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Integrated care systems and workforce collaboration

Hello, I'm Jamie Garnett from NHS Professionals, and welcome to Healthcare People. This is the podcast where we talk about everything health and care workforce: the challenges, the opportunities, and the future. In this series, we'll discuss the workforce pressure points for NHS Trusts and integrated care systems and look at where positive change is possible.

In this episode, I'll be talking to my colleague Jon Waters, Business Development and Client Solutions Director at NHS Professionals. Over the next half an hour or so, we'll look at ICS workforce collaboration, and the concept of one workforce across health and care systems.

JG: Hi Jon, it's good to see you and welcome to Healthcare People.

JW: Thank you very much, Jamie, good to see you, and indeed meet you face-to-face actually, for the first time, isn't it?

JG: It is the first time, and in case you're wondering, we're broadcasting from Manchester, we have a podcast studio up here, so greetings from Manchester, and Jon and I have battled here today from a somewhat struggling transport system due to freezing temperatures because it's being recorded in January 2023, so we're very grateful we're actually here. So, Jon, we're going to be taking a closer look at three issues today, the first one being Integrated care systems workforce, the second one being enabling collaboration, which is obviously a very important part of the integrated care system, and finally we're going to be looking at the concept of one workforce over a healthcare system. For now though I wanted to talk about some of the challenges and what the feedback has been because you work with ICSs around the country, and I wondered what their feedback has been so far on the issue of workforce to you?

JW: One of the things that's coming to us from a number of our ICS conversations, is that collaborative conversation. So how can a regional geography, an ICS geography, that consists of a number of trusts: how can they collaborate more readily to enable more effective workforce deployment across a patch? What does that look like in terms of the process, the technology that needs to underpin it? How does it can deliver benefit back in? What's the benefit for the worker? How does it impact retention, etc? So that collaborative conversation has been a real core starting point for quite a few of the ICS engagements that we've had.

We're also getting quite a lot of interest and quite a lot of conversation around capacity and consolidation. There's opportunity, obviously, when you rise up in terms of level through a system to the top of that system, from a regional perspective, to look at economies of scale, cost saving and efficiencies. So how can you put processes in place to enable effective care, but also generate that care in a way which is cost efficient and effective? It could be the likes of effective engagement, contingent staffing and agency management - how do you deliver efficiency to that extent? It could be looking at regional recruitment hubs to look at roles that are common across the geography as opposed to recruiting separately for each individual element. So there's a number of ways of consolidating services - the principle of subsidiarity, which is another critical part of an ICS build up, is delivering services to the right level within the ICS. Those are the kinds of areas that we're exploring with ICS: consolidation, cost efficiency and process efficiency more broadly.

And I guess the other conversation is around capability development. This is the blend of recruitment and training to look at how you upskill and cross-skill and therefore make the most of incumbent workforce within the system. That ties in with our Academy training capability within NHS Professionals as well.

So those are some of the kind of core conversations but then there's a whole series of conversations around health and wellbeing of the workforce, around retention, around broader benefits and economic and social development for certain parts of the system as well, all of which has an impact on what we do through our workforce. Because of the impact that workforce has living and working within the within the system.

JG: Is there one that is preoccupying them the most?

Our conversations are very varied, and there's a lot of focus around relieving the core operational pressures that are facing NHS at the moment. So you know that is absolutely foremost in our day-to-day work, and indeed at an ICS level. Looking aside from that, and looking at the ICS broader agenda, I think the collaboration approach is seen as a key enabler of a more effective workforce deployment across an ICS.

JG: You just raised something there about, we talked about the need to deal with core operational pressures and today's challenges balanced alongside long-term development, workforce solutions and opportunities. Because the NHS pressures are quite significant now, and a lot of it is about managing front door demand and trying to keep the flow going through hospitals. Is that taking them away from the longer-term stuff? Is it make it much harder for them to actually put in place and focus on longer-term initiatives?

JW: I think the two are closely linked, it's also important to note that ICSs, as well as being a way of binding together a geography, they are actually separate organizational bodies as well within that structure. There is a balance of resource that available, so trusts are running short term and focused interventions and ICSs maybe have that ability to look at slightly long term at the same time.

