Healthcare People podcast, brought to you by NHS Professionals

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NHS trusts: managing demand and reducing agency costs

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 joined by my colleague Karla Boddy, Chief Customer Officer at NHS Professionals. Karla and her team work closely with trusts around the country, so today we'll discuss demand pressures, and the need to reduce agency spend.

Welcome and introduction

JG: Hello Karla, welcome to Healthcare People podcast, how are you today?

KB: I'm really well thanks, Jamie. How are you?

JG: I'm really good. Today, we're going to be talking primarily about the trust sector, which you work extensively with as Chief Customer Officer at NHS Professionals. Let's talk about one of the biggest challenges that we face right now, which is demand. And I just wanted to paint a brief picture of that, in no particular order, we've got urgent and emergency care, we've got a lot a lot more people waiting more than four hours, we've got discharge delays, which are compounding the issue of discharging people who are medically fit to leave, and the care sector, as we know, is under a lot of pressure. We've also got the elective backlog as well and of course, we've also got workforce vacancy rates. So that's quite a difficult picture, it's safe to say. Rather than go into those in too much detail, because the people listening to this, the trusts that are listening to this, will know these problems inside out. But I just wondered what your thoughts are initially on that…what does that picture say to you?

Demand pressures in NHS trusts and bank

KB: Every year, we go into process to forecast what we think the next year's demand may be, and in the last three, every year has outstripped the year before, exponentially. So just reiterating, that the demand that a trust feels directly translates to demand and a requirement for more staff. And it's not just more staff, it's more staff more quickly, it's more skilled staff, it's more specific staff because the complexity of the problems trusts are facing require staffing services to bring with them different options when it comes to the service offering. So for me on the workforce front, if we speak specifically around that part, it's a bit of a push pull because trusts are having a really challenging time, what with better retention, better resilience in the workforce, who have had two years of a really tough time and now find it very difficult to stay in their usual work rate, rightly so. We're trying to cover that gap, not to mention overlaying all of the things that you've just said the elective backlog, the demands on EDs etc, etc.

We also have our own microcosm of that within the bank service. We rely quite heavily on people who need, would like flexible working, people who have retired, but will do shifts, and a whole population that's slightly different from the substantive members of a trust. But those people have changed their behaviours too, because they too don't have the same level of not necessarily buy-in to the bank, but they've exhausted themselves too. So we also don't have the same resilience of our bank that we may have once [been] used to. And when we look at people who are returning and returning because they're retiring, well, actually, they're

not returning and retiring and going on the bank anymore, they're returning and retiring and doing something else. And people are retiring from their substantive posts a lot earlier. So not only do they retire earlier, but they also may not visit the bank as an option once they have retired. So we're compounding the issue, because before we could get quite a lot of return workforce, and now those returners want to do something different. And so the demand issue, look, like you said that some really detailed parts that go far beyond my swim lane to comment on probably, I'm sure I have an opinion like lots of people, but the staffing problem, it's a two-way fix. We need to fix the workplace for the substantive members of staff and for those that work for the trust, and the bank will follow. But it's a really difficult landscape at the moment.

Demand pressures: what trusts have been telling us

JG: What are your trust clients reporting to you about this? What's the general mood out there? And also, is there a sense of optimism? Is there a sense of pessimism? What is the general mood of what our trusts are saying to you in terms of feedback?

KB: Yes well, look, I'm sure some of our trusts are going be listening to this so I will start by saying that every trust is different, and every trust feels things differently. But if I take my experience of three winters now within staffing and healthcare, I would say this year, we have better collaborated with trusts on managing demand than we have previously. We've seen better [shift] fill rates this year than ever and I think that's testament to a couple of things. One is we are working really collaboratively with the trust, and we're getting on the front foot with winter pressures and winter planning. And secondly, we are shaping the right incentives for the workforce, to get them to come and work those additional shifts in this really pressured time. So for me, if I'm reflecting on it from a wholesale perspective of our customers, our response has been strong, and shoulder-to-shoulder with the trust, and we've shut the gap on the fulfilment piece. So while demand is still really strong, our fill has improved. And that's really important for the trusts, especially over winter.

JG: It's quite difficult, because there's a huge amount of media coverage about the NHS, it's quite difficult to really understand what it's like on the ground. I gather you visited a trust this morning, how did it feel to you once you were in there? I don't know if that's not a vague question, but how did it actually feel? What kind of sense did you get from the staff?

