South Yorkshire and Bassetlaw Shadow Integrated Care System
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23 March 2018

Professor Cumming OBE
Chief Executive
Health Education England
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Duncombe Street
Leeds
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Dear Professor Cumming OBE,

1. We are grateful for the opportunity to comment on the draft **Workforce Strategy - Facing the Facts, Shaping the Future**. The attached response includes:

    a. our overview on some major points which need to be considered
    b. summary of the findings of our own work in summer 2017
    c. our response to your specific questions
    d. a copy our own Workforce Framework which we developed on summer 2017 which covers much of the same ground and which we are sure you will find helpful

Background

2. In putting this response together, we have consulted widely across the 'patch' and we also did a comprehensive piece of 'strategy' work led by our Local Workforce Action Board (LWAB). This is response, therefore, represents a summary of views and ideas. Individual SYB organisations may have sent their own responses in parallel.

3. As you will appreciate South Yorkshire and Bassetlaw is one of the leading groups who are developing as an Integrated Care System (ICS). We comprise 5 'places' and we directly employ over 48,000 staff who give care and treatment to meet the needs of 1.5 million people. Many more people work in health and care in our area employed through small scale private sector providers in social care, the voluntary sector and as volunteers.

4. As a leading ICS, we fully appreciate the importance of our workforce locally; we see it as **the key enabler** to help us answer the quality, efficiency and safety challenges and improving the patient and service user experience. We think it is a good thing that workforce is also now attracting national level attention through this strategy and in other ways and we hope this leads to some concrete action to improve coherence and resource flow to support ICS/STP development and work on front line development.

Major Points

5. Some major points we'd like to make in overview are:

    a. **Strategic Alignment** – clear strategic alignment will be essential in the final version of the strategy. We should ensure that the business goals of health and care are underpinned by a clear ambition, direction, and work programme for the workforce. If our overall goals are about integrated and high-quality services our approach to workforce, from planning demand to supporting retirement, need to be suitably aligned.

    We recognise the existing document *'. is unashamedly broad in its inclusiveness …. And detail …'* but the final document could be helpfully more directive and focussed on what the priorities are, what needs to happen, when, and to assign responsibilities for delivery. Being clear on purpose – what are the business goals we are trying to achieve – will be important. This in turn should guide clear workforce priorities.

    b. **Fragmentation** – following on from a) above, we think that the workforce landscape, particularly at national level is fragmented and, therefore, potentially duplicative, and wasteful and can hard to access for support. The diagram on page 17 is a helpful start on mapping some of this but this strategy provides a real opportunity to review roles and responsibilities and provide an 'umbrella' under which (at the very least) we can assign clear strategic roles deliverables to ALBs (HEE, BSA, NHSE, NHSI etc etc) and other national bodies such as NHS Employer, Skills for Care etc all of whom receive public funding support.

    c. **Workforce Resources** – whilst we appreciate that there are some things which are best done at scale and at a national level, we do think there is also an opportunity presented by this strategy to review what resource responsibility could be delegated to ICS/STP level to ensure greater localisation of budgets and resource management, e.g. on commissioning of clinical training places or initiative/pilot monies for trialling new ways of working. We should ask the question about

        i. what <u>needs</u> doing nationally,
        ii. what <u>could</u> be done at STP/ICS level
        iii. what <u>should</u> be done at local organisational level.

We have already taken the decision in SYB to establish our own Workforce Hub, which working under the oversight of LWAB, will take a lead on workforce issues locally. This model is likely to be welcomed by other ICS/STP areas also but will need support resource.

d. **Planning for the future not the past** – much of the current strategy and the workforce infrastructure is based on the past way of organising things from organisational structures to service delivery models. This strategy is a real opportunity to look ahead and organise based on STPs/ICS as planning vehicles, building better more integrated community-based services and capacity, and concentrating acute sector services appropriately. So how are we training the highly skilled community and social care nurses we might need in the future? How are curricula being adapted now to prepare our staff for the future?

   'Double running and transition costs' – if ICS/STPs are to effect real and last service changes from one model of delivery to another, then there will be periods of 'double running' or 'transition' required. Given that much of the cost will be workforce cost, this needs to be factored in to planning and resourcing decisions. For example, if our ambitions are to run more services in primary, community and social care settings then we need to invest in building capacity in those areas as a dependency on being able to move services from other settings.

e. **Management Data and data burden** – good quality data is essential for making good quality management decisions and for predicting future patterns, trends, and outcomes. When we developed our own strategic framework in the summer we found data sources to be mixed both in terms of the data quality and completeness and often caveated with accuracy warnings and at odds with local organisation data. This meant it was hard to make any clear managerial judgements from the Management Information (MI) available.

