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# Understanding the key success factors in collaborative working

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**June 2019**

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# Foreword

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## Flexible working for the NHS, by the NHS

Workforce management, greater flexibility and achieving wider collaboration are the keys to addressing many of the current challenges in the NHS – as identified in the NHS Long Term Plan (LTP) earlier this year and more recently reinforced in the Interim NHS People Plan. The latter, sets the vision for how people working for the NHS will be supported to deliver the ambitious LTP, and this paper is NHS Professionals' contribution to help build a workforce that befits a world-class 21st century healthcare system.

NHSP is the market leader in managed flexible worker services and currently works in partnership with over 55 NHS Trusts. We help Trusts to reduce their reliance on agencies by providing a service that combines an intimate understanding of their temporary workforce requirements with the reassurance of a safe, quality and reliable supply of cost-effective temporary staff. We have over 126,000 members registered on our bank from various roles, grades and specialties. Our dedicated bank members and locums fill around 26 million hours for our client Trusts each year, working flexibly around their lifestyles by choosing the hours that suit them.

Wholly owned by the Department of Health and Social Care (DHSC), all of our investments support our core service to the NHS and any profits are reinvested back into the NHS. It is for this reason that we proudly say that we are *'for the NHS, by the NHS'*.

This paper highlights the need for greater maturity in collaboration on workforce challenges and opportunities, and with a wider footprint than through a single organisation. The conclusion – the need to work systematically within a wider system has challenges for us all, whether it's technology utilisation, compliance processes, governance structures or even 'softer' system issues around culture and identity. Our research respondents point to the need to gather learning in order to mobilise our local workforce. And in doing so, we will increase momentum and collaboration of **the people** to the enduring issues around professional workforce availability.

With this in mind, NHS Professionals is actively helping Trusts to deliver sustainable workforce solutions which maintain and extend world-class patient care. Achieving greater collaboration across the whole system is the next critical phase in that journey. NHS Professionals is here to play its part.

**Colin McCready**

*Chief Executive, NHS Professionals*

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## Executive summary

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The NHS is at a pivotal point in its 71-year history. Since 2002 the NHS has been structured around a “competition is best” model. The Lansley reforms of 2012 sought to shift power and cash away from providers disbanding Regional Health Authorities in favour of Clinical Commissioning Groups. Since 2016, we have seen a shift towards a new regional model, Sustainability and Transformation Partnerships (STPs), designed to help address the ever-growing pressures on a beleaguered health service.

And now the STPs themselves are transforming into Integrated Care Systems that span all of the healthcare pathways across a defined geographical region. With this new model of care, we need a new model of working within the NHS and its associated providers: GPs, Community Interest Companies, spawned out of services previously run by the NHS, mental health services and acute hospitals. Increased demand for services is outstripping the available resources both in terms of cash and manpower.

The NHS Long Term Plan has started to address the financial aspects of running a health service fit for the 21st century and the first step in the resourcing plan was issued this month.<sup>1</sup>

In the meantime, scarce resources will have to be moved to where the patient need is greatest. We need to reshuffle the deck to ensure that care pathways are well served throughout the system and not just at the acute provider services. As we push healthcare out of hospitals and into the community, the imperative is to address the flow of people within the NHS system so that they can be used most effectively and achieve best results for patients and their families.

Collaborative working offers us that opportunity to redress the balance and shift resources to where they can be used most effectively. However, there are many obstacles in the path: past government policy, old legislation and sunk investment in technology that all contribute to the system inertia.

This paper explores some of these issues and considers where we are on the journey to genuine collaborative working across the NHS. It considers the most flexible resource, bank and agency staff, who could be redeployed to where they would make the most difference in the shortest time. There are many issues affecting even this most flexible of workforces, not least of which is the very significant shortage of full-time staff across the NHS whose roles they cover.

There are no insurmountable problems in choosing to work collaboratively. They may be difficult, they may take time and they may require some structural changes, but they are deliverable. We all need the NHS to work for us and we all have an investment in its future. Now we have to collaborate to make it work.

*1. Interim NHS People Plan*

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## Problem statement

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Since 2012, Trusts have been struggling to recruit and retain enough staff to maintain the quality of service required to fulfil their safe patient care objectives.

This is particularly the case in secondary care: both in acute and mental health environments.

*“Staffing is the make-or-break issue for the NHS in England. Workforce shortages are already having a direct impact on patient care and staff experience. Urgent action is now required to avoid a vicious cycle of growing shortages and declining quality.”<sup>2</sup>*

Patient care is suffering, with many disjointed care pathways that leave patients in limbo when they move from primary to secondary and tertiary care. Organisational boundaries have become perimeter fences, difficult for both patients and clinicians to overcome.

This is not where we want to be. NHS organisations are not isolated care providers, they are each an integral part of a care pathway that should serve the public health. They are not bastions of power, they are centres of excellence in helping the public regain and maintain good health. Each care organisation serving a community has a role to play in a bigger picture: dealing with growing demand, increased acuity and scarcity of resource.

