recruit staff into trusts in the local area, supported by joining resources and local knowledge to promote the benefits of living in a local area – something a national or even regional campaign cannot reliably do for every part of the country without the intimate familiarity with places held by those working and living in them day-to-day.

Not only are trusts looking at ways of working within their STP or ICS to draw people into their patch, they are also increasingly looking to work alongside local education institutions including colleges and schools to promote local employment and contribute to increasing opportunities for young people in their local area, where there is demonstrable evidence that doing so improves retention.

CASE STUDY

Cambridgeshire and Peterborough STP

In the Cambridgeshire and Peterborough STP, the system partners work as a system delivery unit to support workforce related projects at a system level. The system developed a memorandum of understanding (MOU) to enable staff to work flexibly across the system. Members of staff are employed by their own trust, but the MOU enables mutual recognition of staff credentials and assurance of skill and competence, removing some of the barriers to sharing resource and staff passporting.

In support of a system-wide approach to recruitment and resource, the STP has developed a system-wide branding and attraction project across health and social care, to attract staff to work in the system and place, rather than simply one organisation. Borne out of recognition of the need to reduce competition between local employers and combine forces to attract people to the area, in a truly collaborative way, system partners developed a promotional film and microsite,[6] illustrating the benefits of coming to work in Cambridgeshire and Peterborough in health and social care. This project was launched publicly in a shopping centre in Peterborough to raise awareness of the campaign.

The STP has also done extensive work around collaboration on apprenticeships. Currently reinvigorating the widening participation agenda, trusts in the region have agreed to implement an apprenticeship collaborative to maximise levy spend, including increasing access to levy funds by employers who don't currently pay it. This has included jointly running recruitment events in the system, and linking up workforce planning colleagues to identify and address recruitment hotspots for specific roles, in particular radiographers. System partners recognise the value of the apprenticeship levy and apprenticeships themselves, and the initiative to work collaboratively across the system aims to maximise the opportunities while tackling some of the complexities of using the levy in full.

6 https://itsallcomingtogether.jobs

All system partners are engaged actively in plans to ensure a whole system recruitment week to coincide with national apprenticeship week in early 2020, offering a range of exciting events to schools, colleges and the wider public, to promote the region and diversity of careers on offer.

CASE STUDY

Greater Manchester Health and Social Care Partnership

The Greater Manchester Workforce Collaborative is developing an employment offer, promoting Greater Manchester as an attractive place to work to support recruitment and retention in the region.

More than 30 public sector employers across Greater Manchester signed up to a continuous service commitment where staff can keep their service related benefits such as annual leave entitlement sick pay and maternity schemes when they move between organisations which have adopted the commitment, to enable flexibility to move between organisations.

There have also been over 5,000 public sector apprenticeship starts since the introduction of the apprenticeship levy in 2017 and this is rising, with 20% more starts in 2018/19 compared with the previous year. Four local authorities and three trusts have met the 2.3% public sector apprenticeship target during this period.

The system has developed a more coordinated approach to apprenticeships, resulting in four times as many individuals undertaking apprenticeships in the year to March 2018. The work included a public sector network to share good practice and discuss opportunities for collaboration across the system, carrying out joint tendering across boundaries to improve negotiating apprenticeship training contracts and offer a more varied experience for learners, and an MOU to agree that Greater Manchester's public sector organisations will pay the national living wage for all apprentices.

A Greater Manchester-wide career and jobs fair in April 2019 for general practice, pharmacy, dentistry and optometry engaged 300 members of the public and over 40 exhibitors from a wide range of sectors connected to primary care.

A joint recruitment campaign across Greater Manchester in June 2018, *Be a Greater Manchester nurse*, brought together trusts, GP practices and the independent care sector to promote Greater Manchester as a place to study and work as a nurse. This formed part of the wider nurse incentives programme which was developed to reshape the support nurses receive in the area, including a guaranteed employment scheme for nurses who complete their studies in Greater Manchester. This programme is system led and by the Greater Manchester project management office (nursing, midwifery and allied health professionals) hosted at Manchester University NHS Foundation Trust.

