Healthcare People podcast, brought to you by NHS Professionals

Edited transcript of Series 1, Episode 4.

Building capacity and optimising workforce

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 Mike Ruddle, Chief Commercial Officer at NHS Professionals. We'll cover three main topics in our conversation, including building much-needed capacity into the health and care system, how to optimize the workforce we have available, and how to reduce costs, especially those associated with external staffing agencies.

Welcome and career motivations

JG: Mike, good afternoon, welcome to the Healthcare People podcast. How are you today?

MR: Good, thank you, Jamie, very well indeed, thanks.

JG: So you have a background, if I'm right, in the private sector, and NHS Professionals is a limited company, although it's much more closely aligned to the public sector than that would indicate and we work extremely closely with the NHS at the centre. What is your personal motivation for working in healthcare? Because with private sector experience, you could have worked anywhere, so what is it that you enjoy the most about working very closely with the health service?

MR: Yeah, great question, I'm glad you asked that actually, because I've been in recruitment now for about 25 years, and I've always worked in the private sector. I've worked for a number of different large global staffing businesses and most of my career has been in what I would call strategic sales, or being involved in the design and delivery of large enterprise staffing programmes that in most cases are national staffing programmes, and in some cases multinational, but all been private sector. But to be honest with you, you know, after 25 years, or 22 years or so, it just became a bit too much about the balance sheet and a bit too much about kind of profitability. I just felt that at the stage I was at in my career, what I was really looking for was purpose and something where I could feel I was, you know, attached to a purpose that was something more than just about making money and profitability. NHS Professionals provides the perfect opportunity in that respect, because we're able to operate like a private sector organization, to think commercially, to act commercially and to deliver growth and some of the things you would expect a private sector organization to do, but to do so in the knowledge that the output of that actually is reinvested back into the system, to the benefit of the NHS. The NHS is such a widely loved organization, that to be part of something that was helping the NHS to achieve its objectives was something that felt quite rewarding and quite satisfying to be a part of.

Demand and workforce pressures in the NHS

JG: Yes, and sort of leaning towards that human side. Of course, the NHS is an absolutely enormous organization, one of the world's biggest, I think it's something like the fourth largest employer in the world….

MR: Largest in Europe.

JG: Yes… just vast. And yet, when we think about the NHS, we think about almost perhaps one person getting care. So it's quite a good house to be in. But I think we'll go on to our first talking point…Demand for health and care services is at an all-time high as people live longer, they carry a greater range of illnesses and conditions. It's probably a safe bet to assume that that demand will continue to rise for the foreseeable future. Obviously, this means that building workforce capacity is a critical issue for the NHS, and perhaps the number one issue, and it's something that we as a business, obviously, really focus on. So to start with, I just wondered if you had any data that might paint just a brief picture of the demand on the NHS currently in 2023, where we are now?

MR: You're right, it's a very big subject. I'm picking up on something you just said there, I don't think you said these exact words, but what you were alluding to was a kind of a system or workforce in crisis in many respects, because yes, there's a capacity issue. You could argue there's a capability issue, you could argue that the issues that the NHS is facing are leading to escalating costs, and these are all really pertinent issues, and what do we do and how do we address them?

But I guess just to put a bit of context to that kind of concept of the NHS being in crisis, so there was a snapshot poll carried out by the Nursing Times that showed, I think it was 98.2% of nurses, believe that the NHS is now in a crisis. But I think looking into that in a bit more detail, it's interesting to see how the NHS has changed and to put that in context in terms of the demand placed on the services. I think it was in December last year, the Nursing Times again reported a further rise in nurse vacancies to almost 47 and a half thousand, which was a vacancy rate of 11.9%. That's versus 10.5% on the previous year. However, those statistics are below the high that was reported in quarter 1, 20 19-2020, when it stood at 12.1%. So therefore, I think the point I'm getting to, is that the relative position today is little different, actually, to what it was pre-pandemic, it's just the landscape has changed significantly. There's more sickness absence, and there's greater demand for services and that's risen considerably faster than the growth in workforce supply. The workforce does actually continue to grow. So it's kind of interesting, isn't it? Yes, there's a crisis, but actually the changing shape of the workforce and the demand placed on the NHS has also changed.