The current NHS secondary care model was designed in a time of plenty, when Trusts could go it alone in splendid isolation. That time has passed. To make the NHS work, we have to join forces and work together.

Among other initiatives, the NHS Long Term Plan will “support improvements in regional workforce planning, with us [DHSC], Health Education England and NHS Employers working together with local employers.”<sup>3</sup> Despite being “one NHS”, it is not easy for NHS organisations to collaborate.

This paper focuses on one aspect of collaboration, namely workforce. The single biggest spend across the NHS and the resource now in shortest supply. With 100,000 vacancies across the NHS, we need to take steps to share that resource in a way that best meets the needs of patients.<sup>2</sup>

And now for the good news. One component of our NHS workforce that should be easily shared is the flexible working bank. In late 2017, NHS Improvement (NHSI) reported that “more than half of all Trusts (53%) are either in a collaborative bank or planning to introduce one.”<sup>4</sup> In December 2017, 38 out of 44 STPs had a collaborative bank in place or under development and NHS Improvement (NHSI) aimed to ensure all STPs either have a collaborative bank or are developing one. More recently, NHSI advised that towards the end of 2018, it was 41 out of 44 STPs.

This paper aims to address some of the challenges we see NHS organisations across England face as they endeavour to share the most important resource they have - **people**.

2. *Closing the Gap*, March 2019; joint publication by The Health Foundation, Nuffield Trust, The King's Fund

3. *Improvement* - <https://improvement.nhs.uk/news-alerts/new-chief-people-officer-help-build-nhs-workforce-future/>

4. [https://improvement.nhs.uk/documents/2198/Developing\\_collaborative\\_and\\_medical\\_staff\\_banks\\_event\\_slides.pdf](https://improvement.nhs.uk/documents/2198/Developing_collaborative_and_medical_staff_banks_event_slides.pdf)

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# Background

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## How did we end up here?

There is no doubt that the NHS is strapped for cash; it always will be. The majority of NHS Trusts are unable to balance their budgets.<sup>5</sup> There is a general shortage of staff across the NHS particularly nursing staff, medics and other clinicians, with no improvement expected in the foreseeable future.<sup>6</sup> Trusts are actively competing against each other to attract and retain both permanent and temporary staff. They are also competing in a global healthcare environment where clinical staff have transferrable skills that are valuable not just across the region or throughout the UK, but internationally recognised all over the world.

Skills' shortages are likely to get worse as the 'baby boomer' generation progresses towards retirement over the next ten years. International recruitment has been stifled by government migration policy coupled with English language testing policy for non-British nationals implemented by the Nursing and Midwifery Council (NMC). Recruitment from EU countries has dried up, no doubt partly due to Brexit concerns but mostly due to changes in the implementation of language testing constraints on EU subjects.

Individual NHS Acute Trusts are sending parties of senior nurses on fishing expeditions to India and the Philippines. Rather than a coordinated recruitment activity for the UK as a whole, each Trust competes directly with others to recruit the same few people that have met either the IELTS (International English Language Test System) or OET (Occupational English Test) standard.

## What's working, what's not?

On the whole, the NHS does an amazing job with limited resources. But the ability to recruit the right staff to meet the clinical needs of their patients is severely compromised and unsustainable. The introduction of 44 Sustainability and Transformation Partnerships across England in 2016 has given us a different perspective on how we might change the way the NHS delivers services by realigning service delivery across the local geography and demography. According to the HSJ, They will be "working across organisational boundaries to help build a consensus for transformation and the practical steps to deliver it."<sup>7</sup>

5. Nagendran M, Kiew G, Raine R, et al. *Financial Performance of English NHS Trusts and Variation in Clinical Outcomes: a Longitudinal Observational Study*; *BMJ Open* 2019.

6. *The Future of the Health and Care System: Developing the Long Term Plan*; Ian Dalton, Chief Executive NHS; October 2018

7. *Revealed: The leaders chosen for 41 of England's STPs*; *Health Service Journal*. 30 March 2016

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## Sustainability and Transformation Partnerships (STPs)

*“Sustainability and Transformation Plans are an attempt to find a way through profound tensions in the system – between central and local control, between dealing with the immediate financial crisis and planning for the long term, between prevention and treatment, and between organisation and system.”*

*“The STP process – particularly the opportunity for local public sector organisations to pool resources, such as buildings and replace obsolete IT with integrated, cloud-based services – offers huge scope for higher productivity at lower cost. If these opportunities are not seized, the biggest risk to the NHS is that it will fall further and further behind public expectations of how it should use technology to provide seamless, personalised and timely care which fits into our busy lives, and how it should be caring for us in our old age.”*

*“The opportunity for change presented by the STPs has to be grasped; collaboration across local health economies has to be the way forward.”<sup>8</sup>*

The role of the STPs has since been further enhanced by the NHS Long Term Plan, issued in January 2019. Integrated Care Systems (ICS) are being launched that take a system wide approach to healthcare across the community, matching delivery capability to public healthcare needs using evidence rather than anecdote.