   Our own Workforce Hub will try and take pre-existing data and triage it with (qualitative) intelligence from employers. In this way we are hopeful that we can make informed decisions about priorities.

   Often systems are established for specific purposes or collections made by one organisation for its own reasons. This can be duplicative of effort and burdensome on front line providers (disproportionately for small providers). Existing systems include workforce planning, ESR and some attached payroll, NHS Pensions, NHS Jobs, National Minimum Workforce Data Set (Social care) and so on. An urgent review of data sources and how they can become '*Management Information*' to support front line decision making would be helpful.

f. **Social Care** – the social care workforce has some huge challenges with recruitment and retention. Turnover is high, pay levels are low and there is a constant battle to recruit and retain care assistants (inc domiciliary care), registered managers and social care nurses. It is essential that this capacity grows, and that staff are appropriately developed for a career in the sector as opposed to just 'jobs'. This should include investment in digital skills also.

   We also note that DH recently launched a consultation on social care workforce strategy and wonder why this is separate if our goal is to be integrated?

g. **Mental Health** - The need to train staff to understand Parity of Esteem and how they personally impact on the interplay between physical and mental health conditions should be an expectation across the wider NHS. Each professional body, group and organisation should ensure this is a key professional expectation. Training on prevention and early intervention and an ability to recognise the interplay between physical health and mental health should be built into the skill development of all professionals. Embedding mental health professionals into MDTs is a vital step towards integrating a holistic mental and physical health approach within primary and secondary care.

   Staff must also have the support to look after their own mental and physical health. All staff with staff management responsibilities should receive mandatory Mental Health First Aid evidenced based training. The Mental Health sector will be working to achieve 6,000 FTE staff retention savings by 2020, and all mental health trusts will be required to produce detailed improvement programmes on how they plan to address their high leaver rates. This strategy should acknowledge the reasons why people leave the sector: lack of historical investment in mental health services compared to other areas; one of the most pressured environments; and resources which don't match demands. The decline in mental health, community and learning disabilities nursing numbers is of huge concern and needs urgent attention.

South Yorkshire and Bassetlaw – The Workforce Framework

6. In 2017, SYB ICS undertook work to identify the local work force challenges and provide recommendations for the way forward. These are summarised in the table below – further full detail is available in the full framework. This work was inclusive and involved a range of stakeholders including senior managers and senior clinicians, HR Directors amongst other.

7. As well as looking at the generic workforce challenges across the board, the work also looked at each service workstream in the STP/ICS and place and identified the workforce issues in each.

South Yorkshire and Bassetlaw – The Workforce Framework

1. **Local Workforce Action Board (LWAB) –** has established work programmes which focus on building capacity in Primary Care, the Excellence Centre leads work to recruit and retain the non-registered workforce and apprentices and, the Faculty of Advanced Practice which aims to develop further clinical support capacity through Advanced Practice roles. These need to be set-up formally as work programmes on behalf of the ACS/ACP with resources and demand led targets.

   LWAB should be confirmed as the executive leadership function on behalf of SYB ACS and its existing and new work programmes should be actively supported as central planks in the delivery of the region's workforce strategy.

2. **SYB ACS Clinical Service Programmes** – whilst many are at the early stages of development, all recognise workforce as a key enabler to the delivery of success and are starting to outline the workforce requirements and challenges. They should be encouraged to develop clear workforce plans.

3. **Place Based Accountable Care Partnership (ACPs) and Organisational Level –** there is already a lot of work underway in 'places' and in individual organisations which aims to tackle the workforce challenges of recruitment and retention and developing skills of the future. This includes increasing collaboration between health organisations and local authorities.

   Each 'Place' should develop a local workforce plan/strategy which addresses the specific needs of the locality (Accountable Care Partnership (ACP)) in health and care, including any specific recruitment or retention needs of employers in the area. These strategies should align with the wider ACS clinical and workforce priorities and take account of neighbouring ACP plans/strategies.

4. **ICS/LWAB Workforce Intelligence Function -** LWAB and the system more widely needs to be supported by a 'Workforce Intelligence Function' which is employer led and which has an overview of the workforce supply and demand intelligence. This function should have a problem solving and initiating role on behalf of the system, leading responses to identified challenges and, crucially, supporting ICS clinical programmes to develop workforce strategies. Its role needs to be developed and it will need resourcing.

