

INSIGHT PAPER

Working Together: Collaborative Approaches for Healthcare Staffing

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About NHS Professionals

NHS Professionals runs the largest NHS flexible staff bank, placing skilled clinical and non-clinical staff in a range of healthcare settings to meet temporary workforce needs. Uniquely we are owned by the Department of Health and Social Care and reinvest any financial surplus directly back into the wider healthcare economy.

Originally formed in 2001, we now have more than 50 partner Trusts and 180,000 healthcare professionals (Bank Members) registered with us, all working to NHS-assured training and governance standards. They include nurses and midwives, doctors, allied health professionals, healthcare scientists, personal social services and a wide range of non-clinical staff.

Our award-winning recruitment solutions range from local shift cover at short notice, through to longer term national and international workforce campaigns, such as the COVID-19 Rapid Response programme where we recruited 20,000 people nationwide within weeks. We also support partner Trusts to implement major service improvements and drive down external agency costs.

Driven by a passion for the NHS and its people, our vision is to become the NHS' workforce partner of choice.

Foreword

In Summer 2022, the Health and Care Bill became law. It heralded a shift away from competition in the NHS and established the foundations for new models of delivery based on partnership, integration and collaboration. The intention is to encourage NHS, and other care system providers, to work together even more closely for the benefit of their communities.

NHS Professionals wholeheartedly embraces this change. We see it as a major opportunity to deliver more joined up, personalised care for everyone. It's also an opportunity to innovate the way we recruit, develop and retain the health and care workforce. It's a chance to put more people in more places to care in ways that are good for them, and good for their patients.

The COVID-19 pandemic has been traumatic and harmed many lives. Without doubt the health and care workforce has suffered. And there is a significant backlog of postponed care to get through this year and next. In theory, it hardly seems a good time to attempt the biggest transformation in health and social care in decades.

However, seen from another angle, it is the perfect time. As we show in this report, even before the pandemic, there is clear evidence that when empowered to design their own solutions at local level, Trusts can come together and innovate at pace. In so doing they can deliver significant returns to the taxpayer and free up more money for front line care.

The pandemic then made partnership not just desirable but essential. We saw some extraordinary work. Via focused collaborations such as the National Vaccination Programme, we unlocked local and national workforce potential and successfully recruited and deployed an army of 'net new' people talent into the health and care system within weeks.

Integrated Care Systems give us the opportunity to take this energy and achievement forward and adopt new contingent workforce solutions, such as reservists and volunteers. They give us the chance to create a more diverse, agile and sustainable health and care workforce.

This report offers insights into how we deliver this opportunity. It will help providers navigate their way through the challenges of setting up and managing collaborative workforce solutions. In particular, we challenge some of the 'myths' associated with the barriers for collaborative bank management and how this learning can support other workforce partnerships.

As a provider of collaborative workforce solutions, we know working together brings many benefits to Trusts. Financial savings can be made by sharing critical support functions and the opportunity for staff to work across different locations raises the potential for workforce optimisation. Added to this is the ability to proactively manage the agency supply chain to reduce spending for all parties.

We look forward to supporting more and more Trusts maximise these benefits through collaborative work in the years ahead.

Nicola McQueen

CEO, NHS Professionals, 2022

Summary

This Insight Report offers guidance on collaborative working by drawing on lessons learned from established partnerships in the NHS and public sector. It highlights evidence from NHS Professionals' shared staff banks and cross-system working, which pre-date ICS legislation and support providers to solve systemic workforce issues together. We discuss this within the national context and present 12 key success factors for healthcare workforce collaborations.

The workforce challenge

The 2022 Health and Care Bill establishes the foundations for a new era of co-operation and collaboration across place-based healthcare systems. It places Integrated Care Systems (ICSs) on a statutory footing with a clear mandate to integrate care, improve population health and reduce inequalities.

This new environment offers considerable scope for providers to collaborate on workforce recruitment, deployment and development in a way that optimises the effective utilisation of people and skills and better enables consistently safe and effective healthcare across systems. It also supports innovation in tackling some of the biggest workforce challenges we face at the present time. These include:

- facilitating staff movement between providers
- attracting a new generation of workers by better promoting healthcare as a career
- retaining staff in the system by creating better cross-system pathways
- maximising the benefit from the pandemic workforce and those 'curious' about a new career in the NHS.

Collaboration: 12 success factors

Drawing on data gathered from shared staff banks run by NHS Professionals and other evidence from the NHS and public sector, we propose 12 success factors collaborations can use to guide their work. (For more detail on these, see Chapter Three.)

1. **Focus on a common purpose**
2. **Collaboration is a process, not a quick fix**
3. **Work to build trust**
4. **Be willing to compromise**
5. **Work to get buy-in from stakeholders**
6. **Balance strategic and operational perspectives in the co-design process**
7. **Get 'permission' from senior stakeholders to compromise and work differently**
8. **Explore technology solutions**
9. **Share data and information**
10. **Allow divergence within the partnership**
11. **Be prepared to innovate**
12. **Think 'patient first, system second, workforce third'**

Summary (continued)

Collaborative staff banks: key messages

- For many years, it has been recognised that collaborative bank arrangements bring a variety of financial, planning and workforce optimisation benefits
- Rarely will providers come together simply to create a staff bank. They have more specific motivation to, for example, maximise workforce skills or reduce spend on external agencies
- Trusts in a shared bank may end up filling more shifts at the expense of others because their pay, training and other factors differ. However, collaborations can accommodate differences with limited impact
- Of approximately 5,000 substantive staff on a bank shared between three Trusts working with NHS Professionals, only 2.9% elected to do shifts outside their Trusts
- Most staff will continue the same work pattern post-collaboration and pay alone is not necessarily the main reason why people choose where they work; other factors including transport and familiarity with a Trust may be involved
- Substantive pay rates, rather than bank pay rates, have more influence over whether people gravitate towards external agency
- A 'passport' arrangement allowing compliance staff to move between organisations requires providers to trust each other's governance processes – but it can reduce duplicated effort and improve staff experience
- Through more joined-up external agency management, a bank share in Yorkshire supported by NHS Professionals saved £1.72m in year one and almost £1m in year two. It also created shared service efficiencies and improved shift fill rates.

Introduction: The National Picture

The NHS People Plan, the White Paper on Integration and Innovation and the Health and Care Bill have all established the foundations for a new era of co-operation and collaboration across place-based healthcare systems.

Integrated Care Systems (ICSs) are now on a statutory footing with a clear mandate to integrate care across different organisations and settings. The objective is to bring about major change in how health and care services are planned, paid for and delivered in a way that improves population health and eradicates inequality.