## NHS Long Term Plan

*“Local NHS organisations will increasingly focus on population health and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs) everywhere. ICSs are central to the delivery of the Long Term Plan.”*

*“ICSs will become the level of the system where commissioners and providers make shared decisions about financial planning and prioritisation.”*

*“As ICSs take hold, we will support organisations to take on greater collaborative responsibility.”*

*“This will mean that neither Trusts nor CCGs will pursue actions which, whilst potentially improving their institutional financial position, would result in a worse position for the system overall.”*

*“...leaders in all parts of the NHS will be encouraged to support one another across and beyond their organisations.”<sup>9</sup>*

The move to Integrated Care Systems is being strongly promoted by NHS Improvement will take a more proactive role in supporting collaborative approaches between trusts.” Funding will be directed to support service integration. “ICSs will agree system-wide objectives with the relevant NHS England/NHS Improvement regional director and be accountable for their performance against these objectives.”<sup>9</sup>

### Do we need to work together?

Is collaboration between healthcare providers necessary or even desirable? Why bother?

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8. *Swimming Together or Sinking Alone - Health, Care and the Art of Systems Leadership*, Richard Vize, Institute of Healthcare Management

9. Reference: Extract from NHS Long Term Plan, January 2019

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The first value set out in the NHS Constitution is *working together for patients*.<sup>10</sup> Everything we do, every business process, every interaction across organisational boundaries, should help us better serve that purpose. That is why we need to take a systems wide approach to how we manage vital resources to work together to better serve patients and their families.

### **Systems Leadership across the NHS<sup>11</sup>**

In 2019, the Institute for Healthcare management held a roundtable to explore systems leadership across the NHS. A few extracts relating to integrated care systems follow.

*“So far, discussions have been heavily focused on closing, merging or moving acute services rather than the more painstaking, detailed work of looking at the end-to-end experience of patient journeys, and how connections between services can be made more effective and efficient: ‘People understandably go for the system architecture, which is not the answer.’”*

*“With STPs conducting their meetings in the language of acute Trusts and their problems, other perspectives that should be at the heart of the conversation – notably mental health, social care and primary care – have all been getting too little air time.”*

*“The shift from a hierarchical, centrally controlled, health service driven by the needs of hospitals to place-based health and care systems driven by patients and communities demands leadership of the highest standards. As well as relentless energy and hard work, leaders need to role-model the values and behaviours of systems leadership in everything they say and do.”<sup>11</sup>*

### **Integrated Care Systems**

The NHS Long Term Plan makes it clear that “ICSs will have a key role in working with Local Authorities at ‘place’ level and through ICSs, commissioners will make shared decisions with providers on how to use resources, design services and improve population health.”<sup>12</sup>

We need to find ways to work together to design services and utilise resources to maximum benefit for the people in our community, not just while they are in our care but throughout their care journey.

### **What are Integrated Care Systems?**

*“Local services can provide better and more joined-up care for patients when different organisations work together in this way. For staff, improved collaboration can help to make it easier to work with colleagues from other organisations. And systems can better understand data about local people’s health, allowing them to provide care that is tailored to individual needs.*

*By working alongside councils, and drawing on the expertise of others such as local charities and community groups, the NHS can help people to live healthier lives for longer, and to stay out of hospital when they do not need to be there.*

*In return, ICS leaders gain greater freedoms to manage the operational and financial performance of services in their area.”<sup>12</sup>*

10. The NHS Constitution; Department of Health and Social Care, 2015

11. *Swimming Together or Sinking Alone - Health, Care and the Art of Systems Leadership*, Richard Vize, Institute of Healthcare Management

12. <https://www.england.nhs.uk/integratedcare/integrated-care-systems/>

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## Defining the role of the ICS

*“While workforce was acknowledged as a critical part in enabling successful ICS development, the NHS Long Term Plan left the detail in this area to a subsequent national workforce implementation group.”<sup>13</sup>*

*“Workforce is now widely regarded as the biggest single challenge facing the health and care sector.”<sup>14</sup>*

*NHS Confederation considers the following crucial to the development of the ICS model*

- *“Managing the on-going, system-wide deployment of the health and care workforce, including through schemes such as passporting.”*
- *“Establishing an in-built expectation of flexible working across clinical and non-clinical boundaries throughout the system.”*

*“ICS leaders should be expected to commit to working together across ICS boundaries ... This will involve regional collaborations with like systems in terms of locality and ICS maturity...”<sup>14</sup>*

13. Extract from “Defining the Role of Integrated Care Systems in Workforce Development: A consultation” by NHS Confed, Jan 2019

14. NHS Confederation (2018), *Letting Local Systems Lead*

15. <https://www.kingsfund.org.uk/publications/year-integrated-care-systems/site-profiles/south-yorkshire-bassetlaw>

## An ICS in action

Ben Chico, Programme Manager, Working Together STP, South Yorkshire and Bassetlaw NHS. A number of organisations in the STP have joined with local authorities to work in collaboration to provide a joined up care service for their community.