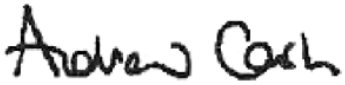
5. **Efficiency -** there is a need to build on the existing streamlining work to enable appropriate functions to be delivered at regional level on behalf of constituent organisations e.g. recruitment campaigns, support functions, systems procurement.

6. Given that the **primary, community and social care workforces** are crucial to the delivery of ICS ambition, greater emphasis and investment is required in this these critical areas. Investment here will ultimately be more cost effective and higher quality care across the system and is a critical dependency for the delivery of many other ambitions.

7. **Retention -** Specifically, at organisational and place levels, there is a need to focus on retention best practice to ensure the existing workforce is retained and developed. Linked to this, and to ensure flexibility, it may be appropriate to consider flexible employment models which enable workforce mobility

and development across the local health and care workforce economy.

Yours sincerely



Sir Andrew Cash
SYB Shadow ICS Lead

Annex A

HEE Consultation questions:

1. **<u>Do you support the six principles proposed to support better workforce planning; and, in particular, aligning financial, policy, best practice and service planning in the future?</u> Areas to explore may include:**

• What more can be done to help staff work across organisations and sectors more easily?

• What data do we need to ensure we can plan effectively, and how do we align across workforce, finance and service planning?

• For what sort of measures/plans/proposals should the Workforce Impact Assessment be used?

The 6 Principles – the 6 principles are good and capture all the key workforce themes, though they don't seem to touch social care employers explicitly. This needs to be considered. They are generic workforce themes or organising principles and arguably need to be more focussed and linked to the purpose (the so what) of the strategy (assuming the strategy is explicitly linked to achieving business goals as per 5a) of our general narrative.

We would strongly endorse the need to align finance, service, and workforce planning. Workforce is THE most expensive part of running a service and so for it not be considered as an integral part does not make sense. In some cases, we have seen service plans developed first and workforce implications added later and in others we have seen service plans driven by workforce shortages or workforce availability. Neither is right. Care Group based workforce planning at national level has worked well in the past and is a possibility going forwards

Workforce Impact Assessments should be more standardised in their usage. This should start at national policy level in DH and NHS England.

We support joint training and development opportunities across health and social care, and across mental and physical health services. Joint training and development and short-term secondments along with opportunities to 'rotate' between roles. In addition, placements and rotations across MH provision and physical health provision at the start of any placement (e.g. junior doctors on acute wards). This approach should also be applied to General Practitioners during their training period.

2. **<u>What measures are needed to secure the staff the system needs for the future; and how can actions already under way be made more effective?</u> Areas to explore may include:**

• Are there fresh ideas for attracting more people to work in the NHS, either as new recruits or returners?

• What scope is there to extend workforce flexibility using ideas such as credentialing, transferable qualifications, scope of practice and others?

Retention and vacancies – many areas are experiencing vacancies with different staff groups including: general and specialist nurses, middle grade doctors and consultants in many specialties, GPs, social care nurses, mental health support staff and so on. (See our local assessment). Recruitment is obviously one way of resolving this, but a far more cost-effective way is via ***retention*** *mechanisms and we think that the strategy needs to focus more strongly in this area and help provide national level support and locally adaptable tools. Retention, retention, retention!*

Why do people stay? The answer to this leads to modern employment practice, being treated well at work, being engaged, and involved in decision making, having a career path, supported training. It means having managers who are good at what they do managerially and who get the best out of people; it also means being flexible with employment patterns to help people stay and balance their individual needs. Don't underestimate our public service values and ethos which are very strong, but equally don't stretch goodwill based on it too far.

We also need a wider than traditional view about people's careers. If they leave one employer to join a different health and care employer, this is not an overall loss to the system and perhaps if we understood why they wanted to move we might be able to offer it and retain them. We were struck by stories of paramedics who wanted primary care experience and left accordingly and once the local ambulance service realised this they put in place a rotational arrangement which meant the paramedics didn't need to leave to gain the experience.

Flexible employment models are becoming increasingly crucial if we are to enable flexible deployment of the workforce across traditional boundaries in a world where STPs/ICS. What are these technical employment models which enable the movement between organisations without necessarily having to give up employment with one employer to take up employment with another NHS (or social care) employer?

In building our mental health workforce we might consider the targeted recruitment of psychology graduates who achieve below a First-Class Honours Degree in their

undergraduate degrees who are then unlikely in a competitive market to secure psychology assistant posts in order to go onto to Clinical Psychology training. This is an untapped resource and lost skill base. New bespoke roles could be developed which provide attractive development opportunities for both psychology and other graduates wishing to pursue a career in the NHS.