JG: It's fascinating that actually see that the workforce has grown in certain places. However, the variable is the demand, isn't it? I think if you look at, for example, urgent and emergency care, you've got very, very acute pressures, which have continued to grow, haven't they? They're higher than they were pre-pandemic.

MR: Yeah, absolutely. I mean, we know that a lot of the growth in the workforce…has come from international recruitment, there's been a big drive hasn't there to boost the capacity the system has for international recruitment. And again, it just may interest listeners to know that according to the NMC, the register of nurses, midwives and nursing associates has also grown to a record level of over 770,000, which is actually an increase of over 13,000, between April and September 2022. So there's more workforce coming, but it's the demand that's outstripping the supply. And let's face it, the employer value proposition or the employer brand of the NHS has taken a bit of a hit recently, hasn't it? You know, I mean, it was at an all-time high. The reason that's relevant is because that's not going to help the NHS attract and retain a workforce is it. So there's lots and lots of work we've got to do and lots of challenges we've got to face to kind of address that. Some of those challenges are very relevant to the issues that we face around capacity and the ability to build better banks through better retention and engagement of staff so they can be more productive, and doing all of that against the backdrop of, as I said before, costs that are escalating and the

budgetary constraints that we're faced with, given the economic environment that we're operating in, and obviously, the recovery post-pandemic.

Feedback from the trusts we work with

JG: So you've mentioned a couple of things that we're going to talk about…about banks, different options for building capacity into the system, and also the issue of reducing costs, so making sure that is a cost-effective growth as well. In your experience, and your work with the trust clients that we have, in terms of what they're reporting to you, what are the key workforce capacity challenges for trusts right now, what are they telling you?

MR: It's a bit of a mixed bag. I think that, you know, they're telling us that they haven't got enough substantive staff and/or bank staff to fill the shifts that they have available, which is obviously driving behaviours for them to increase their reliance on agency. And they can do that in a compliant way through using framework agencies or, needs must, they sometimes have to resort to going off framework because at the end of the day, they have to fill the position, and they have to be in a position to be able to give care and to provide safe staffing levels to the public. It's a really challenging situation. I think that there are pockets, certainly by sort of disciplines or specialisms, where the supply is far, far less than what the demand for that supply needs to be. And there are other areas where there's relative stability, I guess, in terms of the stuff they're looking for.

So if you look at some of the A&C (administration and clerical) roles, some of the support roles that operate within the NHS, generally speaking - although it's not the case in all scenarios - the NHS is probably in fairly good shape there, it's when we get into some of the clinical roles. You've got a number of pretty significant macro challenges that the NHS is facing, and a very difficult time, which means that collectively, we as providers of services into the NHS have to work very collaboratively with our colleagues in the NHS, and think of ways that we can approach situations differently and be a bit more imaginative and creative about how we address some of these solutions. But…I would suggest that whilst there may be some quick wins, and we're making progress in some areas, some of these are broad and systemic challenges that will take a long time to address and for us to see the return on the investment we put in now in order to see the improvements.

Options to build more workforce capacity

JG: So how can we build that capacity? Let's just look at some positive options and opportunities. How can we build more capacity into the system in the short and the longer term? What are the opportunities in your view?

MR: Capacity longer term, I think part of this solution lies in training and education. So making sure that we've got a really robust approach to how we can train individuals, upskill individuals, cross-train individuals so they can be more mobile, more flexible, provide care in in different ways more than what they do so today, so just think more holistically. But that is a longer-term challenge that is not going to fix the capacity on day one. I think looking at it from an NHS Professionals perspective, if I can for a second, I think there are a number of opportunities. We could look more proactively to convert or look for opportunities to convert individuals that work flexibly into substantive roles. So making sure people that are engaged with us via the bank are actively supported into a substantive workforce position, if that's their preference. That's something we can do that is relatively tactical, but something we probably don't do enough of, something we should consider.