*“An Integrated Care System is a more developed STP that functions with clear governance based on a memorandum of understanding and approved plan.*

*The ICS includes a Workforce Hub established to support Partner organisations collaborate in delivery of:*

- *Workforce transformation including introduction of new roles*
- *Reduce unwarranted variation across systems and processes*
- *Enabling delivery of clinical transformation programmes*

*A new operating model for the NHS is in development which aims to clarify appropriate levels of devolvement for ICS.”*

*“This represents a step change in the level of collaboration between organisations.”<sup>15</sup>*

The Working Together STP consists of 23 members, including Barnsley, Doncaster, Rotherham, Sheffield and Bassetlaw CCGs and nine provider organisations across the region: Barnsley, Doncaster and Bassetlaw, Sheffield, Rotherham, Chesterfield, along with Ambulance Services.

Other members include the local authorities, borough councils, county councils district councils, and nearby providers in Nottinghamshire and South West Yorkshire.

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## Evidence of good working practice

Good things tend to happen when NHS Organisations choose to work together.

### Primary Care Networks: The building blocks of an Integrated Care System – Dorset, South West

*Dorset is one of 14 Integrated Care Systems in England, between them serving over 12 million people.*

*Primary Care is central to every ICS, but rising demand for services has led to substantial pressure on staff. A different model of general practice is needed to help clinicians and other staff to have appropriate workloads and patients to get the best possible care.<sup>16</sup>*

These organisations are collaborating, changing care pathways and joining up healthcare.

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## Our Dorset Integrated Care System

***We need a highly mobile workforce and it's really important that technology helps us and enables us to deliver this care in a different way... We need to remove the traditional barriers to stop people from working across services and different providers... we need to think differently about how we enable our workforce to work together.***

*Dr Karen Kirkham, GP Weymouth, Dorset ICS Clinical Lead<sup>17</sup>.*

## WIIFM - What's in it for me?

NHS England has changed its focus away from competition between Trusts, to a sharing approach that favours a benefit for the local healthcare economy over an immediate need of the Trust. While many CEOs are realigning their organisations to accommodate those changes, that has yet to filter down to the people who make minute by minute decisions.

We need to consider performance management and reward mechanisms that favour the best overall outcome, not just the outcome for any one organisation within that healthcare economy.

ICS leaders will have to wrestle with the WIIFM problem every day, in every organisation until we have a set of common objectives and targets agreed and enshrined in the objectives of each individual operating unit across the ICS.

## Systems Leadership – putting the patient at the centre

*“This is not just about engaging consultant doctors and social work directors. Involving senior staff is relatively easy; the difficult part is creating an environment in which middle managers and junior staff feel empowered to think and work differently – collaborating across organisational boundaries and putting the patient rather than administrative systems at the heart of what they do. In other words, creating a culture and systems which empower people to do the right thing.”<sup>18</sup>*

16. <https://www.england.nhs.uk/gp/case-studies/primary-care-networks-the-building-blocks-of-an-ics/>

17. Extract from video in presentation given by Our Dorset: How our technology partnership transformed the workforce; Telegraph healthtech conference

18. Swimming together or sinking alone - Health, care and the art of systems leadership, Richard Vize, Institute of Healthcare Management

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## The 'non-zero sum' game – optimising outcomes through collaboration

Concerns about beneficial outcomes are seen clearly in the "prisoners dilemma". The sharing of resources in the NHS is an example of a non-zero sum game: by cooperating, better outcomes can be achieved.

When resources are scarce, people are inclined to put their own Trust needs first. Only when clear guidelines for cooperation and escalation are established between both parties away from the heat of the decision making will they consider putting their own Trust needs as secondary. This is clearly the role of the ICS – helping individual care providers make difficult choices.

Collaborating on workforce across a health economy is a complex task with associated risks. There are many variables to consider and many approaches that might be taken.

Following a secondment with NHS Improvement, Claire Scrafton, Deputy Director of HR, St Helen's & Knowsley Teaching Hospitals NHS Trust, has direct experience of collaborative working practices across the Cheshire and Merseyside STP.