Through the work of the Greater Manchester project management office (nursing, midwifery and allied health professionals), Greater Manchester saw a 3% increase in the number of pre-registration students starting nursing programmes in the academic year 2017/18 compared with 2016/17, in the context of a 6% fall in starters nationally.

Enabling staff to work across the system

In a climate of severe workforce pressures, and where there is an overall shortage in many professional groups, trusts can find themselves competing locally to recruit and retain staff. Incentives for staff to come and work in one trust may disadvantage another nearby. Trusts are cognisant of the local system dynamics of recruitment and retention that make filling workforce gaps a process of give and take between organisations competing for the same insufficient supply of staff.

While collaborating on recruitment and retention is one way to help trusts reduce unhelpful competition for staff, flexible working within systems through passporting arrangements, shared staff banks, or enabling staff to develop portfolio careers, are some of the ways trusts are working with their partners to take a system-wide view of what the workforce needs are and how they can be met with existing resources.

With increasing flexibility of roles, there is also an opportunity for staff to develop 'portfolio' careers, moving between roles and sectors where initiatives such as staff passporting arrangements allow staff to move from one organisation to another without changing employers. This enables staff to develop a wide range of skills and experiences, which benefits their experience of working in the NHS, but also enriches the skill mix of the workforce, and supports cross-sector relationships. There is potential for closer working to either help fill rota gaps or lessen their impact.

CASE STUDY

South London Mental Health and Community Partnership[7]

South London Partnership's (SLP) three trusts – Oxleas NHS Foundation Trust, South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS trust, looked to improve career and development opportunities and working environments for clinical staff as part of its nursing development programme.

Staff moving to new permanent roles or secondments in different trusts faced a long wait and delayed start to their new role, and so were not motivated to stay within SLP trusts. The time taken to fill posts can affect care continuity and become costly with agency cover often required. The partnership aimed to offer staff flexibility to move easily, quickly and promote the trusts as attractive employers.

7 https://improvement.nhs.uk/documents/3442/15-SLPEmployment_Passport_clc16102018-Innovation_ed.pdf

The partnership developed an 'employment passport', which allowed staff to move between trusts easily. Several processes were redesigned as part of the work, including:

- Pre-employment checks – confirmation that they have been completed by the original employing trust, and are clear with the individual approved to work. Trusts retain their own approaches to managing anomalies safely.
- Mandatory and statutory training – common areas do not need to be repeated providing the training is current, regardless of variations in delivery, and additional courses are only required where training is out of date or specific to the new employer.
- Appraisals and development records – individuals are invited to share records of their performance appraisal and development review with their new employer to continue their development path. The nursing development programme has introduced a shared career ladder for band 2 to 6 nurses across the trusts.

Ensuring safety throughout the recruitment process was essential. Each trust remains responsible for providing a safe workplace and the passport does not override this. It provides an alternative streamlined process for most transfers between SLP trusts. Variation in mandatory and statutory training was a challenge, for example only one trust has a mandatory smoking cessation course. It was not manageable to harmonise each course and so a more pragmatic approach was taken which respects each trust's individual position.

Staff can now move across trusts into new jobs or secondments up to 75% more quickly and initial evidence suggests it is effective for trusts to move quickly between trusts. While the passport was originally aimed at nurses, other clinical and non-clinical groups have benefited.

Learning points include the importance of senior management's support, and a culture that is positive about change. Ongoing work helps ensure managers understand that the passport does not devalue previous checks, and SLP will continue to review the initiative.

CASE STUDY

West Yorkshire Association of Acute Trusts

West Yorkshire Association of Acute Trusts (WYAAT) is a collaboration of six acute trusts in the West Yorkshire and Harrogate ICS, Airedale NHS Foundation Trust, Bradford Teaching Hospitals NHS Foundation Trust, Calderdale and Huddersfield NHS Foundation Trust, Harrogate and District NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust and Mid Yorkshire Hospitals NHS Trust, that are working together on behalf of patients to deliver the best possible experience and outcomes. Their philosophy is that WYAAT is the combination of the trusts not a separate organisation and have been working together to make decisions for the benefit of the system, and to remove barriers to flexibility for staff to move around the system. Work has included developing collaborative arrangements for staff passporting, standardised job descriptions and a shared medical staff bank.

