PLANNING YOUR WORKFORCE TO DELIVER NEW CARE MODELS

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SESSION SUMMARY

- The NHS workforce at present is largely disconnected from the ambitions of the NHS Five year forward view (5YFV) – numbers of mental health and district nurses are declining, as is general practice. The current challenge for providers is to deliver transformation under constrained circumstances. Workforce design is not only a question for vanguards; every part of the system has a role to play.

- There are challenges in balancing roles and responsibilities for workforce planning at a national, regional and organisational level, as well as in attempting to plan for the appropriate skills mix without knowing how the workforce will look in 10-20 years’ time. Data capture has not kept pace with the plurality of providers, and there are also real declines in practice and a lack of reliable information about vacancies. Structural and policy changes in education and training are underway, as well as efforts to make it easier to return to practice. At a local level, there is a focus on recruitment, particularly from abroad, and there is more potential for providers to work together on negotiating agency rates, planning across a community or local health economy, and to collaborate on international recruitment.

- Strong leadership is also needed from national bodies. Health Education England’s (HEE) focus is on how to support innovation at scale in the context of the ambitions of the 5YFV. They are working to support workforce changes today through the 13 LETBs and planning and delivering the workforce of tomorrow. The planning round for nurses in 2019 has recently ended and the workforce plan for England is to be published.

- Workforce plans need to take into account local authority planning and voluntary sector availability. HEE takes into account exits out of the NHS into social care when planning for demand, as much as it can. Providers can support this by consistently recording destinations when staff leave. Conversations are also needed in other government departments around student loans and funding.

- Workforce has been pulled out as one of the eight key enablers for new care models. HEE local teams are working alongside vanguards to take their service vision and describe it as a workforce model. This can be challenging from the starting point of an established, traditional workforce model. If the new care model is based around population health needs, we need a population-based approach to workforce planning as well. HEE and providers can challenge each other about workforce planning assumptions. The vanguards are helping HEE to model better.

- There is a need for some new roles, but primarily the task is to look at what we’ve got and refresh and extend it to build the workforce of the future. For example, what does a “super healthcare worker” or a bridging role between a HCA and nurse need to look like? Where workforce is well managed between
health and social care, how can we spread that? Questions of medical indemnity and whether or not to TUPE are also arising, as well as instances of providers looking at contract conditions other than Agenda for Change where that is right for their model. Part of HEE’s role is to enable providers to break down some of these barriers where appropriate. Today’s workforce supply shortages are driving some of the innovative work including the transfer of skills between sectors and into other settings (such as in the care home vanguard). Culture and leadership are the biggest enablers of these changes.

- The Dudley Group transferred community services a few years ago – but did not transform them. They had been bolted on and teams felt left without sufficient direction. When you tell staff you want to change the way they work they hear “redundancies”. They know that as well as being the biggest asset, they are the largest cost, so it is essential to communicate clearly. Their model puts the person at its centre, with the GP as coordinator – it is focused around providing the right care from the right team, rather than being team-driven from the organisation’s perspective – they call this ‘teams without walls’. The front line staff on the project team agreed that this was what they wanted to do and they brought everyone together – disregarding professional groups – to learn from each other with the aim of providing continuity of care. A focus on organisational development is key to keeping everyone together.

- An HCA in a nursing team can do basic cognitive assessment – you need a core set of skills to deliver a one-stop-shop. Whenever there is a crisis, new skills become available to a new set of workers. For example, following the last junior doctor shortage, nurses acquired new skills. A worker in the voluntary sector is ideally placed to take a rounded look at a person who smokes, drinks excessively, eats unhealthily and does not exercise – rather than a healthcare led approach. This has been one of their biggest successes.

- The Dudley Group was able to ensure staff did not feel their existing roles were at risk and band new roles appropriately to motivate staff to apply. Staff themselves do not see the change as radical. The sharing of learning from vanguards should be up and running within eight weeks, including sharing some of their job descriptions.

- High sick rates among some staff groups or in some services within an organisation compared with others can be seen through the lens of wellbeing – a happy workforce will take less sick leave. We need to treat our workforce as ‘ours’ from the moment they enter training. Junior doctors are looked after and their careers effectively managed, but this is now always the case for nurses. We can’t afford to have the same model for the whole nursing workforce, but why not fast track some nurses to band six? Young people now start with a different set of beliefs and expectations and so we need to build their loyalty in a different way, and we have to get the training right or it can take years to correct. The biggest single factor to improve your workforce is to retain what you’ve got – people have to want to belong. There should be a shift from training clinicians primarily in secondary care to primary and community care but the financial incentives currently make this hard to do. Setting the right expectations from the off is critical. If trainee doctors don’t expect to be caring for elderly people with complex co-morbidities from day one, they will be resistant to doing it when they get on to wards.