Within this new environment, the scope for workforce collaboration is considerable. Beyond building collaborative staff banks, opportunities exist to liaise on all aspects of the people agenda including new job creation, recruitment, training and development, deployment, retention, equality, diversity and inclusion (EDI) and wellbeing.

NHS England and Improvement's (NHSEI's) ICS Design Framework¹ sets out requirements for each ICS to establish two separate bodies: an ICS partnership (focused on aligning the ambitions, purpose and strategies of system partners, and an ICS NHS body (focusing on an integrated plan for meeting population health needs for all system providers). In addition, ICSs will lead on oversight and performance management of their constituent organisations. Further technical guidance on the role provider collaboratives will play in ICSs is also expected.

In some regions, whole system provider collaboratives are being established involving all or most providers from all sectors across the ICS patch. In others, the collaboratives are more region- or task-specific. They may have a borough-based partnership to embed primary care, community care, mental health and local government, and a separate provider collaborative for acute and mental health².

Guidance on managing people issues within the new ICS structure suggests that individual employing organisations in the system will continue to have direct responsibility for their own staff. Collaborative elements will be focused on benefits of scale, removal of barriers (such as non-standardised practices) and making the best use of available people talent³.

The guidance recognises that planning is currently carried out at different levels (provider, system, region and national) and considered through different lenses (place, pathway, profession) across different timelines (annual, multi-year and long-term).

1. 'Integrated Care Systems: design framework', NHSEI, Version 1, June 2021

<https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf>

2. 'ICSs "may cease to exist" after setting up strong provider groups', HSJ, 28 October, 2021

<https://www.hsj.co.uk/integrated-care/ics-may-cease-to-exist-after-setting-up-strong-provider-groups/7031201.article>

3. 'Building Strong Integrated Care Systems Everywhere: guidance on the ICS people function', NHSE, August 2021

https://www.england.nhs.uk/wp-content/uploads/2021/06/B0662_Building-strong-integrated-care-systems-everywhere-guidance-on-the-ICS-people-function-August-2021.pdf

Introduction: The National Picture (continued)

The ICS role is to align and co-ordinate plans at the system level in a way that benefits staff – and, by extension, patients and citizens. Every ICS will be allowed to create their own plans, with no ‘one size fits all’ approach. However, workforce plans are expected to address a set of 10 outcomes:

1. Supporting the health and wellbeing of all staff (with focus on physical and mental health)
2. Growing the workforce for the future and enabling adequate workforce supply (with a focus on retaining, recruiting and growing the workforce to meet future needs). ‘One workforce’ across the ICS is representative of the local communities served
3. Supporting inclusion and belonging for all and creating a great experience for staff – ensuring the workforce is representative of the diverse populations served
4. Valuing and supporting leadership at all levels and promoting lifelong learning
5. Leading workforce transformation and new ways of working – including through service re-design which makes the most of people’s skills and enabled by new technology
6. Educating, training and developing people and managing talent
7. Driving and supporting broader social and economic development, acting as ‘anchor institutions’ that play a role in creating a vibrant, local labour market
8. Transforming people services and supporting the people profession to deliver the ‘one workforce’ enabled by technology and digital tools

9. Leading coordinated workforce planning using analysis and intelligence ensuring an integrated and dynamic workforce that meets current and future population needs

10. Supporting system design and development.

Building on earlier thinking from the NHS People Plan, a common principle is the concept of ‘one workforce’, operating seamlessly across all parts of the system. Understanding this concept is key. In its ICS design framework⁴, NHSEI suggests:

“ICS NHS bodies will play a critical role in shaping the approach to growing, developing, retaining and supporting the entire local health and care workforce.... we expect ICS NHS bodies to adopt a ‘one workforce’ approach and develop shared principles and ambitions for people and culture with local authorities, the VCSE sector and other partners.”

The emphasis here is on recruitment, retention and workforce development. The guidance also suggests standardising high-quality transactional services (such as payroll), maximising opportunities for collaboration, and securing benefits of delivering at scale (with an implied ‘nod’ towards shared back office services while recognising the importance of subsidiarity). They also reference ‘inclusive employment models’, with workforce sharing arrangements and passporting or accreditation systems.

4. “Integrated Care Systems: Design Framework”, p17, NHSEI Version 1, June 2021,

Report template - NHSI website (england.nhs.uk)

Subsequent guidance⁵ is more prescriptive and states that ICSs should establish:

“...a collaborative system for managing temporary staffing across the system; this could include establishing shared staff banks; encouraging the formation and use of GP locum banks across federations, networks or geographical clusters; and setting system-wide bank rates to secure greater alignment.”

Use of shared staff banks is further emphasised in a NHSEI report on the future of NHS human resources⁶ and a follow-up operational communication with NHS leaders on the elective recovery, which urges providers to:

“Maximise the use of collaborative staff banks across systems where possible to create greater staffing resilience across organisations and reduce reliance on agency workers...”⁷

It is clear that collaboration now plays a central role in healthcare planning and delivery and we will explore how shared staff banks can support this in chapter two. Before then, we will capture some lessons learned from other examples of joint working in the NHS and wider public sector.

5. “Building Strong Integrated Care Systems Everywhere: guidance on the ICS people function”, NHSEI, August 2021

https://www.england.nhs.uk/wp-content/uploads/2021/06/B0662_Building-strong-integrated-care-systems-everywhere-guidance-on-the-ICS-people-function-August-2021.pdf

6. “The Future of NHS Human Resources and Organisational Development”, NHSEI, p30, November 2021,

[B0659_The-future-of-NHS-human-resources-and-organisational-development-report_22112021.pdf](https://www.england.nhs.uk/wp-content/uploads/2021/12/B0659_The-future-of-NHS-human-resources-and-organisational-development-report_22112021.pdf) (england.nhs.uk)

7. [B1512-Enabling-the-workforce-for-elective-recovery-letter-3-May-2022.pdf](https://www.england.nhs.uk/wp-content/uploads/2022/05/B1512-Enabling-the-workforce-for-elective-recovery-letter-3-May-2022.pdf) (england.nhs.uk)

Chapter One: Lessons From The NHS And Public Sector

Collaboration is not a new concept in the public sector although it certainly does have renewed focus in the NHS thanks to the recent Health and Care Bill. The question is: what can we learn from past experience that will help us to collaborate more effectively today?

1.1 Lessons from the pandemic

A renewed clarity of focus

Despite causing great disruption and harm, the pandemic has also taught us much about collaboration.

The health and care sector's response, especially in the early response to the crisis⁸, illustrated the power of system-working between NHS providers, local authorities, voluntary, community and social enterprises and the private sector. Jointly, providers were able to rapidly mobilise solutions and respond to urgent needs with simplified governance and decision-making.