The hospitals have developed a portability agreement, which will form part of the NHS Improvement staff portability toolkit.[8] In particular, the trusts are currently looking to enable flexible working across pathology and vascular services, but all clinical services have embraced the agreement immediately improving patient care.

In support of this work, the trusts working across the ICS have also undertaken work to standardise job descriptions. After learning that there were 27 job descriptions available in the system for a single role, they carried out analysis of the similarities, differences and language across the descriptions, and created a standard description using the commonalities, adding an addendum of specialist duties as necessary. The system is now looking at how staff in existing roles can be moved over to the new job descriptions, supported by extensive conversations and moving slowly and testing as they go to enable staff to feel confident in the process.

While moving money around the system and sharing staff rosters was uncomplicated, there were challenges around liability to address. Staff remain employed with a host organisation and as part of a portability agreement there was a need for a degree of trust in other organisations' hiring, disciplinary and performance management processes. This was achieved by a focus on normalising collaboration, and sharing and learning from one another in order to build relationships. Underpinning this is ground work to develop the culture and behaviours needed to help people understand the role they play in forming a system, so that they do not feel like change is being forced upon them, and they can feel empowered to be part of it.

The system is now on a good trajectory, with a culture in which organisations work on the principle that it is better to do something together once, rather than do it individually six times. While the environment of competition has meant that people working in the system have often felt isolated, enabling people to spend time with their peers gives them an opportunity to tackle challenges and leads to a sense of energy.

Working together to fill rota gaps

Trusts are increasingly seeking to collaborate on staff banks, both to reduce agency spending and to share resources. The vast majority of trusts use staff banks, and in some STPs and ICSs trusts are connecting their staff banks, giving staff more flexibility, making more effective use of workforce capacity across the system, and reducing agency spend across trusts by increasing the fill rate via bank.

Trusts using shared staff banks describe the benefits of developing a system-wide overview of rota gaps and bank staff availability. Models such as these can help reduce duplication of induction, employment checks and occupational health checks across trusts, and supply more robust information about the working patterns of staff who may otherwise be signed up to banks across multiple trusts as well as employed in a substantive post in one trust.

8 https://improvement.nhs.uk/resources/enabling-staff-movement-toolkit

CASE STUDY

Rotherham NHS Foundation Trust

Within the South Yorkshire and Bassetlaw ICS (SYB ICS), trusts have come together to develop a shared nursing/non-medical staff bank as well as piloting of a medical collaborative bank.

The six acute trusts in the ICS delivered a collaborative recruitment exercise for nursing/non-medical bank and agency cascade service in 2018. This led to NHS Professionals being appointed as strategic partner. Subsequently the trusts have also implemented collaborative bank model *Bankshare*, as well as supporting increased agency control and reducing unwarranted variation in processes.

The trusts have agreed not to employ staff members through an agency if they already hold a substantive post at one of the partner organisations, instead using only the collaborative staff bank. This will have the effect of enabling greater visibility of how many hours staff are working, and reducing both overall agency spend, and off-framework agency usage.

The medical bank pilot has been taken forward by four of the trusts in SYB ICS supported by a common master vendor agency, Holt Partners Ltd. This has been in place since May 2018 with an evaluation underway to inform ongoing participation and wider engagement across the system.

Challenges included the move from a competitive agenda to a more collaborative environment. Workforce is a key issue in terms of collaboration, due to the limited supply of staff in relation to the number of vacant posts. In a competitive environment, there are fewer incentives to take a system view of workforce supply, and trusts compete for staff. Building organisational readiness to collaborate is underpinned by effective system level governance, a focus on relationships and programme facilitation.

Collaborative banks depend on the alignment of systems and processes between the trusts involved. This includes skills and training requirements for staff across trusts, rates of pay, terms and conditions and role descriptions, and the larger the group of trusts using the shared bank, the more time it can take. Trusts implementing this model often describe working in phases, starting with a few neighbouring trusts before engaging more widely across a region with multiple sectors.