Within any sort of complex system with severe pressure on it, of course there's going to be a lot of focus on getting the short-term stuff right. But part of the reason part of relieving that short term pressure for tomorrow is looking at the reasons that underpin it and some of the things that you can do in the medium and longer term to help relieve that over time. You've got to look at the two things at once as well. I wouldn't say that short term interventions have been compromised by looking longer term. I think it's a case of learning from what's going on now, to put in play the kind of things that will continue to deliver in the medium and short term as well. There's always a balance of priorities, every organization knows that, and the NHS would be absolutely highly aware of getting that balance right is also part of the solution.

JG: What would you say are the opportunities for integrated care systems to make workforce improvements across the system?

JW: I think the opportunities are to enable an individual worker to gain broader and more fulfilling work experience, to give that individual a greater flexibility to work in different environments, to look at different training routes, to look at a broader set of skills that will therefore help retain and develop individuals. I think for the individual worker the opportunity is about a more fulfilling career, a broader career, a career that can be developed in line with the needs of the local community, as opposed to being tied to a single organizational environment.

And then you need to look at what that then delivers for the ICS. It should mean that that ICS is able to enjoy more effective retention, it should lead to increased capacity within the system, because there's greater flexibility for people to work in the way that they want to work. And it should also enable more effective collaboration across that system as well, which means more resource to go round, which again, delivers that kind of capacity peace. And with more effective engagement, with more effective deployment across a system, there's an opportunity for increased efficiency for a sensible cost saving agenda as well. A series of benefits, I think, focused around a better balance for a worker, leading to improved outcomes for the individual parts of the ICS and increased health care provision and wellbeing for the broader community and broader patient base.

JG: You've made me think of staff banks as a potential mechanism for that, and particularly the idea of shared staff banks. Is that something that is a mechanism here?

JW: What we're finding…is that on the back of the principle of collaboration, there's been an appetite to look at how those individual staff banks can work and link together to offer workers the opportunity to work across different trust environments, or indeed across a complete ICS. And we've also looked at pilots within other environments outside of acute hospital environments, in primary care and care homes, using similar sorts of technology. This is what enables us to link together different bits of the system.

The principle of a shared staff bank is about enabling a worker to work across a number of different environments. Obviously they will need to have the specific skills and the specific compliance requirements met to work in those environments, but it's all about knitting that broader market together. In terms of the opportunity, again it's about offering flexibility, variety and opportunity for an individual worker. What that brings to an ICS is a potential fillip with capacity, a retention technique as well to keep workers more engaged and to upskill and give them more rewarding work. All of that brings a great benefit to what collaboration can deliver to a system.

JG: In your experience, what does successful collaboration actually look like? Are there any particular common themes of successful collaboration?

JW: In delivering a collaborative workforce, a workforce that can work across a multiple of multiple environments, you've got to have collaboration at an ICS level to enable that. You've got to have a conversation going between the various bits that you want to work, and you've got to align on all the standard project-based criteria to get all that stuff moving. …You've got to have a common vision, you've got to have a shared approach to the project enablement and you've got to have the resource to get behind that overarching project.

I think part of what we've experienced in our conversation with ICSs is getting that sort of common view about what you're looking to achieve, and why, is absolutely critical to getting the principle of collaboration going. If you then look at enabling different trusts to collaborate, to share their workforce, you've got to have the right people around the table to understand the kind of operational reality of how that can work. There's pay alignment considerations. There's also the principle of shared compliance understanding as well, which is an interesting one. Even within an ICS there can be different requirements for compliance within a worker base. So making sure there's a shared understanding of how that works between the participating trusts is really key.

JG: How successfully is collaboration happening now? What are you hearing from the local systems that you're working with on that particular issue?

JW: It's a very important consideration for ICSs and individual trusts involved in our conversations, a lot of ICS is moving at pace to get that collaboration going. A lot of it is to do at this stage - we're relatively early in the ICS cycle - a lot of it has to do with getting the process set up. A number of ICSs are going through that kind of early phase of enabling collaboration and understanding the technology and the partnerships that they might need to generate to get collaboration moving. But we've already got a number of collaborative banks up and running, which are delivering, agency reduction and delivering increased shift fill and those have been running for some time. There is a proven concept there and ICSs are a moving proactively at pace to build and scale that up.

JG: *Collaboration is a quite a simple concept in some ways, but it's very hard to deliver sometimes, isn't it? Let's not kid ourselves on that point. What advice would you give on that?*

JW: It's about getting it right for your workforce. There is such pressure on the NHS and broader health care workforce at the moment that offering that workforce to be deployed in a way that works for that workforce, is a central question that will help inform better retention, better output, better engagement, better patient output and therefore better results for a local healthcare body and a broader ICS.