The NHS People Plan⁹ recognises this created a shared purpose and permission to act. We witnessed fresh thinking across a range of areas including:

- The health and well-being of healthcare staff
- Understanding and planning for existing and deep-rooted inequalities
- Developing and promoting flexible and remote working (including remote consultations)
- The value and potential in returners
- The creation of new roles and the upskilling of staff to perform specific tasks and duties
- The value of the NHS providing additional support to care homes
- The value and contribution of volunteers
- The value of playing an active role in supporting national and global research.

Later ICS guidance focuses on learning from these experiences:

“The COVID-19 pandemic accelerated the shift to system working, empowering clinicians and care professionals to work across traditional organisational boundaries to overcome challenges, protect communities and redesign services when needed. It is important to retain and embed this spirit of innovation as ICSs develop.”¹⁰

The power of unified goals

The Care Quality Commission¹¹ describes how systems with shared goals, a clear mission and the willingness to adapt visions and strategies to the pandemic, were able to respond flexibly to the challenges of COVID-19 and shared resources more effectively. Conversely, those without a clear vision or inflexible priorities were far less inclined to collaborate in a constructive way.

8. “The Health and Care Bill [Bill 140 of 2021-22]”, House of Commons Library, 12 July 2021

<https://researchbriefings.files.parliament.uk/documents/CBP-9232/CBP-9232.pdf>

9. “We are the NHS: People Plan 2020/21 action for us all”, NHSE, July 2020 www.england.nhs.uk/jourhpeople

10. “Building Strong Integrated Care Systems Everywhere: ICS implementation guidance on effective clinical and care professional leadership”, p6, NHSEI, 2 September 2021

<https://www.england.nhs.uk/wp-content/uploads/2021/06/B0664-ics-clinical-and-care-professional-leadership.pdf>

11. “Better Care Through Collaboration, Covid-19 Insight, Issue 3, July 2020”, Care Quality Commission

<https://www.cqc.org.uk/sites/default/files/20200715%20COVID%20IV%20Insight%20number%203%20slides%20final.pdf>

Work by the Provider Collaboration¹² also suggests that organisations reframed ‘success’ more towards patient outcomes, rather than pounds and pence:

“Across our reviews, we were consistently told previous barriers to collaboration were put aside during COVID-19, particularly around sharing information, resources, and staff redeployment. We heard this included a shift of focus from financial consequences and individual provider needs, to what was right for the patient. It was described as a liberation, placing people at the heart of decision-making, removing barriers and bureaucracy where possible to be more responsive.”

1.2 Other lessons from the NHS

System-wide thinking

A case study published by NHS Confederation¹³ on collaboration between the Black Country and West Birmingham ICS demonstrates the challenges of collaborating in a highly complex System involving four acute Trusts, a provider collaborative, mental health and community Trusts, five places, a CCG, primary care, local government and voluntary sector care partners.

The parties worked together to map out common ‘drivers’ and problems they faced collectively. From this they created five separate programme groups to each work on projects and tasks to solve the identified problems.

The collaborative’s key advice points were:

- Invest time in relationship building and creating a safe environment to challenge ways of working

- Develop an inclusive people board with clinical representation, along with local authorities and voluntary organisations
- Map out the range of challenges and inter-relationships
- Identify the common issues and challenges and use these as the basis for collaboration.

Building trust

Without doubt, a lack of trust is a barrier to effective collaboration. Success is much more likely when collaborators take time to build trust rather than expend effort on trying to eradicate barriers and differences. Richard Vize suggests¹⁴:

“The bedrock of systems leadership is trust. Without it there is no system, just individual institutions manoeuvring, negotiating and compromising. The first thing is trust. The whole thing is based on understanding and trust.”

Arguably, this is easier to achieve when all parties are aligned to a common cause: improving patient outcomes, for example. It also relies heavily on data sharing and transparency and how ready partners are to adapt and develop the solution over time to make sure all parties benefit. In addition, it means trusting collaborators to all work to the same standards.

12. “Provider Collaboration Review: Urgent and Emergency Care”, Care Quality Commission, April 2021

<https://www.cqc.org.uk/publications/themes-care/provider-collaboration-re-view-urgent-emergency-care>

13. “Taking a system-wide collaborative approach to people and workforce”, Alan Duffell, NHS Confederation, 15th December 2021

14. “Swimming Together or Sinking Alone: Health, care and the art of systems leadership”, p6, Institute of Healthcare Management, 2017

Even under the pandemic's exceptional conditions, we saw evidence of a lack of trust between system providers. For example, individuals recruited through NHSE's Bring Back Staff and National Vaccination programmes often went through a second round of vetting and compliance when deployed at Trust level. This suggested two things: a lack of faith in the rigours of processes carried out elsewhere and a lack of flexibility in the Trust's own process. Regrettably, this resulted in duplicated work across the system and a frustrating experience for candidates.

In any collaborative arrangement, establishing a common standard for compliance – for example, pre-employment checks and statutory and mandatory training - may be seen as the best solution. However, migrating thousands of workers through a process that requires compliance to be 'topped up' to a single standard can be costly, time-consuming and disengage bank workers. The more efficient alternative – a passporting or a staff sharing arrangement – requires a degree of trust in compliance processes.

The COVID-19 Digital Staff Passport, signed up to by more than one hundred NHS organisations, was the first attempt to clarify legal obligations and indemnities and create consistency in the data shared between organisations¹⁵. It is attractive because local arrangements, (covering details like pay variations and parking needs) can be put in place alongside core terms in the digital passport.

Although developed only for the pandemic, it is likely that the COVID-19 passport may give rise to other solutions. For example, Workforce Sharing Agreements (Memoranda of Understanding or MOUs) can be shared with organisations outside the NHS family. Within such arrangements, it is possible to reduce duplication with a 'warranty' recognising a postholder's transferable employment checks and mandatory training.

In an article in the Health Service Journal¹⁶, Adam Doyle, Chief Executive designate for the Integrated Care Board for Sussex and current ICS lead is quoted as saying:

“Trust is built, and is built over many, many interactions. You can break trust in a second but it takes weeks and months and years to build it.”

Doyle goes on to say that working together to create a single vision and identifying shared issues gave the collaboration purpose. It meant that, when problems arose, collaborators worked to find a joint solution, rather than pulling in different directions.

In the same article, Helen Buckingham, Director of Strategy and Operations at the Nuffield Trust, noted the policy environment is now more aligned around collaboration. She said leaders were “getting collaboration in their hearts as well as their heads”, rather than just focusing on payment by results. She did, however, also suggest the performance environment hasn't sufficiently moved on and more needs to be done to recognise the value in collaboration.

People sharing a common problem

As the above suggests, a consistent theme in all of the evidence is the power derived when people come together to solve a common problem.