CASE STUDY

Royal Wolverhampton NHS Trust

The Royal Wolverhampton NHS Trust, part of the Black Country and West Birmingham STP, has collaborated with trusts across the system on exploring options for a joint staff bank, which aims to enable staff to work more flexibly across the system.

They are looking to develop a collaborative nursing staff bank in three tiers, working locally with Walsall Healthcare NHS trust as the first tier, reaching out more widely to HR directors across the Black Country to develop a proposal for a system-wide bank. The trust is working across the West Midlands, as the third tier, to explore the potential of a medical staff bank. The local, system and regional approach has made varying levels of progress and the trust has found it easier to progress a smaller scale collaborative bank in the first instance than the medical staff bank across the region.

Building relationships and trust within the system has been a key enabler, as creating any form of joint staff bank requires trusts to be comfortable with letting staff go to other trusts in light of their own workforce pressures, as well as a need to trust the recruitment processes of other trusts and the qualifications of their staff. The work has progressed through slowly building relationships and developing people's thinking and readiness, rather than making bold moves from the top down.

Some of the considerations include variation in the rates trusts pay for bank shifts, as well as the different systems for rostering the trusts are using, especially given the financial burden of purchasing a new system. Different models of care also add to the level of complexity of sharing staff between organisations. With different levels of vacancies and workforce pressures, the incentives to collaborate on workforce initiatives vary and garnering the political will to engage is more challenging.

Trust leaders feel that system-wide regulation may support the progress of system working. The trust has reduced its own turnover, but is conscious that this has potentially happened in part at the expense of other trusts whose staff have moved to the Royal Wolverhampton NHS Trust. Measuring trusts' performance as part of the system was felt to be a potential incentive to progress system working and reduce the need for organisations to focus inwards.

Joint efforts to train and develop staff

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In many systems, efforts are underway to grow the workforce locally, provide training opportunities for people to develop their skills, and, where staff passporting and joint banks are being used, align training and development for staff in similar roles. Integration offers members of staff an opportunity to build a 'portfolio' career or gain a broader range of skills, and with this comes a need to ensure the workforce across the system has skills and knowledge that are compatible with this way of working.

One way systems are working in a more joined up way on staff training is through apprenticeships, a model of recruiting and training new staff well suited to a place-based approach to building the workforce according to local needs. In STPs and ICSs, the largest employers with pay bills over £3m per year pay the apprenticeship levy. They can use this levy to fund the training costs of apprenticeships.

There are flexibilities to either use the levy, or share 25% of it with other, smaller, employers in the system. Trusts which cannot always use their levy contribution in full themselves are working with smaller employers in their STPs/ICSs to make use of a larger proportion of the funding without incurring the additional costs associated with training an apprentice, giving smaller employers access to funding to grow their workforce through this model. Sharing funding for training in this way comes with an opportunity to discuss system-wide workforce priorities, including what skills gaps can be addressed through training apprentices.

CASE STUDY

Staffordshire and Stoke-on-Trent STP

The Staffordshire and Stoke-on-Trent workforce programme team has been in place for just over 12 months and fosters system-wide, collaborative working to deliver the NHS long term plan and interim people plan workforce aspirations and address the local workforce challenges. The team have made significant progress in taking actions to address the workforce challenge within Staffordshire and Stoke-on-Trent. The programme has delivered both on savings to the system and workforce solutions, proving value for money in the investment in the team. The majority of the success has been delivered via fostering positive relationships with system colleagues, thinking creatively about potential solutions and supporting providers to challenge 'the norm' in regards to career pathways/collaboration.

The health and care graduate scheme which is unique to Staffordshire and Stoke-on-Trent STP, was developed by the workforce programme in collaboration with system partners to increase supply of young people choosing the health and care sector. The sector has traditionally had limited success in attracting young people directly from college as our registered careers required them to do A-levels and go to university (and pay fees). Young people are increasingly opting for vocational qualifications rather than A-levels due to concerns about future job availability. Therefore, the workforce team developed the scheme to allow young people to start straight out of college, earn while they learn without accruing course fees, and experience a rotation between sectors which will allow them to make the right choice for registered professional route. Fourteen outstanding candidates have now been appointed and will carry out five placements over a three-year period, including adult

community, acute mental health, community mental health and learning disabilities, primary care (including care home and domiciliary care experience) and social care. The candidates will also spend time in A&E, therapies and the ambulance trust as part of their placements, while carrying out level 2 and 3 apprenticeships diploma in health.