KB: That's another really good question, because I can answer it in two heads. I can answer this morning in a specific trust without naming them, that you walk into an environment that's quite calm, that's structured. And I wouldn't necessarily know the members of staff for the trust rather than the managed service provision staff, whether they're bank or agency or substantive. I would say that proactively three people asked me if I was okay, because I was looking at where to go. For people to have that ability to see that someone needs help when it's not their job, and it's not their job to direct me around the hospital. I know I'm trivializing it, but that sentiment that people are still thinking, people are still caring, it wasn't chaotic, it was calm, it was focused as well, you know, patients are going in the right direction. The setup of the trust in general is working, there isn't sitting there looking at a situation that looks like it's uncomfortable. However, if you walked into a different trust on a different day, you might get a very, very different sense. And I've walked into trusts that it feels like chaos, and it won't be unique to that trust, it will be unique to the environment that they're in and the stress on them. Maybe some trusts, you go in a different entrance, and the demand on that entrance might be quite close to ED, so it feels very different very quickly. Whereas another one, you go in a different entrance, and it's calm, and it's a different specialism. So it does vary, but there isn't the chaos in trusts that might be insinuated by the media.

Benefits and challenges of ‘recruiting to task’

JG: It's a very tricky picture, we can't be dishonest about that. At the same time, it's really important to ask that question, what can we do? So I wanted to talk and shift the conversation a little bit to the opportunities that are out there. One of the things I know that you've been looking at, and you're quite keen to talk about, is the idea of recruiting to task. So could you just tell us what that is? And the potential benefits of that?

KB: Yes, absolutely. So let's rewind our minds back to November 2020, when the vaccine program was a new but incredibly important thing, and we needed in excess of 25,000 vaccinators. We don't have 25,000 vaccinators in this country. We have plenty of people that can vaccinate but whether or not they can be vaccinated on a specific program is very, very different. So we worked with our colleagues in NHS England and the trusts to develop a model that recruited to task. We recruited people who fitted the specification of somebody who can give a vaccination but without the skill. And then we, the system, trained them in the skill and the will to be able to do that and make sure that it was safe and it was structured correctly, and we put that in place.

So we've proven to ourselves on a huge scale - when there's a problem we can recruit to task, and train to task. And those two are slightly different things actually, because recruit to task is slightly different because the person could have the skill but train to task could be you already have [the person] but you just need to add a layer of training in order to make them competent in another area. The National Vaccine Programme is proof of that. Now, slightly different platform, right? It's not the reality of running a trust in everyday life, and it's not as simple as necessarily overlaying that exact same methodology. But there will be opportunity where you can use staff that you've got today, and give them additional training in order to be able to handle a different situation, which means you could potentially put them on a different ward, a different skill, which means you could potentially put them in a different role at different times, and you could use your workforce a bit more sophisticatedly. So training to task and recruiting to task are two really important things that we need to work with trusts and look at in the time to come.

JG: What do you think the appetite for that is within the NHS at the moment?

KB: I think if you just answered that question very quickly with trusts, there probably would be appetite for the concept. But getting it done on the ground would be where the challenge is and identifying what we can do. But I think at a system level, the appetite would be there. I think that all of these great ideas, it’s sometimes very difficult to put into practice, because it requires someone to really help identify with you, what workforce you’d change and why and the skills gap analysis. But I think it needs to probably come down as a piece of policy. I'm not sure us on our own [could] maybe turn the dial on that as quick as we would like. But I know there are other examples where it's happening, not necessarily National Vaccine, but screening centres and training people how to screen who wouldn't have otherwise been able to do the job. So it's being done, it's being done in pockets, but it's not being done at a wholesale level.

JG: What do you think are the chief benefits of trying to scale that model up?

KB: Well you have versatility, scalability and resilience in workforce, because clinical professionals don't grow on trees, and we don't have enough of them, so we have to grow our own. That does not mean just a care support worker or just a nurse or just to doctor - excuse the word just, I'm not diminishing, it’s just in the context of that. It means why can't you be cabin crew, who now wants to come into the NHS and find an alternative role that might not follow the three, four or five core pathways that exist? We make millions of people

fit into very small career clinical pathways, and we just have to spend some time investing in how you can adapt that to make it far more accessible because not everybody wants to do the four or five core clinical roles. But there's stuff out there, which would require them to have a level of clinical skill that we would need, or the system would need to train them at, that would make them extremely handy to have in your locker, and in your roster, and that you could depend on. So I think it's not the panacea, but it goes some of the way to figuring out how we close the gap between what can be delivered through policy and the normal recruitment channels of getting workforce into the clinical settings and what we need to look at to future-proof the NHS.