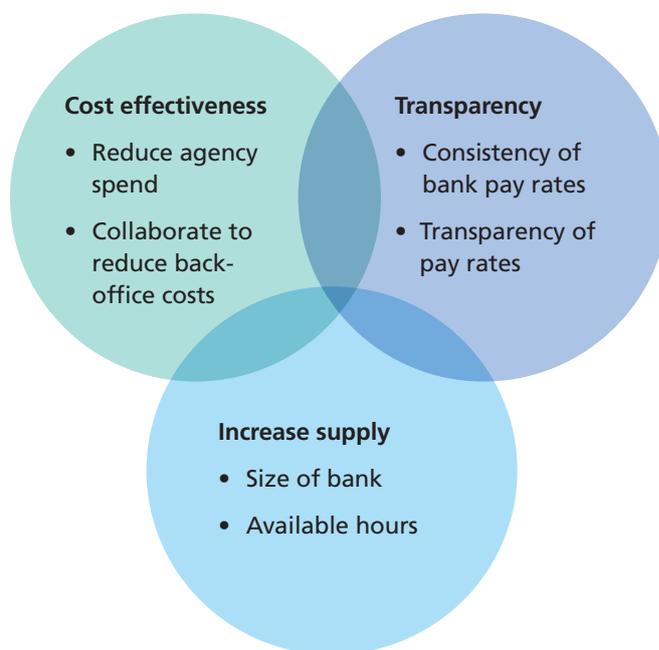
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***There is no 'one size fits all' model for collaborative banks. NHS organisations need to develop more collaborative approaches to solving challenging workforce supply issues - together. If they don't, then temporary staffing agencies will continue to drive up rates of pay and commission. NHS Trusts need to take control through place based or regional collaboration to ensure they continue to reduce agency spend.***

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There are clearly benefits to be gained from working together including reduced agency spend; shared back-office costs, increase transparency and supply.

## Common motivations for introducing a collaborative staff bank: cost, transparency and supply



## Do we have the capacity to change?

*"Management overstretch may be the biggest threat to STPs' ability to continue as effective networks. Virtually every part of the country has serious concerns about whether they have the management capacity and skills to deliver these ambitious plans.*

*Over the last few months, STPs have been run on goodwill and long hours, but that will be insufficient as the engagement and implementation phases approach. Do we have what it takes?."*<sup>19</sup>

19. Swimming Together or Sinking Alone - Health, Care and the Art of Systems Leadership, Richard Vize, Institute of Healthcare Management

# Big issues in collaborative working

In this section, we will review some of the ‘big issues’ that can easily get in the way of collaborative working; consider the genuine concerns that underpin them; and discuss how those concerns might be mitigated.

There are three principal issues to consider if NHS organisations want to work together:

1. **Perceived risk**
2. **Harmonisation across cultures**
3. **Interoperability of IT systems**

The latest Interim People Plan from NHS England is highly aspirational in its outlook and expects many of these problems to be simply managed away. But there is no magic wand to change employment law; only legislative change or a change in the employment model will resolve some of these issues.

*“We need to remove practical barriers to movement of staff between organisations.”<sup>21</sup>*

We explore some of these multi-dimensional issues below, however a deeper dive into this is covered in a follow-up report by NHS Professionals.<sup>20</sup>

Principle Issue	Challenge	Mitigation
<b>1. Perceived risk</b>	Pay rates	Harmonise bank and agency rates
	Payroll	Managing pay across Trust boundaries
		Alternative employment models
	Governance	Managing common governance standards
Accountability	Taking responsibility for governance failures	
<b>2 Harmonization across cultures</b>	Recruitment policy	Common recruitment standards
	Training standards	Common training standards
	Uniform	Standardised uniform policy
<b>3. Interoperability of IT systems</b>	Provider of software	Data exchange interfaces
	Version of software	Backward compatibility
	Interoperability within the Trust	Working with out of date software
	Interoperability across Trust boundaries	Exchanging information in real time

Collaborative Working across NHS organisations is likely to be held back by the structures that we have put in place. To engage someone in work, we have to pay them and to pay someone, they have to be employed and go through full legal employment due diligence. The current NHS employment model cannot support collaborative working in its current form. All of these issues could be resolved but only if Trusts are receptive to a different employment model or if employment law changes with respect to transfers between NHS organisations.

20. Collaborative Working in Action, NHS Professionals, June 2019

21. Interim NHS People Plan

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## Perceived risk

As usual, the devil in all implementations is in the detail which is covered in a supplementary document *Collaborative Working in Action* covering NHS Professionals' experience of supporting 28 NHS Trusts who are involved in workforce collaboration of one form or another.

Concerns about risk are manifest across the NHS. It is the prevailing culture across the whole NHS and no organisation is immune from it. No one ever lost their job by not taking a risk!

The principal risks perceived by stakeholders in any collaborative workforce model are:

- Pay rates and payroll
- Governance
- Accountability

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***The employment model is the key – Trusts can make it challenging to work together or straightforward depending on the decisions they make about who employs and pays bank workers. It's important to make the experience frictionless or people just won't use it.***

*Megan Grant, Director of Business Process & Change, NHS Professionals*

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## Harmonisation across cultures

We need to recognise and enforce NHS common standards if we want people to work together. Credentials and clinical governance records need to be portable.

## Interoperability of IT systems

Exactly when does investment in IT systems become a problem?

To paraphrase Sir Colin Marshal, one-time chief executive of British Airways, "Once we thought of investment in IT as a competitive advantage. Now we see that our investment is a hindrance to progress, preventing us from moving on."

IT investment across the NHS is uncoordinated and haphazard at best. Since the failure of the Investing for Health initiative in the early part of this century, Trusts have invested in IT systems and software that are most suited to their own Trust's immediate needs, with little regard for the interoperability with other NHS organisations. In fact, their very remit was to exist in isolation.