15. 'Staff Passporting within the NHS', NHS Digital, 2021
<https://beta.staffpassports.nhs.uk/about/>

16. "How Leaders can Embed Collaboration in Integrated Care Systems", HSI, 15th December 2021

According to one NHS Leader, quoted in an industry report: ¹⁷

“Where I see [collaboration] working well it is due to individuals and their values as well as the depth of relationships. That depth comes from the personalities and building trust around collective ownership of difficult problems as opposed to people who are coming together now because they have to and they can’t survive on their own – but they would prefer it if they could.” (p6)

What is more, the tougher the problem, the greater the incentive to collaborate:

“Significant problems can make the...process easier because you have a mandate for change.” (p4)

Thinking differently

An NHS Providers Briefing reflects on the importance of framing problems in a system-wide context¹⁸. It suggests that 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. It argues that 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.

It adds:

“...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 the system for new opportunities, and creating a more efficient mechanism for filling vacancies where they arise.”

This demands new system-wide thinking and may require a significant shift in mindset; instead of trying to prevent staff from applying for jobs at a neighbouring Trust, this can be encouraged as part of a strategy to promote staff development opportunities and help to retain people in the system.

NHS Providers also refers to the importance of leaders promoting the benefits of cross-boundary working and giving staff ‘permission’ to work in different ways across traditional lines:

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

Shared resources

While some ICSs state that shared back office solutions are a strategic ambition of system-wide collaboration, others are simply using such resources tactically to support projects and initiatives.

17. “Swimming Together or Sinking Alone: Health, care and the art of systems leadership”, Institute of Healthcare Management, 2017

<https://www.leadershipcentre.org.uk/systemsleadership/wp-content/uploads/2017/01/Swimming-together-or-sinking-alone-Richard-Vize.pdf>

18. “A Place to Work: Collaborating to Support Recruitment and Retention”, NHS Providers Briefing,

<https://nhsproviders.org/media/688878/workforce-briefing-1j.pdf>

In its recent annual report¹⁹, Leeds Community Healthcare NHS Trust writes:

“...during 2019/20 we developed an ‘Employ and Deploy’ service for the Primary Care Networks (PCNs) across Leeds. This service uses the Trust’s HR and professional support infrastructure to enable PCN’s to attract and deploy the best possible candidates for vital roles.”

Supporting a ‘one workforce’ solution by using recruitment capacity in part of the system has clear benefits for the collaborators. There are also wider benefits for employees as part of this deal - they have sought approval for staff to join the NHS Pension Scheme.

Learning together

Leeds Community Healthcare also gives us an example of an organisation learning with its peers and co-designing new workforce solutions. The Leeds Health and Care Academy is described as a joined-up solution for innovative learning, using the best research to support staff in health and care across the city to improve the health and wellbeing of local people.

The experience of partners in the Healthy Communities Together programme,²⁰ supported by the King’s Fund, highlights the value of iterative joint problem-solving:

“The evolution of [the] learning approach is generating new insights on what it means to ‘partner’. This isn’t so much about getting the work done, but ‘how’ the work is done together. Key themes around the importance of purpose, membership and how to enable contributions from all partners has come up in all sites in different ways. As partnerships reflected on the first year, they noticed how their understanding developed iteratively

through trying things out, learning together and really challenging themselves about their assumptions and beliefs about what partnering involves.”

These new solutions don’t simply look to re-create old strategies in a new world of collaboration: they are creating innovative approaches to workforce problems. We have not seen this previously but NHS Providers offers some examples²¹:

- Cambridgeshire and Peterborough Sustainability and Transformation Partnership developing a system-wide branding and attraction project to attract new staff to work in the system and place, rather than one organisation. It also includes collaboration on the Apprenticeship Levy and allowing all system providers to use funding
- Greater Manchester workforce collaborative growing their own capacity by investing in training and development, supporting apprenticeships and extending work placements
- Teams in Northumberland using job shadowing and co-location to break down barriers to joint working
- Teams in Mid-Yorkshire using a multi-disciplinary approach across care pathways.

19. Annual Report and Accounts 2019/2020, Leeds Community Healthcare NHS Trust,

<https://www.england.nhs.uk/wp-content/uploads/2021/08/leeds-community-healthcare-nhs-trust-ara-2019-20.pdf>

20. “Healthy Communities Together – embarking on a journey of partnership working”, Helen Gilbert, The King’s Fund, 25th March 2022

https://www.kingsfund.org.uk/blog/2022/03/healthy-communities-together-embarking-journey-partnership-working?utm_source=The%20King%27s%20Fund%20newsletters%20%28main%20account%29&utm_medium=email&utm_campaign=13094756_NEWSL_HMP%202022-03-29&dm_i=21A8,7SNZ8,5PFFBM,VSW11,1

21. “A Place to Work: Collaborating to Support Recruitment and Retention”, NHS Providers Briefing,

<https://nhsproviders.org/media/688878/workforce-briefing-1j.pdf>

The message from this evidence is clear: think system, think patient, and shrug off the constraints of any out-dated cultures and processes. There is no longer any such thing as: ‘this is the way we do things around here’.

Collaborative mindset

It has often been argued that Trusts’ failure to collaborate is a direct result of putting their own organisation’s needs first when resources are scarce. However, there is increasing recognition that it is better to collaborate. A recent survey of NHS Confederation’s Health Leaders Panel²² states that:

“...there was much optimism about how organisations were now working together to address staff shortages. Eight in ten respondents said they are pooling their resources and collaborating with other organisations either a little or a lot when it comes to deploying staff, with 15 per cent saying they were doing this a lot.”

How can providers assess their readiness for collaboration? One guide²³ offers a checklist including questions such as: ‘Is there a general sentiment at the Trust to work in a more open and transparent way, breaking down any pre-existing silo-driven ways of working?’ Other questions cover key stakeholder buy-in and ask whether medical and nursing directors are in support of a collaborative bank.

These cultural and people-based elements establish the importance of having the right mindset to support a change in thinking towards common goals. Following process like this, therefore, can help prepare Trusts for change and compromise and avoid focusing solely on their own requirements.

Mindset also includes strength of values and a sense of collective responsibility for solving problems, especially complex ones (such as, for example, the pandemic emergency).

In his paper on healthcare systems leadership²⁴, Richard Vize quotes two healthcare leaders:

“Where I see [collaboration] working well it is due to individuals and their values as well as the depth of relationships. That depth comes from the personalities and building trust around collective ownership of difficult problems, as opposed to people who are coming together now because they have to and they can’t survive on their own – but they would prefer it if they could.”