I mentioned before also the Healthcare Support Worker Development Programme…and I also referenced looking at ways in which we can be a bit more creative to solve some of

these problems. So we could look at a recruit, train, deploy model. This is a combination of actually bringing new workforce through, whether it's at grassroots or from other countries or anywhere really, but [bringing] net new workers in, and making sure that we combine the attraction of that workforce with the ability to train that workforce to a specific task, so that they can then be deployed effectively to work in a trust or in any other place of care. There's something in there for me around a sort of wraparound service, a more holistic service that looks at the individual, and not just brings the individual through into the system, but makes sure that individual is fully equipped with everything they need to do to do their job effectively and productively. There's a kind of recruitment and training blend and package there. They are some of the key opportunities.

The importance of staff retention

But at the end of the day, I think one of the things we shouldn't miss is the fact that the capacity is the capacity we've got in the system at the moment. We know there's a capacity gap. But in the short term, what the NHS must do is do everything possible to ensure we retain what we've got. We won't fix the capacity challenge we've got today, but we don't want it to get any worse. It's like a leaky bucket, you know, if we don't look after what we've got, and we put all of our effort into kind of bringing new in and training them and deploying them and all of that great stuff - if we're actually losing the same amount or more than we're bringing in, we're not making any progress.

So retention is absolutely key if we're to grow the workforce and curb attrition. Do we really value the individuals we bring into the system? Do we really understand what their working environment is like and how that can be improved? How well are these individuals looked after? Do they have a sense of belonging? I think the equality, diversity and inclusion angle is key, particularly as it relates to international recruitment. I think we've got to be more flexible, we've just got to recognize that flexibility is key. That may require a change in culture, it may require looking at self-rostering, and may be moving away from some of the traditional rostering patterns that we see. If an individual can only work six hours a week, let's make sure they're the best six hours the NHS can get from that individual and not be constrained by roster patterns or shift patterns that don't fit the individual. What I'm talking about here is maybe personalizing the opportunity a bit more to the individual.

Self-rostering and more flexible ways of working

JG: It's very interesting, you're saying that about self-rostering, because I was at a conference last week and a trust a major acute trust in London did talk about a pilot, a self-rostering pilot that they put in in some acute wards and reduced absence. But not only did it reduce absence, because you gave nurses more control, it also kind of supercharged their personal, sorry, professional development. They suddenly started applying for promotion. It started to solve capacity issues, say Band 6 or 7 level, but because they suddenly thought I have more time, I have more control, I have more time to consider promotion. Before I just couldn't because the roster, basically a bit of a dramatic word, but it bullied me, I've been bullied by the roster. But now because I've got more control, I can see these opportunities. And now I'm energized again to grow my career. But of course, that benefits not only the trust, but the system as a whole, doesn't it?

MR: Yes, and it's a bit of a fundamental shift from where we are at the moment, where the NHS is a huge organization and to make this huge organization, this machine of an organization work effectively, it needs systems, it needs processes, it needs structure, it needs organization, it needs all these great things. But actually what I'm talking about and what we're talking about here, is the individual…and if the NHS can find a way to tailor the

experience of working within the NHS based on the needs, desires, wants and preferences of the individual, which is about that flexibility piece, I'm making it easy for individuals that want to work for the NHS to work for the NHS in a way that appeals to their career development aspirations and their ability to experience and try new things and work in different specialisms. It needs to create the environment that facilitates that for the individual.

I think in some cases it's too rigid at the moment. That self-rostering pilot you're talking about, there is a great example of looking at things in a slightly different way, oriented around the individual, to ensure that we can get the best out of that individual. That's going to be rewarding for them, it's going to give them access to the variety that perhaps they're looking for, if that's one of the intrinsic drivers for them. It's just making the best out of the workforce that you've got at the moment.

Collaborative staff banks opportunity and passporting

JG: You're absolutely right, in terms of optimizing our workforce, when we're looking at building capacity into the system, so it can meet demand, we obviously have to really look at ways to get the very best out of the staff we already have. There's a number of different dimensions to that - health and well-being is a key one, to perhaps offset the difficulty we've got with burnout and fatigue in the workforce. I guess it also involves how the workforce is deployed, and mechanisms we used to deploy the workforce so we can make the best use of their skills within local health and care systems, and also the staff themselves getting more freedom of movement, and growing their own skills and careers in a more agile way. So I wanted to talk about the role of flexible staff banks here, if that's okay to move on to that, especially shared or collaborative staff banks, and what potential, in your view, they have to build extra capacity into the system.