We are now asking NHS organisations to work together in a way that was never envisaged when they were making strategic investment decisions. We should not be surprised that their infrastructure does not support collaboration. Even Trusts that have invested in the same IT systems from the same software vendors are just as likely to be unable to work together.

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***There are few common data standards, so mapping workforce data sets between Trusts can be a complex task. Some collaborative bank arrangements depend on everyone adopting one software solution from one vendor. We're not convinced that software is the only answer. Your choice of software shouldn't be a hindrance to collaboration. Ultimately, any inter-operability issue can be resolved.***

*Megan Grant, Director of Business Process & Change, NHS Professionals*

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# Solutions to support collaborative working models

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Collaborative working is not a 'one-size fits all' issue. Each Trust is different, its role within the health community that it serves is different to any other and its existing infrastructure is unique.

## **Beware software vendors peddling snake oil**

There are many software vendors who claim to have software solutions to all of the issues that NHS organisations face in working together. Some are good at dealing with some things and some are better suited to other aspects of the problem.

Let's be clear, there are some very clever software tools out there, but none has all the answers. Neither information technology in its broadest sense nor point software solutions are the answer, though they may be useful to help with part of the puzzle. Where flexibility or guidance is required, service providers rather than software vendors are the answer.

## **Levels of workforce collaboration**

With such a variety of needs between Trusts and other organisations across a health economy, it is highly unlikely that a single solution will suit everyone. Let's now take a look at a range of levels that could form the basis for cooperation and collaboration between providers.

## **Workforce intelligence sharing**

The basic needs of each provider are served by its substantive workforce, but they do not live on an island (except maybe the Isle of White). People share information about bank and agency rates with their friends. In a world dominated by social media, there are no secrets, but there is a fair amount of 'fake news'.

Providers can share knowledge about their workforce issues – hard to fill locations, difficult recruitment challenges and non-compliant agencies. Sharing knowledge and experience helps providers plan, organise and work better together.

Sounds easy enough, but experience suggests that sharing resources is only achievable in a forum mandated by the Trust executive management teams and managed by an external mediator, such as an STP lead or managed bank service provider. Suspicions always prevail until people develop trusted networks.

## **Agency management**

Next on the agenda is controlling the activity of staffing agencies across an STP.

Only by providing shared intelligence in a standardised format can providers hope to exert authority over the agencies that supply their staff. Some agencies are clearly gaming the system, holding out for higher rates.

Of course, staffing agencies can play a crucial part in a system or Trust resourcing strategy and need to make a profit to stay in business; that's understood. With the right intelligence, Trusts can collectively set rates across the region to establish best value for the NHS and stop agencies playing one off against another.

## **Moonlighting**

Another vital piece of intelligence that will come out of sharing this knowledge is which substantive staff are moving between Trusts to work additional hours through agencies. Providers can place restrictions on who can work where within the region to encourage people towards working additional hours in their own Trust or via the bank.

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## Staff banks

With the agency position under control and visibility of which substantive staff are working where, the next step is to consider collaborating across nursing banks.

This is where software tools can play an important role in coordinating activity and people across Trusts but only after working through the collaboration issues first.

None of it will be easy. None of it should be undertaken by junior staff unempowered to seek common ground with their colleagues across the STP or ICS. Ideally, each provider should be represented by a senior member of staff, deputy director or above to ensure that a common understanding is reached, with the full backing of their executive team.

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## DHSC perspective on collaborative working

*We believe that, through effective and intelligent use of local and collaborative banks, the NHS can offer true flexible working to its staff, while fostering a workforce that is agile and responsive to real-time patient needs. A collaborative bank, underwritten by interoperable technology, enables trusts to take a holistic approach to workforce planning and empowers them to deploy their staff both within and between trusts, drastically reducing reliance on expensive and opaque recruitment agencies, while improving working lives.*

*Collaboration is essential if we're to make the NHS the best it can be for patients and the workforce. We have seen that collaboration on temporary staffing can, in particular:*

- *pave the way for the harmonisation of pay rates and give trusts collective bargaining power when dealing with agencies;*
- *can greatly increase the pool of staff able to fill any given temporary shift, and thereby increase opportunities for those who choose to work flexibly; and*
- *can break down barriers, such as incompatible pre-employment checks and mandatory training, that currently makes the movement of staff between Trusts so burdensome.*

*Sam Rodger, Head of Temporary Staffing Strategy, Provider Efficiency, DHSC*

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## Medical locum bank

In many cases, scarcity of locum doctors in key areas such as general medicine and trauma represent some of the biggest challenges in terms of availability and agency cost. "Medical ... has the lowest compliance with the price caps."<sup>22</sup>

Sharing locum doctors presents unique challenges. Their work patterns are different and they require specialised rostering tools to make the shift patterns work.