1.3 Lessons from the public sector

Diversity of skills and thought

The Institute for Government reflects on personal perspectives of government effectiveness through collaboration²⁵. It highlights the importance of three inter-related variables that make success more likely:

- Creating a common purpose – linked to an appreciation of the service user’s perspective
- Taking a whole-system approach
- Sharing power

22. *Manifesto for Recovery: the health and care system after Covid-19*, p28, NHS Confederation, September 2021

<https://www.nhsconfed.org/publications/manifesto-recovery>

23. “How to create a collaborative staff bank: the NHS way”, p3, NHS Providers, NHS Innovation Accelerator, Locum’s Nest

<https://nhsproviders.org/media/692687/locums-nest-how-to-create-a-collaborative-staff-bank-the-nhs-way.pdf>

24. “Swimming Together or Sinking Alone: Health, care and the art of systems leadership”, pp 4&6, Institute of Healthcare Management, 2017

<https://www.leadershipcentre.org.uk/systemsleadership/wp-content/uploads/2017/01/Swimming-together-or-sinking-alone-Richard-Vize.pdf>

25. “Collaborative Working: A series of personal perspectives on government effectiveness”, The Institute for Government, 2011

It states the activities related to sharing power are:

“...spending time on relationships (including people staying in jobs for more than a few years); serving other perspectives (another way of saying, disassociating from your own perspective and allowing others’ versions of the world to be valid); and distributing leadership so that others closer to the service user had power and authority to allow the service to flex and adapt.” (p19)

The Institute also highlights having the right mix of individuals in the collaboration team - ‘thinkers and doers’ – to support the solution, both strategically and operationally.

Collaboration as a process

The Institute’s guidance presents collaboration as a process of continual iteration of a problem, rather than a singularly designed solution. It requires people to come together with an open mind, no pre-conceived agenda and a willingness to flex over time as the service evolves.

An article produced by the Department of Social Services in the Australian Government on shared workforce models²⁶ confirms much of this thinking:

“It can be a big mindset shift for organisations who may have been competitors to collaborate towards a common goal. As such, it is important for the design process that a high level of trust is established between the organisations so that they feel comfortable to openly and honestly discuss their strengths and weaknesses...A good co-design process involves staff at different levels to help as the service model is being developed.”

System benefits

A more recent report by the Institute for Government²⁷ suggests lack of collaboration incentives at departmental and individual level may create barriers to achieving co-operation across public sector organisations. Measures and reporting lines exist within individual organisations, meaning there is a reluctance to commit resources that deliver benefits to other parts of the system.

This implies that collaborations need to evaluate the synergistic benefits to the system – and these benefits need to be valued and rewarded by senior management in all provider organisations.

Communicating these benefits is also key:

“The final barrier participants touched on is the lack of emphasis on why collaborating with others matters. Some of this comes down to poor communication of the benefits of working together to deliver services seamlessly to people. Collaboration is not an end in itself, but a means of achieving better results for the public.”

26. “Case Study: Shared Workforce Models”, Australian Government, Department of Social Services,

<https://blcw.dss.gov.au/articles/case-study-shared-workforce-models/>

27. “How to Improve Collaboration Across Government”, IfG Oracle roundtable, p7, 13 October, 2020

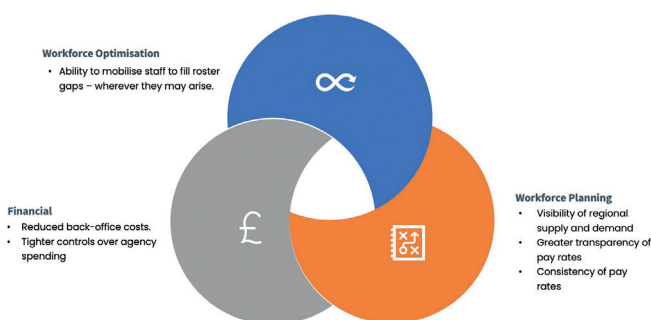
https://www.instituteforgovernment.org.uk/sites/default/files/improve_collaboration_across_government.pdf

Chapter Two: Lessons From NHS Professionals Shared Staff banks

For the past six years NHS Professionals has helped to set up and manage a number of collaborative staff bank arrangements across England. These have involved Trusts working together to solve common problems, rather than triggered by ICS legislation. However, the principles of collaboration remain the same and so provide us with valuable data to take forward into the ICS sphere.

Why collaborate?

It is recognised that collaborative bank arrangements bring a variety of financial, planning and workforce optimisation benefits, which we summarise below:



As well as the more obvious efficiencies coming from providing a shared business service, there are indirect efficiencies from data visibility and being able to use this information to manage agencies and pay rates. This helps to avoid pay competition within the regional supply chain. Importantly, it also offers the potential for 'sharing' flexible workers across the wider NHS estate.

Clarifying common purpose

Before the COVID-19 pandemic, the legacy of divergent bank management solutions adopted by Trusts led to some proposed collaborations being abandoned. The perceived complexities of working together were sometimes seen as too great.

However, the pandemic experience has shown that Trusts can create innovative solutions together when there is a common goal and they are freed from the constraints of often outdated policy constructs. Collaboration is, therefore, very much 'back on the table'.

Collaboration is not something that can be 'done to' a group of employers, and it certainly isn't an 'out of the box' technology solution. Every collaboration has its own journey. This is partly dependent on the point from which the different players are starting their journey, and partly dependent on subtle nuances in the shared problem statement.

For example, we have seen groups come together to maximise workforce skills; others have focused on reducing spending on external agencies others have been jointly interested in providing a better employment experience for their flexible workers. Rarely have we seen Trusts come together to simply create a shared bank; in itself, that is not sufficient motivation to deal with the various issues and challenges associated with bank collaboration.

What, then, is the 'problem statement' behind a collaborative bank? We have seen various:

- How can we reduce agency spending and pay escalation which comes from Trusts competing for scarce talent?
- How can we provide our flexible workers with greater diversity of opportunity?
- How do we use our scarce people skills more efficiently across our geography?
- How do we give staff more opportunity to work in different settings so they can learn and develop?
- How can we ensure that we can readily deploy staff where they are most needed?
- How do we grow our flexible staffing resource for all providers across our patch?

In all instances the solution is a shared bank arrangement, but the specific nature of each problem may well determine a different type of collaborative bank. If the intention is to add new resource or capacity, then a 'top-up' collaborative bank, working alongside existing banks, may be the preferred option. Here, the focus is likely to be on the technology linking different systems (interoperability), rather than collaborators debating the merits of a common platform.

Conversely, if the intention is to use scarce skills more effectively across the whole system, then the focus may be to provide existing staff with opportunities to offer their discretionary time and effort to a wider provider base. In this instance, providers may prefer to have a single shared bank for all staff across the system.