3. <u>How can we ensure the system more effectively trains, educates and invests in the new and current workforce</u>? Areas to explore may include:

• Are there any specific areas of curricula change or new techniques such as gamification or new cross cutting subjects like leadership, public health or quality improvement science taught to all clinicians?

• How does the system ensure it spends what is needed on individual CPD and gets the most effective outcomes from it?

Strategic Alignment – clear strategic alignment will be essential in the final version of the strategy. We should ensure that the business goals of health and care are underpinned by a clear ambition, direction, and work programme for the workforce. If our overall goals are about integrated and high-quality services our approach to workforce, from planning demand through training to supporting retirement, need to be suitably aligned.

So, we need to be planning for future service models and this strategy is a real opportunity to look ahead and organise, train, and prepare the workforce for a system based on STPs/ICS as the 'new' planning vehicles, building better more integrated community-based services/capacity, and concentrating acute sector services appropriately. This will impact virtually every curriculum going forward but there is a real danger that even by the time we start to make the changes it could be too late given the lead times involved. These changes will be in part about behaviours and attitudes of key staff groups and members and, therefore, this new system thinking needs to be built into training as a priority. All clinical training should include some element of system specific training, by which we mean the interaction between physical and mental healthcare, secondary and primary care and health and social care.

Advanced Communication skills should be taught to all front line clinical staff: (e.g. the use of simple augmentative communication tools) linked to the Accessible Communication Standards.

Digital Skills – digital skills are obviously of increasing importance both in terms of high end technical health care developments but also in managing routine business such as record keeping (and sharing) and patient and drug administration. We need to be skilling

our staff to be ahead of and not behind this curve and, therefore, the strategy needs to major on this area.

4. **<u>What more can be done to ensure all staff, starting from the lowest paid, see a valid and attractive career in the NHS, with identifiable paths and multiple points of entry and choice?</u> Areas to explore may include:**

• What more can be done to create careers not jobs for all staff, regardless of qualifications, entry level and current skills?

• What reforms are required to medical education and training to deliver the doctors the system needs in the future but also supports the needs of the system now?

A clear simple to understand career ladder which spans health and care will help. It should cover all the pay bands and include (and normalise) the Assistant Practitioner and Advanced Practitioner roles. It needs to be used uniformly and recognised as the only "ladder" / "framework" and should be discussed consistently.

Being valued and having opportunities to progress and develop are essential flexible working practices/ career breaks/ sabbaticals/ personal development opportunities/ good employment policies and practices. Having opportunities for short experiential learning based secondments/ job swaps across primary, secondary and community physical and mental health services. Ensuring that all roles in the NHS have a demonstrable career structure, with opportunities provided to enhance individuals skill base (i.e. on-the-job professional qualifications).

There is a need for a greater focus on apprenticeships and school leavers to be introduced into health and care careers and, where possible should span both sectors. There are existing examples, including in Leeds, but these initiatives need to be done on a more 'industrial' scale to have a real impact.

All education, but particularly Medical education, needs to look ahead to other new models of service where greater work is done in community settings. Mandatory time spent in Mental Health and General Practice and include leadership and health economics in the undergraduate curriculum as well as equality and diversity training.

5. **<u>How can we better ensure the health system meets the needs and aspirations of all communities in England</u>? Areas to explore may include:**

• What more can be done to attract staff from non-traditional backgrounds, including where we train and how we train?

• How we better support carers, self-carers and volunteers?

This question is linked to how to make the NHS and social care sector more attractive as employers. Additionally, we have to consider whether training fees are appropriate, and whether there is greater flexibility to assist those who want to train but can't afford to do so. We also need to challenge preconceptions about things like nursing being a degree level occupation, especially at a time where we are experiencing (and will experience) chronic vacancy rates, particularly in areas such as mental health.

NHS organisations should be set targets for increasing employment of people from the 9 protected characteristic groups as identified under the Equality Duty. Improved Equality and Diversity Training for all staff with specific focus on delivering "reasonable adjustments" required through equality legislation. Staff need to really understand both their legal duties, but also to be given practical guidance on how to apply this.

6. <u>What does being a modern, model employer mean to you and how can we ensure the NHS meets those ambitions?</u> Areas to explore may include:

• What more would make it more attractive to work or stay in the NHS as you progress through different careers stages?

• What should the system do to ensure it is flexible and adaptable to new ways of working and differing expectations of generations?

Being a model employer means doing the sorts of things explained at paragraph 2 above. The key thing is also to further create a sense of pride about working in health and care. It is unique, and to build a sense of belonging which picks up people's public service ethos is important. All too often we hear negative stories about threats to staff from reorganisations, privatisations, and redundancy when we should be turning these stories around to talk about job security, permanence, job, and career opportunities. Our employees are our best ambassadors, so if they have a positive work experience they are more likely to encourage family, friends etc. to work for the NHS.