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## Harmonising medical locum banks

***Some STPs are trying to collaborate but little information is available on cost-benefit on collaborative banks, especially where the STP is widely dispersed over a large geographical area. In our experience, at any one time, there may be 20-30 doctors working in one trust waiting to be cleared to work in another neighbouring Trust within the same STP. Therefore, we believe Trusts can achieve quick wins if they implement passporting as the first step towards a collaborative bank.***

***Collaborative/regional banks require harmonisation of processes and pay rates. This takes time and effort: it's a long programme of 12-24 months' work. Therefore implementing collaborative banks are best achieved if they are broken into six-month sprints rather than big, expensive programmes. This ensures realisation of early benefits, such as movement of clinicians across different Trusts, before the entire programme of work is delivered.***

***The most important thing is goal alignment between Trusts so rather than focus on challenges, focus on goals.***

***Agencies work across wide areas, even if the bank doesn't, so passporting is key.***

*Dr Anas Nader, CEO, Patchwork*

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22. Reducing reliance on medical agency staff: sharing successful strategies, June 2018, Kathy McLean, Executive Medical Director and Chief Operating Officer, NHS Improvement

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## Levels of collaborative working practice

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Workforce Policy Alignment	Agency Management	Collaborative Banks	Flexible working across boundaries
<p>Pre-employment checks and recruitment practices – aligning these as standard amongst collaborative partners, recruiting to the same standards, and then accepting pre-employment checks completed by others</p>	<p>Collaborative procurement of agency vendors</p>	<p>Can use different providers (in-house, Managed Service Provider, etc.)</p>	<p>One lead employer for the region</p>
<p>Remuneration alignment – the importance (or not) of this, for both substantive and bank work</p>	<p>Collaborative management of vendors</p>	<p>Different technology implementations (Allocate Cloudstaff, Patchwork, Lantum, provider's own)</p>	<p>Contract covers all providers across the ICS</p>
<p>Restriction of substantive workers working via agency in any of the collaborative partners</p>	<p>Collaborative agency rate management</p>	<p>Different models – e.g. different employment options etc.</p>	<p>Credentials passport</p>

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# Organisation structure

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In the words of Peter Drucker, the founder of modern management<sup>22</sup>: *“Good organisation structure does not by itself produce good performance. But a poor organisation structure makes good performance impossible, no matter how good the individual managers may be. To improve organisation structure will therefore always improve performance”*.<sup>23</sup>

Is the wider NHS organised to work collaboratively? The NHS Foundation Trust reforms introduced in 2002 were designed to create a system of healthcare where large hospital Trusts operated independently of the state in as many ways as possible. Workforce demands are not consistent in their profile across care settings within a healthcare system. As such, with appropriate collaboration workforce shortage can in part be resolved by balancing demand peaks and troughs across a system through the sharing of resources.

## Good times, bad times

Among other changes to NHS design, the Lansley reforms enshrined in the 2012 Health & Social Care Act sought to place the funding with an independent group of CCGs that oversaw the whole spectrum of clinical needs for their locality. What these reforms have in common is that they were designed for a time when the NHS appeared to have adequate resources to deliver the care needs. That all changed in 2013 following publication of the recommendations of the Francis Report.<sup>24</sup>

Increased longevity and attendant complex care needs coupled with a protracted period of austerity following the banking crisis have left the NHS short of the very resources it needs most: people.

## The many faces of the NHS

Across the NHS, we have a complex structure of primary care practices that sit outside of the NHS, community service organisations set up as Community Interest Companies outside of the NHS. Secondary acute and mental health Trusts are mainly within the NHS but with varying degrees of independence depending on their foundation status and most recent CQC rating.

## Partially built structures

All of this chaos is bound by a structure of Clinical Commissioning Groups whose role is to direct funds to the right provider to deal with the forecast needs of the local population. Many of these structures are the result of decades of partially implemented government policy, superseded by further changes in policy half way through implementation. It would be hard to find a more complicated and disjointed approach to healthcare delivery.

## Systems Leadership

*“Transformation is being held back because it is being grafted onto existing systems, structures and cultures which are resistant to change: If our job really was to unite both community and acute and social care then we would run it in a new way. Apart from [NHS England chief executive] Simon Stevens cajoling us, the incentive is not strong.”<sup>25</sup>*

23. *The Practice of Management*, Peter Drucker, 2006

24. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*

25. *Swimming Together or Sinking Alone - Health, Care and the Art of Systems Leadership*, Richard Vize, Institute of Healthcare Management

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## The role of technology as an enabler

It has long been the view that technology will replace human activity in the workplace and enhance our ability to optimise resources to deliver effective outcomes. It is certainly true that technology has freed up resources in some industries and allowed us to achieve many things hitherto impossible. Yet, today in the NHS, people are employed to print and then fax patient records between care organisations because security is suspect and enter shift data into roster systems because there is no automatic interface.

There are many examples of technology being used effectively for clinical interventions in the NHS. There are fabulous financial IT systems that track physical objects through their complex journeys and account for every penny. But there are far fewer examples of technology being deployed to support the people who need to deliver the care, to unburden them of administration and to free them to get on with their real job, helping patients.