MR: Yes again, it's very relevant…to the integrated care system agenda that we've been focused on for several years now, but which is really starting to bear fruition. The concept of shared banks or collaborative banks is not particularly new, but there are some challenges associated with that. Typically, if a collaboration is going to be successful in a bank environment, there are lots of factors for the parties involved in that collaboration to be able to agree on. [The] principles, it might be something around a process, it might be something around compliance standards; will one trust accept the standards for compliance-related activity that are the same as another trust's standards? There could be differences of opinions on the standard of compliance, there could also be issues around pay harmonization as well. If we're going to collaborate effectively, we need to be clear on the staff groups that we want to collaborate on, how we're going…to recruit those staff groups into the system in a way in which is consistent and agreed by all the parties and then, obviously, how we remunerate the workers involved in that collaboration as well.

All of those things – they are just a few examples - they need to be aligned if the collaboration is going to be successful. Then of course you've got the actual mechanism or vehicle to facilitate that collaboration, so you need to have the technology, you need to have the transparency so that there's visibility of the workforce as it relates across the collaborative system. When we talk to trusts about collaboration, typically we're talking about horizontal collaboration, which I would define as trust-to-trust. So it might be four or five trusts in a collaborative or an ICS, where we're implementing a shared staff bank or [our] National Bank solution that facilitates that collaboration for a defined specialism of worker - it could be a nursing and midwifery group, it could just be purely doctors, or it could be a subset of a nursing midwifery; Band 5 registered nurses, for example. Those are the things we see.

What we're seeing less of, but what we anticipate in the future as the ICS agenda matures, is the ability to be able to do that collaboration vertically. So as we start to provide care services or services that deliver care into an ICS system, it might be if the system values the opportunity for staff to be very mobile across that system and to deliver care in different places, that we might need to consider care homes, for example, or other entities that provide care and how we mobilize the workforce across different entities that aren't necessarily trusts NHS trusts. So there's a horizontal integration and a vertical integration piece that says, the utopia has got to be that we're providing the environment facilitated by technology that enables the mobility of the workforce to provide care in the places the system needs that workforce to provide that care. What we're seeing at the moment are definitely more of the horizontal collaborations and we provide and facilitate that either through outsourced bank provision or through [our] National Bank service.

JG: I think you've definitely touched upon this already, but what do you think the opportunities [are] to grow the staff bank model? And how could the staff bank model be used differently in light of the NHS right now, and its priorities and the direction of travel?

MR: I think there's been a lot of progress made to date on staff banks and the staff banks have matured, and we've learned an awful lot about that. I think that mobilizing staff across systems [in a] truly flexible way - and by truly flexible, I mean shift by shift - that is going to require more thought around the creation of, for example, shared rostering and booking systems. We saw during the pandemic the challenges associated with mobilizing staff, as I mentioned before, and the impact that had when trying to move people from one contract to another, which typically required them having to go through multiple onerous processes for application and registration. And we also had challenges between different employing authorities where issues such as visibility, and availability of worker insurances, were also an issue. So there's definitely work to be done there.

We use banks in a traditional way in a traditional setting…the opportunity could be to use staff banks in different settings, different contexts. From an ICS perspective, you could have a staff bank in theory, if the collaborative agreed on Band 5 registered nurses as the key specialism they wanted to operate a collaborative shared bank for, and there was a need and a demand for those types of workers to be able to provide their care in different settings outside of traditional acute or mental health or community trust setting and in care homes or in the community, the future of staff banks…could be that they could be designed in such a way that could be very relevant to meet the needs of an ICS.

JG: Yes, in a very localized way, as every ICS will have different specific local needs. Is it things like passporting, that's a key enabler, isn't it?

MR: Yes, really good point, absolutely. I think passporting…anything that can facilitate the movement of workers. I find that interesting, that whole area, really fascinating actually, and I'm really looking forward to the day when, and I might be speaking far too far in the future here, but when we can use things like blockchain technology to support credentialing. Part of the issue with compliance and one trust accepting the credentials of an individual having worked somewhere else, is that there's no necessarily easy way to actually verify the validity of that information. I know that over in the States, they're doing lots of work around this concept of credentialing using blockchain technology, where you've got an absolutely de facto view of a person's skills [and] experience, educational attainment etc, that's assured and guaranteed to be reliable, and is validated. So yes, the idea of digital passports and sharing all of these things, are highly relevant to be able to facilitate the movement of workforce.