JG: Is there anything holding the NHS back from that, that idea, because that is very exciting. And it does tap into what we clearly saw during the pandemic, which was people rushing to help the NHS, they went out of their way to do that, and it's about tapping into that. But what is kind of holding it back…because traditionally the NHS recruits around vacancy, you have a vacancy, and you try and find near enough the perfect fit for that. And of course with some clinical roles, it's non-negotiable, you have to have the right skill set, it's very difficult to go from in…you can't make a lateral kind of swing with some roles. But as you say, there are a whole host of other roles that you could train up for and train to task for. Do you think there needs to be…perhaps the NHS needs to embrace recruiting around skills?

KB: I'm going to bring us back to the National Vaccine again, and I believe that there is very different risk appetites across the system, where some would embrace this and some would less so. I think change has always got risk. Change in a clinical environment has even more risk, and doing something differently in this landscape is actually really tricky. So to those who already do it slightly, and we, you know, we've gone through a couple of examples, it's brilliant, but those that haven't, there'll be a reason that they can't. So the thing that standing in anybody's way is the complexity of resolving the issue, probably something around risk and risk and balancing it off with opportunity. I think the opportunity outweighs the risk, but I'm also not a clinical professional, nor am I a clinical governance director to be able to make a really informed decision on that. Because my simple mind would say if we could allocate any task and train somebody on that specific task, that reduces a huge amount of workload in the system and maybe its pressure points, it needs investment.

JG: But as you say, there is this gap between theory and reality and it's really difficult to bridge that particularly when, of course, [in] all trusts, the number one priority is always going be patient safety. So that is an appropriate inhibitor, you know, it's something that should be holding them back a bit, and it does. But it's about trying to get that balance, isn't it?

KB: Yes, I think so, and where there are areas doing something like this, other trusts in the system are looking in. So they are seeing what's happening, they are saying does it work? Can we be a part of it or take it away ourselves and do it? So I think there's a, you know, who's first to jump? Who's first to test the theory? And you do have to start small, although I'd say that from vaccination that was 25,000 people, and by far more than that were trained and jabbing effectively, very, very quickly. So I do think that you have to start small on big change in this instance.

JG: But there is, to an extent, proof of concept there, isn't there?

KB: Yes, absolutely.

Reducing agency costs

JG: How about we move on to agency reduction? There is, within cost pressures generally, you know, there's specific emphasis on agency reduction. If I could ask you, what are your initial thoughts based on the conversations you have with trusts about agencies? And obviously, we're right at the heart of that debate as a workforce provider. What kind of feedback have you got from trusts on that issue?

KB: I start by saying that I always believe there is necessity for an agency. I don't want to come on here and be the person who thinks that the answer is to abolish all agencies, because that's definitely not the answer. I think it's also important to note that this is about reducing agency spend by 10%, not necessarily agency usage, and they are also two very different things. If the agency can see that there is a situation they need to respond to, they need to look at what they can do to help solve that before it gets done to them. Because if I was the agency who was supplying, and I knew that, in the main, my books were going to have to decrease by 10%, I'll be finding very sophisticated ways to articulate that to a trust to support them, rather than waiting for the rug to be pulled out from under my feet, which could happen if we don't get to the answer quick enough, and we haven't got the answer quick enough because we're already in the year. The reality is [that] the shift hasn't happened at the speed that you would like to see if you're measuring it on an even basis through the calendar year, but that's because we're in the middle of winter, absolutely right, so we've got to overlay that.

So it's not really 10%, it's actually 20% outside of winter pressures, so it's a big problem to resolve and trusts are committed definitely to doing that. But fundamentally, and I'm with them on this, not at the price of running their service and making their patients unsafe. So these directives we are probably all in support of, but we're equally in support of patient care and patient safety, and they can sometimes be in conflict when you try and pull something quite big away without a clear pathway of what to put back in. However, NHSP are well placed to support this type of work because we can work with trusts, whether it's reducing the agency rate and coming up with a more sophisticated rate card, whether it's trying to find different ways to put more exclusive bank workers in place that aren't substantives and aren't working agency (so new workers), or whether or not it's working with the trusts to figure out how we begin to migrate their agency workers into a bank profile.