### Technology investment

NHS Connecting for Health (CFH) was set up to deliver the NHS National Programme for IT (NPFIT) in 2005. Contracts let in late 2003/early 2004 were designed to deliver local software solutions rather than a single nationally imposed system. The programme was the subject of a review by the Public Accounts Committee in 2007 following a cost estimate by the National Audit office of £12.4 Bn.

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***The edges of the care pathways should be clearly defined for patients at the point of entry and exit or crossover to other services. Different systems and processes across adjacent regions have a direct impact on continuity of care.***

***In the Scottish system, Integrated Health Boards cover wide geographies, which facilitates forward planning for population demographics to help position services for the years ahead. Such large-scale preparations are not commonplace in the NHS England system. In Canada and Norway they have deployed technology to support with similar planning, which is not available in NHS England.***

***We appreciate the reasons for constraints over wider access to patient records, but we must be careful not to use the protective rules as a reason to not share information, even where it may be in the best interest of the patient.***

***Patients simply don't want to give their personal details more than once!***

*Lynn Marsland, Strategic lead for HR Corporate Services, Greater Manchester Health & Social Care Partnership*

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## Benefits realisation

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In preparing this paper we have met with a number of leaders from the NHS and from other interested organisations. Some were more enthusiastic than others about the perceived benefits for the NHS and for patients.

Workforce collaboration is still in its infancy and consequently, there is a lack of system-wide empiric evidence to support it. Conversely, all current indicators are that, managed correctly, workforce collaboration delivers a positive impact for patients, staff and provider organisations, without any of the perceived risks described previously being present as contra indicators.

We have heard of considerable cost savings from carefully choreographed management of agencies across the STP. There are reports of significant reductions in the use of agency staff in the area where Trusts are collaborating to share their bank, mainly through NHS Professionals' Bankshare@.

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### Collaboration saves money

**There are 19 Trusts in Cheshire & Merseyside spending £39m per annum on agency and they aim to provide better value for Cheshire & Merseyside by avoiding £1.4m of medical agency cost in 2019/2020 and growing to £2m the following year.**

*Claire Scrafton, Deputy Director of HR,  
St Helens & Knowsley Teaching Hospitals NHS Trust*

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What is not counted is the cost of duplication: of operating more than one system. There are clearly further savings to be made by having a single passport tool that allows clinicians to move freely between Trusts, either as substantive staff or via the bank. Duplication is largely wasteful but NHS procurement policy doesn't easily support system wide needs.

These benefits are not achieved without cost in terms of people and intellectual horsepower. There are IT software products that might help but on their own, they are of little value. The real value is in the experience of the people deploying them in a way that meets the specific needs of the NHS organisations involved.

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**Early wins have emerged such as in South Yorkshire and Bassetlaw, where acute Trusts collaborated to deliver more efficient bank staffing systems, reducing administration and agency costs by over £1.72m, with a further £940k targeted.**

*Ben Chico, Programme Manager,  
Working Together STP, South Yorkshire  
and Bassetlaw NHS*

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While these savings shown above don't appear at first glance to be exceptional, they do represent a significant proportion of the bank and agency spend in those Trusts. That's real money saved by introducing collective agency management and escalation policies and by growing the available bank hours.

With this kind of savings demonstrated, there is clearly a great opportunity for the future.

Of course, collaborative working is not just about hard cash savings, it's about continuity of care across collaborating units; it's about minimising competition for staff between neighbouring Trusts and it's about reducing the need for agency staff by having the right people, in the right place at the right time. That's where the real benefits lie.

### **Jam tomorrow?**

*"The impulse to work together has been strongest in areas with the biggest difficulties; a sense of crisis focusses minds on the necessity of change because the alternative is insolvency or clinical failure."*

*"Creating momentum and belief will require some early victories: We have to demonstrate some of the successes. If it's all jam tomorrow it will be too late, so some of this has to be about taking risks and doing early wins."*

*Swimming Together or Sinking Alone -  
Health, Care and the Art of Systems Leadership,  
Richard Vize, Institute of Healthcare Management*

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## Conclusion

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It is now clear from the NHS Long Term Plan that organisations within NHS England must find ways to work together across organisational boundaries, both for the benefit of patients and for the NHS to succeed. Supporting policy of DHSC makes this abundantly clear and intervention by NHSI is likely to drive it home.

How we deliver on that promise is open to debate, but Integrated Care services, driven by STPs clearly offer opportunities for organisations to work together to establish better care pathways that support patients through in their journey through the NHS. They should also help us to improve efficiency in care delivery and provide better overall value for the tax payer.

However, these efficiencies are only attainable if we can create an infrastructure and employment model that supports the flow of people between organisations.

Collaborative working is not just a worthwhile objective, it may be the only way to deliver a successful NHS. Going it alone is no longer a viable long-term option. Making it work is where we need to invest our time. Choosing the right partners to help deliver it could make all the difference.

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## Credits

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Many thanks to all those who participated in this paper through various means.

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