Key questions to answer

Regardless of which shared bank arrangement used, providers have other key questions to answer together. In our experience, working through these challenges takes time and requires people to come to the table with an open mind and a focus on synergistic goals - 'what's in it for all of us', rather than 'what's in it for me'.

These questions aim to address any structural, policy, procedural and cultural differences. The following table illustrates some of these:

Principal Issues	Challenges Posed
Structural	Who is going to manage the bank (onboarding, compliance, payroll, bank member engagement and management etc) – a lead employer, distributed employers or a third party managed service?
	Which software provider should be used (with consideration of software version and interoperability with existing system for data exchange)?
Policy	What policies, procedures and systems should be used to recruit new staff?
	Should a standardised set of compliance arrangements be established (including statutory and mandatory training) or arrangements made for staff sharing?
	What pay and terms and conditions should be used?
	What Memoranda of Understanding need to be put in place for sharing data?
Procedural	What key performance indicators (KPIs) need to be put in place? How can these be designed to make sure everyone is getting the level of service and resource they need?
	Who is accountable if something goes wrong? What needs to be put in place to make sure any workforce sharing arrangements are covered by existing indemnity schemes?
	What systems need to be put in place for invoicing and recharging for shifts undertaken?

We can see that some of these issues are strategic and some are operational – reinforcing the idea that successful collaboratives require a mix of both ‘thinkers and doers’, working at both strategic and operational levels. Building operational thinking in from the start reduces time spent later translating strategic solutions into tactical plans.

Building trust and managing risk

Experience also shows that collaborations can fail due to perceived risks. It’s often felt necessary to harmonise pay, policy and process because there is a fear collaboration is a ‘zero sum game’ – that is, one party’s gain will end up being another party’s loss.

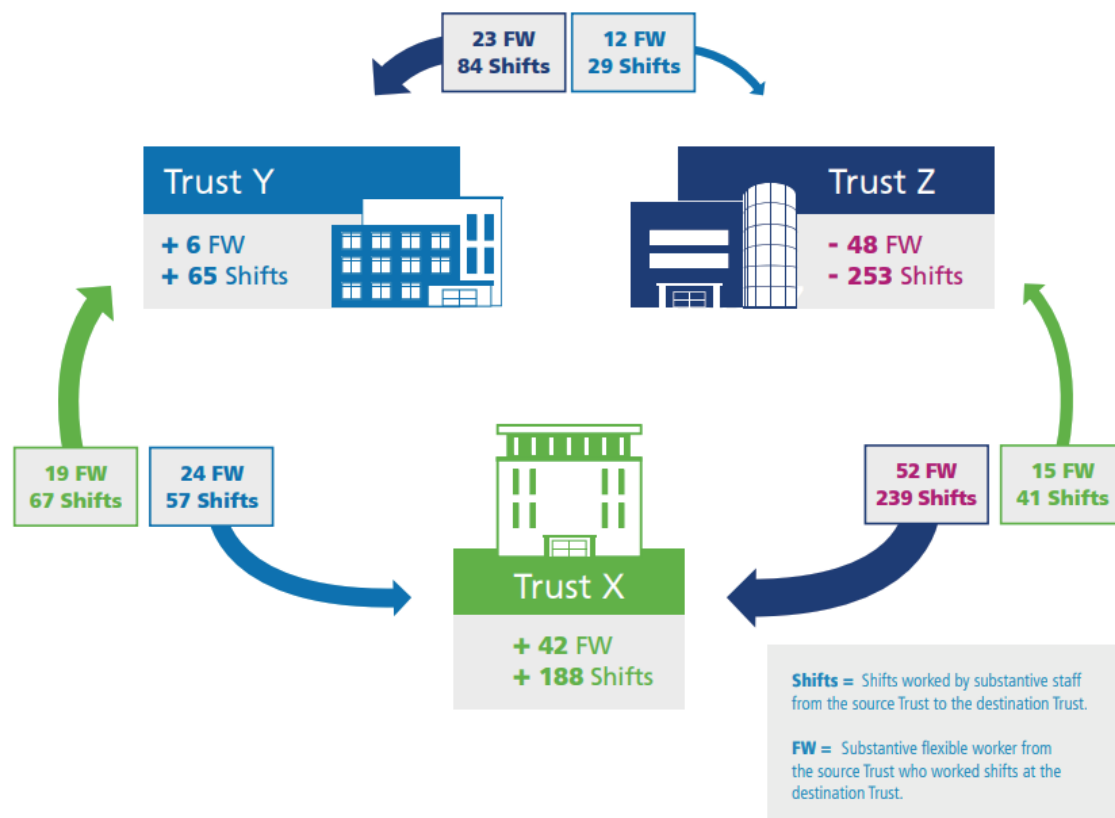
In a bank share arrangement, some Trusts will end up filling more shifts at the expense of others. For example, Trusts on the edge of a geographic grouping may typically offer slightly higher pay rates to attract staff to their more remote hospital sites. They may argue they need to maintain these rates in the shared agreement to make sure they do not lose access to their current supply. There may be valid geographic, socio-economic or contractual reasons why pay rates and training and development might differ.

However, the bigger question is: does it matter? How important is pay variance for similar shifts offered across the shared bank geography? Does it matter that the parties do not use the same technology platform to manage their banks?

The reality is that some differences can be accommodated with limited impact. Providers should, therefore, aim to avoid any potential disagreements over a single pay rate, a common job description or all parties migrating to a single technology. These things need not derail progress on collaboration. Where Trusts use different technologies, for example, ‘interoperability’ solutions can be built to create common workflows across different platforms. And – as the evidence from the shared banks managed by NHS Professionals clearly shows - while there may indeed be inequitable flows of personnel between Trusts in a shared bank arrangement, these exist anyway. There are a range of behavioural factors determining where and when people choose to work.

A tale of three Trusts

Following an agreement between three Trusts to create a single, regional bank, NHS Professionals published a report²⁸ analysing the behaviour of substantive bank members over a three-month period. The research revealed important features of substantive bank staff behaviour, as the diagram and points below summarise:



- Of the approximately 5,000 substantive staff on the shared bank from across the three Trusts, only 2.9% elected to do shifts at a Trust other than the one at which they were substantively employed
- Two of the three Trusts (X and Y) experienced a net gain in terms of the number of bank workers electing to do shifts at the Trust – e.g. 76 workers from Trusts Y and Z elected to do shifts at Trust X whereas only 34 staff from Trust X undertook shifts for Y and Z.
- The Trust with the net outflow of bank workers (Trust Z) offered the highest average hourly bank rate -17% higher than the lowest paying Trust. Conversely, the Trust with the lowest average hourly bank rate (Trust X) recorded the biggest net gain – although this Trust also offered more shifts that pay extra for anti-social hours (38% of all shifts being night shifts and 51% 'long days'). It was also suggested that Trust X may be a more attractive alternative location for bank workers because it was smaller and more intimate. This implies that pay alone is not necessarily the main reason why people choose to work at one Trust and not another

28. 'Creating a Successful Regional Bank', NHSP, December 2017
<https://www.nhsprofessionals.nhs.uk/Partners/Publications/-/media/E41BC82FF3CC401E997123647635745E.ashx>

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- More than half of all external agency shifts during the three-month period were undertaken by substantive staff from the smaller Trust X, with lower average bank and substantive pay rates. It was apparent this was 'the norm' for staff from this Trust. From this we can argue that substantive pay rates, rather than bank pay rates, have more influence over whether people gravitate towards external agency.