All things here are on the table to turn that dial. There are some that will impact the agency more harshly than others but still get the trust the same benefit. I think the trusts will be fairly agnostic about how it's done, they generally are, but at the same time, I think [they] appreciate that you do need a supply of agencies. So we can't just go out there and make a switch, but committed to also making sure it's the right sourcing mix. By that I mean, there has to be there is an element of agency, make sure it's relative fair and reasonable and proportional to the problem you're faced with. Because right now I think it's in place because there's lots of situations where that does not measure correctly, and it's not proportional or reasonable and it isn't right that the agency spend is so significant. That's the bit that for me, is what this policy is aimed at. There are trusts out there doing wonderful things already to keep their agency spend down, and those trusts will be struggling this year probably to try and solve this problem. But the trusts where agency dependence is high, they have the most amount of opportunity to change this and they can probably do bigger damage than 10%.

JG: And is that simply by really focusing on the off-framework agencies?

KB: No, not specifically. So from my experience of our trust, our framework is not a endemic issue across the trust that we manage, but then we're in place to help manage that. But yes,

I think there is a big ask of get what you know, on into the same place, if you don't know it's happening, and it's not on framework, it makes it very difficult for you to manage as well, because you don't have the controls in place in order to manage it. So that's one element. That is something that if you were a non HSP, managed service customer that you'd probably have to, you'd have to look at in more detail. But in our case, there isn't a significant amount of a framework, and there's a lot that we do to make sure that's prevented.

Migrating agency staff to bank

JG: Okay, so you mentioned about agency migration and migrating agency staff to, for example, [the] NHS Professionals bank. Could you talk a little bit about that because that's to me, as an outsider, that sounds like quite a potentially tricky process with some challenges in it, but also a huge opportunity. So can you paint a picture of this and steer us through that process?

KB: Yes, of course. So it's very tricky, it requires a directive from the trust that supports bringing agency to bank and there's different ways you can do it. You can do it punitively, which is you remove the worker from the agency with contractual notice. And I'm sure in many cases, you're going to have to pay a penalty because that agency owns that worker, but you would effectively remove them from the books of the agency. But what that doesn't solve is the fact that the worker got paid a significant amount more money than they would do on a bank. So migration comes in two ways, it comes as a directive, and about how can you move them, and unless you're going to do that across 100% of your agencies, which is unlikely, you won't necessarily get to that point.

But there is a way, and we're talking about to many trusts at the moment, and I spoke to one last week, I spoke to a [Chief People Officer] last week, who's, you know, really interested in how we make sure we start to move this agency to bank. What we're trying to do is go if you proportionally pay an agency member of staff – I'll make it up, 30% more than you do the ban - trying to convince that agency member to come and work on the bank is only going to happen if you meet them in the middle. And it might not even be the middle to start with; the middle might be three quarters, so it might be 75% of that 30%. And then maybe in six months' time, when they are a member of the bank, they're engaged by the bank - in our case, with NHSP, they have a good experience, they're getting first refusal and shifts now remember, they get to see shifts, they get to bump other agency workers who were in a shift, we've got some great mechanisms that make it advantageous for that bank member to be on the bank, because they get all the flexibility that they need in order to be able to pick their work. But you're going have to bring the rates down at a rate that is palatable for that bank member and that needs some thought, [it] has some risk. And of course, it doesn't immediately bring your costs down, but it goes some way to getting us into a place where we migrate agency to bank.

JG: How confident are you in that this year 2023, where we are facing significant cost of living pressures, how much of an impact do you think that all has on people's decision making?

KB: Yes, a lot. People are in really difficult positions right now and they will move roles for not a lot of money. Because it's a lot of money to them, even though on the surface it might look a pound or two a shift, that actually adds up over a significant working week, especially when you consider those people doing overtime as well. So I don't necessarily sit here and think it's going to be straightforward. But there is a balance that says if the workforce isn't predominantly driven by just the money from an agency perspective, they're driven by their engagement on the bank, they're driven by their ability to book more flexible shifts have a

more direct relationship with the trust, then I think that the theory that we're discussing - which by the way, isn't theory, it's done, it's really well taken up across many of our managed service trusts - is really something that will make a difference to both the trust and the worker. But like you said, it's really difficult to even challenge people, because you can have an efficacy conversation with somebody and say…say your friend is working agency, but they could pick up bank, who are we to judge them? And who are we to make that decision on their livelihood? It's not ours to make so yes, I think the point you're making, not that you were making a point, but the point of your question is it's delicate, right? It's a really sensitive area and topic at the moment.