In the first scheme of its kind regionally, the workforce programme has developed and delivered a process enabling system-wide unspent apprenticeship levy monies to be shared with non-levy paying employers. This has resulted in an additional 120 apprenticeships being delivered within Staffordshire and Stoke-on-Trent in organisations such as domiciliary care agencies, care homes, nursing homes and GP practices. The second phase of applications is out to the system currently and an ongoing utilisation process in development.

In partnership, NHS, non-NHS and education providers have developed a one-year rotational apprenticeship programme for the end of life pathway. Ten candidates have been appointed to the level 2 scheme and will rotate between adult community health, hospice, nursing home and acute services to gain a rounded experience of the pathway. It is envisaged that these young people will then apply for level 3 apprenticeships within the sector.

The retention of staff is a key issue for Staffordshire and Stoke-on-Trent providers. They know there is no single action that will resolve staff retention issues – retaining staff is a result of the combined actions that are taken by organisations. Therefore the workforce programme has developed a retention framework in partnership with STP partners. The aim of this framework is to provide various solutions and tools which may be adopted by organisations within the Staffordshire STP. Tools include online resources, 'itchy feet' conversations and 'transfer window' process. Partners are currently collaborating on tackling other big issues including retirement, flexible working, and career coaching.

The workforce programme hosts a central redeployment service which is offered to NHS partners within the STP. Working with HR teams and 'at risk' staff to ensure that they are offered opportunities from all host organisations prior to job advertisement, the team have saved £4m of potential redundancy costs and successfully redeployed 158 people to date. Based on the fostering of strong relationships and processes established with existing partners, the team are currently working with other STPs and NHS organisations outside the Staffordshire footprint and non-NHS partners to extend the service.

The team have recently designed and developed a website which includes a 'talent academy' and 'new horizons hub' in collaboration with system partners. Its primary aim is to create a single point of access for information and advice on organisations in our sector, training and education available, support in navigating careers and opportunities within the system in order to attract and retain the workforce in Staffordshire and Stoke-on-Trent. In creating this hub for retention, career advice and widening participation activity, interest in the sectors is streamed accordingly and creates capacity within already stretched organisational resources.

The programme is clear on the next steps required to further progress and plans are already in place to scale and spread initial successes.

6 Final reflections

Trusts are generally positive about the benefits of system working, and keen to progress integration. The case studies in this report demonstrate the innovative and bold approaches trusts are taking to system-wide workforce development. Many describe a burning platform on which to act, others recognise the value of working towards shared goals to improve the health of the population.

Across the country, trusts are contributing to diverse approaches to workforce planning during this time of transformation, using system working to create a better offer to support, develop and retain NHS staff, and ensure staff are deployed as effectively as possible in support of a local population's needs.

Strong relationships are clearly an enabler of this. These case studies show that bringing leaders across the system together on shared ambitions for health and care makes it possible to act. Trust leaders have highlighted the importance of bringing frontline staff on the journey, and enabling them to get to know their counterparts in other organisations underpinned by a culture which promotes collaboration.

However, system working itself has not proven to be straightforward. Challenges have arisen in terms of relationships, governance, finance and regulation. In some systems this has hampered progress, whereas others have developed at a faster rate. This has had implications for how systems have progressed workforce initiatives particularly where workforce shortages may encourage organisations to focus on day-to-day challenges.

While it is clear that each STP/ICS is on an individual journey, trusts and their partners are expected to make rapid progress towards integrated working. Workforce planning has a substantial role to play in driving the progress of system working. How we work with our valued workforce to enable closer relationships between trusts and other health and care organisations, and how we support members of staff throughout periods of change and transformation, will be an important determinant of how well system partners can work in collaboration.

Your feedback on this briefing is very welcome. For any comments or questions please contact
leanora.volpe@nhsproviders.org

For more information:
www.nhsproviders.org/a-place-to-work

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