These data suggest a key point: most staff will continue the same work pattern post-collaboration. This could be due to a range of factors including transport, familiarity with a Trust and its teams, or resistance to change.

Having said this, staff like the option to work in other locations because it gives them alternative employment if shifts are not available at their current Trust. Those that elected to work bank shifts elsewhere appear to have been less influenced by average bank pay rates, and more by the type of shift (and anti-social pay uplifts), the work environment and possibly other factors such as the convenience and cost of parking.

It is hard to say whether this will hold true in the current economic environment with the rising cost of living. This raises the possibility that staff decision-making and behaviour around bank work may also change with wider economic forces, making it harder to predict. Consequently, becoming fixated on the need to harmonise certain elements of the decision-making process (pay and job roles) can only ever control some of the variance.

The more important issue arising in this case was that the project was not derailed by 'knee jerk reactions' to short-term variance. Through transparency (sharing data and evidence around performance) and clear sight of the wider benefit to the region, it was accepted that some variance was inevitable and acceptable. This was made easier by the fact that the three trusted each other to take remedial action should any one party be materially disadvantaged.

Chapter Three: What Success Looks Like

Collaboration: 12 success factors

Drawing on data gathered from shared staff banks run by NHS Professionals and other evidence from the NHS and public sector, we propose 12 success factors collaborators can use as they work together to optimise the people talent available within a healthcare system. Adhering to these guiding principles gives collaborative ventures a higher chance of success.

- 1. Focus on a common purpose.** Success is more likely when all collaborators are focused on a single issue or challenge. The problem is not, for example: 'We haven't got a collaborative bank'. It is likely to be more specific: 'We don't have a mechanism for moving key talent around the system' or 'External agency spending is rising'
- 2. Collaboration is a process, not a quick fix.** Take time to 'work the problem' and co-design solutions. It is important to consider and agree the process for governance and review as a priority so that decisions don't unintentionally disadvantage specific parties or the wider system. Questions on structure, policy and procedure must also be considered and agreed.
- 3. Work to build trust.** Take time and effort to learn about the various parties in the collaboration and understand different perspectives, especially those outside the NHS
- 4. Be willing to compromise.** All parties need to approach the collaborative process with an open mind
- 5. Work to get buy-in from stakeholders.** These include clinical leaders who need to be comfortable with any changes made to clinical governance processes, such as compliance and training
- 6. Balance strategic and operational perspectives in the co-design process.** This will help to create fully workable collaborative solutions
- 7. Get 'permission' from senior stakeholders to compromise and work differently.** Stakeholders also need to support measurements of success based on joint outcomes, not just benefits to a single organisation
- 8. Explore technology solutions.** Don't let concerns about partners using different technology platforms derail progress before exploring all possibilities for interoperability
- 9. Share data and information.** Better solutions around, for example, pay rates and availability of staff across a system, come from shared insight and transparency between providers
- 10. Allow divergence within the partnership.** Collaboration does not always necessarily mean unifying systems, processes and practices
- 11. Be prepared to innovate.** For example, taking a system-wide approach to employer branding, recruitment, training and careers creates the opportunity for pooled funding and back office resources
- 12. Think 'patient first, system second, workforce third'.** In solving challenges and achieving the common purpose, collaborators need to think patient first, system second and workforce third. For workforce, focus on what is beneficial to the region's talent pool to help retain and nurture staff across the system. The needs of one organisation should not dominate.

NHS Professionals case studies

Here we present three real-world examples of the benefits achieved by collaborative workforce projects managed by NHS Professionals, including shared staff banks.

South Yorkshire and Bassetlaw BankShare²⁹

Establishing a common purpose

The primary impetus for the shared bank arrangement was to introduce a discipline in agency management for nursing and non-medical staff across the system. This established the over-arching 'shared ambition'. Subsequent conversations between the parties also led to agreement that the collaboration should also seek to reduce unwarranted variation in processes across the six Trusts.

Working together

The aims and objectives of the collaboration were agreed over a period of several meetings with the various parties each prepared to commit to a common agenda that was more beneficial to the region, rather than individual Trusts. Working on already established relationships to build trust, their emphasis was on synergy and the fact that working together meant they were all likely to benefit more than working apart. NHS Professionals supported the process by exploring different options and solutions with the Trusts through a process of co-design.

A joint solution

The six acute Trusts in the ICS agreed not to employ staff members through agency if they already hold a substantive post at one of the partner organisations. The overall effect was to enable greater visibility of staff hours worked and a reduction in agency spending and off-framework

agency use. Essentially, the Trusts used their collective power to control the supply chain and create the conditions for flexible staff to work through the bank, rather than register with agencies.

The Trusts also wanted to reduce variation in processes, so they worked together to align skills and training requirements, rates of pay, terms and conditions and role descriptions. The service is provided on one, agreed, technology platform. Although reaching agreement on all of this took time and willingness to compromise, the result is an approach that gives all parties confidence they have equal access to workforce talent. Outcomes are continually reviewed and monitored; the collaboration has its own governance arrangements and key performance indicators that all parties subscribe and work to jointly with NHS Professionals. Benefits are therefore measured for the collaborative, and not individual Trusts.

The benefits

Carefully choreographed management of agencies led to quick wins (£1.72m savings on agency spending within the first 12 months) with additional savings of nearing £1m in year two. This is without factoring in the savings from running a shared service and more effective use of staff, with better fill rates from the migration of staff from agency to bank. There was no apparent adverse impact on shift fill at any individual Trust.

29. BankShare is an NHS Professionals programme that helps clusters of Trusts minimise their use of external agency staff by sharing their own substantively employed staff with each other. It also gives Trusts access to NHS Professionals' bank of assured clinical and non-clinical healthcare staff to meet short and long-term temporary workforce needs.