Reducing agency costs

JG: So look, we can't talk about people, we can't talk about workforce, without talking about costs. As we know, the workforce, it takes up perhaps the biggest slice of the healthcare budget, so finding ways to control and ideally reduce those costs, especially when there's so much demand and pressure in the system, is really tough, and it's pretty inescapable. So for context, can you just give us a brief idea of where the costs are with temporary staff and what these can be?

MR: Yes, I mean as if the challenge wasn't great enough to try and solve the capacity and capability gap that we've been talking about, we've got to do so in such a way that means that costs don't get out of control, and particularly in the current environment. I think the figure that's been set, or the target that's been set across the system [for] flexible workforce, is it should account for no more than 3.7% of the total pay bill across systems providers. It's the ICS that has the responsibility of driving that down. When it comes to temporary recruitment, and the make-up of that cost, you've got the worker pay element, you've got the on-costs, whether it's National Insurance and holiday pay. Then of course, you've got the margin, and the margin will vary considerably, depending on whether you go through a compliant route to bring in the temporary resource. So that's through a framework, for example, or whether needs must, as we were saying before, the demand is so acute, and you can't fill the requirement, you have to go off framework, and it's at that point where you go off framework where costs can really escalate. I've heard, and it's been reported in the media, in fact I was having a conversation with a trust earlier this week about some of the variants there, the variance is substantial. In some cases, you're talking about the difference between a pound or two pounds margin, for example, on a framework, up to £30, £35-40 margin per hour, and if that worker is engaged in a long line of work, then it's pretty obvious that the costs start to escalate pretty quickly.

So we absolutely need to try and solve these challenges, whilst having an eye on what we can do to try and control, manage and ultimately reduce the cost. I think there's a number of things and questions for us to consider in and around all of that. Firstly, are we doing enough to help trusts manage these costs in terms of total workforce spending? Again, going back to what I was saying before, we often look at the different buckets of substantive, agency and bank. That's helpful in some cases, but actually we should be looking at it in context of spending on the workforce as a whole, and not necessarily just being focused specifically on temporary workforce associated costs. We probably need to look beyond agency management to total workforce management, with agency as a part of that as well. Do we measure the right things? So talking before about that, the changing profile of supply and demand. Are we measuring in the right way? Are we measuring agency as a percentage of the total? Or are we just looking at agency reduction in isolation?

I think there's a number of different things. We hear all the time about extortionate agency rates being paid, and whilst we don't deny there are problems in areas where there's high usage of off-framework agencies, particularly in the medical side and for doctors, where there are strong supply chain disciplines in place and strong agency management [and] governance in place, average hourly costs for agency workers can be effectively managed, it's proven that they can be effectively managed. Our data shows rates tracking above those from 12 months ago, by an average of about 5.4%. From an NHS Professionals perspective, one of the things that we are great at, one of the things that's the kind of core capability of what we do, is work with trusts, work with ICSs, to get control over the agency supply chain.

Nobody's saying agencies are a bad thing…they absolutely have a place in the workforce, there's always a need for agencies. But what we've got to try and do is find a way to control

the usage of agencies, and to ensure that our framework, or the rates associated with off-framework, for example, don't escalate beyond control. There are plenty of examples at the moment of trusts that are at 5%, 6%, and I even know of a few that are above 12 and 13%. So there are pockets within the system where there are absolute opportunities to work with a provider like NHS Professionals that can come in [and] review the supply chain, and start to work systematically over a period of time to reduce the costs associated with some of the extortionate rates that we're seeing. But it doesn't mean that the agencies aren't necessarily needed.

JG: It's interesting…you've kind of pre-empted another question…is the idea of using agency always a bad thing? How can the system work with it? I was just wondering, can you bring it to life in any way? Can you think of examples of where agency spend has been reduced? And the way that we've helped trusts to do that?