One definition of being a modern, model employer is to enshrine the concept of developing staff so that they are equipped to move onto new roles but through providing such opportunities ensure that they want to stay <u>within the NHS</u>. Retention and continuous development should be the cornerstones of what it means to be a model employer

7. **Do you have any comments on how we can ensure that our NHS staff make the greatest possible difference to delivering excellent care for people in England? Areas to explore may include:**

- What opportunities are there for making a difference through skill mix changes, staff working flexibly across traditional boundaries, and enabling staff to work at the top of their professional competence?

- What more can be done to deploy staff effectively and reduce further the use of agency staff?

- What more should we do to help staff focus on the health and wellbeing of patients and their families?

- What are the most productive other areas to explore around management and leadership, technology and infrastructure?

We do need to enable staff to work across traditional boundaries. The introduction of Assistant and Advanced Practitioner roles is a positive step in this direction and a benefit to staff. But, how can we industrialise the scale at which these roles are introduced into service?

Digital Skills – digital skills are obviously of increasing importance both in terms of high end technical health care developments but also in managing routine business such as record keeping (and sharing) and patient and drug administration. We need to be skilling our staff to be ahead of and not behind this curve and, therefore, the strategy needs to major on this area.

Embedding a real understanding and explicit expectation on organisations and individual staff relating to how they address Parity of Esteem in their delivery of care (in both directions across mental and physical health services). A move of staff from secondary care into early intervention and prevention service models within primary care would also assist to help build more integrated services.

8. What policy options could most effectively address the current and future challenges for the adult social care workforce?

Social Care – the social care workforce has some huge challenges with recruitment and retention. Turnover is high, pay levels are low and there is a constant battle to recruit and retain care assistants (inc dom care), registered managers and social care nurses. It is essential that this capacity grows. The first thing to say here is that we need to view the service as ONE service not two. Too many people still refer to "AND social care". Social care services are integral to breaking the cycle of many NHS challenges resolving which

are fundamental to its success. Greater cross-sector working, and training will help but some of this will have to be mandated into curricula. There is the ongoing "elephant in the room" of social care pay levels which also need to be tackled and which mean social care employers are competing with lowish paid retail sector jobs.

We also note that DH recently launched a consultation on social care workforce strategy and wonder why this is separate if our goal is to be integrated? Any national workforce strategy for health and/ or social care should include the views of both sectors or ideally should be coproduced.

Annex B

The HEE six principles underpinning workforce planning for the future are:

1. Securing the supply of staff that the health and care system needs to deliver high quality care in the future. Since the NHS began patients have been well served by staff from around the world. However, maximising the self-supply of our workforce is critical. It cannot be right for the NHS to draw staff from other countries in large numbers just because we have failed to plan and invest.

2. Enabling a flexible and adaptable workforce through our investment in educating and training new and current staff. Individual NHS professions have distinct roles but there is scope for more blending of clinical responsibilities between professions. This flexibility is rewarding for staff and can provide the NHS with more choice in how we organise our services.

3. Providing broad pathways for careers in the NHS, and the opportunity for staff to contribute more, and earn more, by developing their skills and experience. Structured career opportunities which enable staff to progress both within and between professions will enhance retention and make the health and care system more resilient and attractive in the face of changing demands from staff.

4. Widening participation in NHS jobs so that people from all backgrounds have the opportunity to contribute and benefit from public investment in our healthcare. This enshrines the public duty to provide equal opportunity for all and will ensure the NHS workforce of the future more closely reflects the populations it serves. If delivered successfully it will increase the pool of people available to be recruited into the NHS.

5. Ensuring the NHS and other employers in the system are inclusive modern model employers with flexible working patterns, career structures and rewards. These need to support staff and reflect the way people live now and the changing expectations of all the generations who work in the NHS. To retain dedicated staff now and in the future requires employment models that sustain the values which drive health professionals every day whilst protecting against burnout, disillusionment or impossible choices between work and home life.

6. Ensuring that service, financial and workforce planning are intertwined, so that every significant policy change has workforce implications thought through and tested. This will help ensure the NHS gets the best for patients from all its resources. Aligning service and workforce planning fosters realism alongside creativity in considering what the workforce in all the relevant groups can best contribute to a new or changing service. This will also increase the resilience of workforce planning and

ensure the NHS workforce is rightly seen as an enabler of improved services, not as a constraint.