JG: What do you think is the way through that? Is it broadening the conversation with, for example, an agency worker and talking about the wider benefits of going on to the bank, not just about pay, trying to broaden that conversation, very challenging as it is this year particularly? How receptive do you think agency workers may be to those wider benefits of going from an agency to a bank with more protection, more benefits?

KB: I think if you spoke to our bank member team within NHSP, they'll tell you that having time with them and speaking to them goes a long way in gaining their trust of the bank member and the opportunity that we can bring to them. Certainly, we have a job to do, it's not a case of oh, just take a little bit of the rate and put them on the bank. It's having a really equitable way of bringing the…agency member across to the bank, and also giving them the right pathway, and we do that in NHSP. If you're on our bank at a trust, you don't just see a shift that an agency sees, there's so many that could fit around people's busy lives. And sometimes time is more precious than money, and we're able to surface to them far more opportunity.

Benefits of flexible shift patterns and working days

JG: Yes, and I think that's come out of the pandemic hasn't it, that people have seen, particularly with things like caring responsibilities, and they started to value life outside work and they need more flexibility. They want more flexibility. Would you agree with that?

KB: Yes, completely. So for those that don't know, NHS Professionals took a really big role in Test and Trace, and we stood up 1000 case handlers, contact centre handlers in about three weeks, it might have even been less than that. But as part of that we discovered really quickly that if we try to take a model hospital in terms of shifts, and put them into Test and Trace and go, well, these are all clinical people, they work this way, this is how we'll operate it, because then they know how the split shifts work, and so on and so forth. And really quickly, we learned and we had the opportunity – and appreciate that it was remote, virtual, and you have, by virtue of it being virtual, lots of opportunities to change how shifts are constructed - we realized that people much preferred the shift pattern that gave, for example, a caregiver, whether that's a mother or father giving their child a lift to school, the opportunity to do three hours before that, and three hours after, but then we'll also make sure that middle hour is covered. So we started develop a shift pattern that met almost everybody's needs to be honest, because we chunked it down so small, that there wasn't really any situation that you were trying to deal with in your own life [as] a caregiver, or you've got a dependent, or whatever it might be, it gave you the opportunity to do that.

So that was brilliant, and one of the things that that allowed us to really leverage, and we're trialling it now with a couple of trusts, is to say, why don't we do that with some of our bank shifts? Tricky because, of course, you can imagine the musters at the start of the shift and the end of a shift, you need all staff there. So it's not an easy decision clinically, on the frontline. You can't just go oh, let's just cut the shift by two hours, so we're helping people in

different direction. But there are certainly shifts out there and wards out there that can take a more flexible approach to their shift booking. For example, for one trust, we gave people that hour of twilight back so that they could travel more effectively, and dawn, so dusk and dawn basically, where…we said, if we move it by an hour, would this shift be more attractive to you? And generally the research, because it was all research-based at the initial step, was yes it would, if I could have an hour less there and an hour more there at the start the day that makes my life so much better. Because it's hard in the winter, let's not gloss over it. Getting up at the crack of dawn and going out to work a really long shift in a really hard environment is tough. And sometimes these small differences change the way in which the bank member receives a shift and, you know, their commitment to it - coming back to that agency versus bank, agencies couldn't do anything like that. The opportunity for us to represent our bank members as bank members and find a way forward to make sure that we give the trusts a really augmented staffing solution, not just one that is, you know, here's a shift fill it, which is the premise of us, but we can do more than that.

'Immeasurable' care shown by staff

JG: So look, we're running out of time a little bit, Karla, so I wanted to ask you one final question. With the trusts you work with, what impresses you the most about them?

KB: I've worked in a lot of industries in staffing, and I can categorically say health care staff, and the service they provide, care more about what they're doing than any other industry I've ever worked with. Their level of care about their skill, their careers, their vocations and their patients is…you can't measure it.

JG: And how does that make you feel as a professional?

KB: Very accountable, to be honest, that we have a serious job here that we have to deliver against, because at the end of this podcast and our day-to-day jobs, there's real people, real patients, receiving real care from our workforce and our people. And so when you see people caring that much on the frontline, it makes you feel very accountable that you are responsible for making sure these things work too.

JG: Karla, thank you very much indeed, it's been great talking to you today.

KB: You too, Jamie, thank you.

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