MR: First and foremost, it's about understanding the profile of agency usage, so has it been trending upwards over a period of time? Has it been static? Has it been reducing, in some cases? What does the profile look like as it relates to different staff groups or specialisms, to try and identify where there's an issue and why it is that we're so reliant on agencies in a specific geography for a specific discipline, or anything else. Once we understand what the profile looks like, and we can understand what the composition of the workforce looks like, we can start to address where the priorities might be. I think most of the time, it's just about proper, strong engagement with the agency suppliers themselves. What we'd ideally be looking to do would be to engage in a conversation with agencies and develop a more partnership-based relationship with those agencies, so that in return for them conforming or coming into line with some of the rate expectations that we would set with the trust, we potentially could speak to them about other opportunities - in that sense, becoming a bit more of a strategic partner.

It would be very risky of us to assume that we didn't need any agencies in any arrangement with a customer that we've got; we absolutely do. It's just making sure that it's controlled and that it's governed properly. The issue is that because of the acuteness of the demand…[there would be] almost be a knee-jerk reaction to go off-framework, because [trusts] know by doing so, even though they're paying a premium, they will get the resource that they need to fill the requirement that's so desperate and so urgent for them. We've got to go back a bit and go, right, what can we do to ensure that we can limit that to a minimum where possible, rather than it becoming something that escalates over time, and then very, very quickly gets out of control.

Passion for the NHS and optimism for the future

JG: We are running out of time a bit, Mike, I wanted to end on a slightly higher note, if possible. We've talked about a number of opportunities, which were great and bring a lot of optimism to the conversation. But I wondered for you personally and professionally, how optimistic are you that the NHS and its people will experience less pressure and challenge in the years to come? The idea of actually things getting easier? Is that something you think is achievable?

MR: That's a really big question. You put me on the spot there. I think one of the things that I've realized, since I've been working [at NHS Professionals] - and to be to be honest, it's relatively short period of time, four years, out of a 25-year career, and many people I deal with, at NHS Professionals and with clients, have worked at the NHS for a very, very long time - but one of the things that strikes me is just how passionate people are about the NHS and about finding ways to create solutions. That means that the NHS will be in a better

position than it's been in recently, it's been under tremendous strain. It was just such a brilliant feeling, during the pandemic, in many respects, to see how valued the NHS was, and to see the sort of outpouring of love and support that people generally have for the NHS. It has been equally disheartening to see over time, since the pandemic, how the NHS has really struggled, is grappling with some really significant capacity challenges, and now in the face of cost pressures as well.

I think there is a lot of love for our NHS. The people I work with every day are absolutely passionate to do everything they can to contribute towards the NHS [and] the workforce within the NHS being in a better state than it is currently, [they] are looking to find ever more creative ways to finding solutions to help the NHS. We have to be optimistic. I have to say, some of the challenges the NHS is facing are very, very acute, they really are. If we're going to achieve these solutions, we're going to have to work collaboratively, we're going to have to think creatively, we're going to have to make the best use of technology and data to inform decisions that we need to take around strategically looking at the workforce. We need to take both a short and a longer-term view. There are things we can do right now, some quick wins, touching on some of the things we've spoken about, which will help. But actually some of the issues that the NHS is facing need a much longer-term view. If we can do both together, and we can bottle up that kind of spirit that we've got, and that passion that we have for wanting to see the NHS succeed and out of this crisis in inverted commas, yes, I am optimistic.

There's new technologies coming all the time, there's better understanding of what the capacity challenges are and what the possible solutions to them could be. We know more about how to run effective banks now. We know more about the critical importance of the flexible workforce as it relates to the overall workforce in the NHS. As the NHS starts to understand how critical that workforce is, and treat that workforce in such a way that it would treat its substantive workforce, that's also going to help. We've got to make the NHS a great place to be so vocationally, we've got to make sure that people believe they've got the right career path, the right opportunity, that we can personalize that experience for them. There are so many different levers that we can pull. So I am optimistic, but that doesn't mean that the challenge ahead is any less daunting.

JG: Mike, it has been a real pleasure talking to you today. Thank you very much.

MR: You're welcome, it's good to chat.

You've been listening to a podcast from NHS Professionals. Find out more about our work supporting the health and care economy at nhsprofessionals.nhs.uk or by searching at NHS Professionals on social media.