Hertfordshire Collaborative BankShare

Establishing a common purpose

The BankShare collaborative solution was launched four years ago, as part of NHS Professionals' existing relationship with Trusts in the Herts area. It initially involved three Trusts (East and North Hertfordshire, West Hertfordshire Hospitals and Hertfordshire Community). Princess Alexandra Hospital joined a year after the initial launch. While the underlying aim of the bank collaboration was the same as that for the South Yorkshire and Bassetlaw implementation - greater control over external agency use - there were subtle differences in the associated objectives. Here the focus was on 'less disparity' over pay rates (rather than pay harmonisation), a better experience for bank workers, and a better overall environment for their deployment.

Working together

The hiring of a dedicated programme manager enabled high engagement and a strong collaborative ethos from the outset. The focus was solely on implementing and realising the benefits from working collaboratively and not in isolation. The Trusts took time to engage with each other and align priorities around five identified core themes:

1. Pay rates
2. Recruitment processes
3. Employment checks
4. Training
5. Contractual arrangements

A joint solution

Using the BankShare platform, NHS Professionals configured a single solution to reflect the pay, process, compliance, training and contractual requirements agreed by the various parties. A Memorandum of Understanding was set up detailing the principles for shift length and pay rates (including clarity on agreed changes to existing pay rates, where relevant). The solution allows both 'bank only' and 'multi-post' holders (such as those that work both substantively and for the bank) to be visible and available on the booking system at all Trusts/sites.

The benefits

By increasing the range of opportunities available to bank workers, the Trusts have created a more compelling proposition for their flexible workers – particularly those working on a 'bank only' basis. The alignment of pay, process, compliance and contractual arrangements also means much greater regional equity, better insight and improved workforce planning. Monthly reporting on worker migration, shift fill and Trust demand has made the use of the flexible workforce across all Trusts more visible. In addition, continued collaboration via the monthly meetings has created an ethos of shared problem-solving and more efficient use of the workforce. The benefits in external agency spending have been tangible: in the period August 2020 to July 2021, the total savings from the migration of staff from external agency to bank was just over £1.3 million

North West Client User Group: supply chain management

Establishing a common purpose

The North West Client User Group (NWCUG) was formed in 2012 as a collaboration between several NHS Professionals partner Trusts in the region. Originally involving Manchester University NHS Foundation Trust, Pennine Acute Hospitals NHS Trust, Salford Royal NHS Foundation Trust, Stockport NHS Foundation Trust and Tameside Hospital NHS Foundation Trust, it was expanded in 2019 to include Greater Manchester Mental Health Foundation Trust. NHS Professionals recognised the opportunity to use the collective bargaining power of the providers to create cost savings and improve regional workforce planning through better workforce data visibility and tighter management of external agency supply.

Working together

The NWCUG holds bi-monthly meetings to share workforce performance statistics and collaboratively solve strategic workforce challenges. It also holds meetings with agency suppliers on a quarterly basis to review staffing supply and exchange feedback on which operational improvement plans are based.

A joint solution

Simon Walsh, Group Procurement Director of Manchester University NHS Foundation Trust, highlights the value of the collaborative approach:

“Manchester University NHS Foundation Trust is an enthusiastic and very active participant in NWCUG – reflecting how important we feel it is in Greater Manchester to collaborate, as opposed to working in competition. This collaboration is with our partner Trusts, suppliers, procurement partners and, of course, NHS Professionals. It is a unique approach that ensures a unified position with our suppliers. Clear messaging means clear expectations.”

“We have worked hard to improve fill rate; drive down unnecessary costs and ensure our suppliers have clear lines of communication. NWCUG combines everyone’s respective skills for the common good.”

Also notable here is the value which can be derived from involving all stakeholders in the collaboration, bringing different perspectives and divergent skills and enabling buy-in from all parties.

The benefits

Ultimately the collaborative has been able to achieve tangible cost savings and service improvements through better external agency management. For example, in the year to October 2020:

- £127,580 of savings were made by aligning pay rates of the 28 agencies supplying workers to Trusts across the region
- Service improvements were made through the implementation of a new set of framework agreed agency KPIs
- KPIs extended to cap compliance – saving the Trusts £780,211
- £782,823 of savings were achieved from aligning pay rates across three of the six Trusts
- Workforce data visibility has also provided the participating Trusts with critical insight to support their workforce planning

Mark Storey, Head of Procurement at the Northern Care Alliance, said:

“The valued support from NHSP ranges across performance tracking, benefits realisation and cap compliance. They have also consolidated supplier monitoring meetings ensuring no mixed messages or ‘divide and conquer’ aligned to a sophisticated agency ranking format and the group’s performance and governance criteria.”

Conclusion: The Road Ahead

In the wake of the pandemic, the requirement for providers to collaborate on a system-wide basis is set to intensify. NHSEI's Delivery Plan for tackling the backlog³⁰ suggests:

“Collaboration has been fundamental to the NHS’s response to the pandemic and will underpin our approach to recovery. We will ensure effective collaboration by enabling staff to work across multiple providers, establishing diagnostic and surgical hubs, building effective partnerships with the independent sector and reducing waiting time variation within and across systems.”

Enabling staff to work across the system forms the bedrock of the plan; without this, much of the ambition will fail. We must, therefore, accelerate collaborative workforce solutions to both reduce pressure on the current workforce and find new ways of delivering services. Similarly, it is critical we add new capacity to this flexible resource to make-up some of the skills shortfall.

NHS Professionals is working with a range of Trust and ICS clients to help them achieve successful workforce collaboration. This doesn't simply mean scaling up services across systems: it involves working closely with providers to fundamentally re-model services for system-wide benefits. Some of the key questions include:

- How can we establish a deployment vehicle that allows all staff in the system to work anywhere?
- How can we ensure that all workforce capacity (including that which resides in the agency sector) is available to all parts of the system while reducing use of external agency?

- How can we better understand skills gaps and support better workforce planning?
- How do we retain talent within the system by offering better cross-system career pathways?
- How can we create new 'recruit-train-deploy' models for newly created roles?
- How can we maximise the benefit from the pandemic workforce and those interested or curious about a new career in the NHS?
- How can we help to deliver Reservist programmes (including training and development of the reserve force), capitalising on the workforce potential from those people keen to support the NHS through any future 'surge' scenario?
- How can we recruit new people into critical parts of the workforce (such as carers) to eradicate bottlenecks and facilitate the through-flow of patients through the system?

Using our position as the NHS's largest staff bank and our knowledge from developing attraction, training and deployment workforce services, we are working to co-design new solutions within established and newly formed collaboratives. As we continue this work, we look forward to sharing our learnings to help the NHS and its partners recruit and retain the best staff and deliver even higher standards of patient-centred care.

30. "Delivery Plan for Tackling the Covid-19 Backlog of Elective Care", p48, NHSEI, February 2022

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