JG: Could you help us define what 'one workforce' is?

JW: If you look at how a workforce runs today, within you an ICS geography, a person will work for an individual organization in a particular sort of location. Across an ICS, with a whole host of organizations delivering workforce into that ICS, there are multiple employees, multiple payroll systems, multiple technology roster systems, multiple X, Y, and Z compliance procedures that exist, and sort of silo that workforce into its kind of employer funnel, you might say. If you look at the principle of collaboration, and enabling a worker to gain greater flexibility about where they work, when they work, and how they do things, you've got a whole lot of stuff in the way of enabling that. So one workforce is a way of looking at how you are unknit that conundrum to offer greater flexibility around deployment. Shared staff banks is a way of breaking down part of the silo, looking at passporting techniques - how you recognize different compliance and training validations across a system can be another way of doing it; looking at common payroll processes could be another way. All of these things add up to enabling this concept of one workforce. Now, you can take it to a level where there's a single employer across an ICS and everybody has the same rosters and technology and all of that sort of stuff. But you've got to kind of look at how you want to break down barriers to enable the best out of a workforce. And that's the concept of one workforce.

The other piece is the typical barriers that exist between contingent workforce and substantive or permanent workforce; they're kind of viewed in different ways, they're typically owned in slightly different ways by different bits of an organization. You've got to unlock the potential of contingent workforce as well as the substantive workforce in getting that one workforce example right. It's about looking at your workforce in terms of breaking down barriers about deployment and how that workforce does its job. But also looking at the kind of barriers that exist between contingent and substantive or permanent staffing and blending that in a way that enables a more effective workforce to do what the system needs and to give that workforce the flexibility, variety and breadth that it needs to flourish.

JG: What kind of difference do you think one workforce could make to the community at large, and to people and their health and wellbeing?

JW: If you have a workforce that can be deployed based on its capability more broadly, you are going to deliver better patient care because you can follow that patient journey. If you've got a workforce which is constrained specifically by only being able to be in a certain location, or only having access to certain sorts of work and may not see opportunity more broadly, the likelihood is that a patient relevant to that worker could potentially move off into a different part of system and therefore not gain access to that individual worker. If you're going to deliver better patient access as they journey through a complex system, you've got to un-knit the silos that restrict the workers from getting to that patient.

JG: It seems to me one of the big drivers behind the idea of one workforce is community prevention, not always curing but trying to prevent in the first place. Is that something that resonates with you? Is there something around prevention?

JW: There's a lot of emphasis across the ICS system about prevention and broader population health and wellbeing. Clearly the more you can intervene to reduce the occurrence of illness, the more well your population and the less pressure on the systems around it. Looking at integrated care as an enabler of that is essential because you begin to understand your population more broadly because you're looking across a whole patch and using data and understanding from a number of different organizations to understand what the current challenges are in order to address those healthcare inequalities in the system. Part of what will make integrated care effective is that breaking down of data and information barriers as well as understanding what your population looks like at a local level and putting in place interventions to address that. I think that's the opportunity for prevention. There's a number of prevention techniques and interventions out in the market at the moment but they are helped and enabled by better visibility of what the challenges are across a patch, more joined up working between different parts of an ICS, from the third sector through to local government through to primary care etc, to really identify what the challenges are and put those prevention techniques into play. It's all about breaking down those information barriers and taking action on what you find.

JG: How optimistic are you that those barriers will come down now that we have some legislation around collaboration in the health service and social care? How optimistic are you that the number of challenges around that will be overcome?

JW: I'm pretty optimistic that from my engagements with ICSs, the legislative underpinning and some of the obligations and focus that produces, are making a real difference to giving us the overall approach the teeth it needs to deliver the change that is possible. There's a lot of good thinking, a lot of good activity underway, and I think it's going to be a real enabler of what a future health service can look like and should look like. We have got to recognize that we are a different population with a different base of illness and that a system with such complexity and such expectation needs to be open to looking at things in a different way and taking hold of these sorts of opportunities. I think the system broadly sees that so yes, I'm quite optimistic about the changes that this ICS approach will bring to the way healthcare is delivered and to the health of the population, absolutely.

JG: Jon, it's been a pleasure talking to you today, many thanks indeed for your time.

JW: Thanks, Jamie.

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