It will be tough to keep the NHS on an even keel as it weatheres the economic downturn and delivers efficiency savings – while encouraging its crew not to abandon ship. Ingrid Torjesen reports on a roundtable debate over the future of the workforce.

At any time, managing, motivating and modernising a workforce as large and diverse as the NHS’s is a challenge. Add in the need to deliver the Nicholson challenge of finding £20bn in efficiency savings and it requires some serious innovative thinking and approaches.

HSJ invited a group of workforce experts to a roundtable meeting to discuss how that challenge could be met. It began with a discussion of the significant factors – both threats and opportunities – impacting on the NHS workforce.

For Gary Taylor, recruitment expert at the Recruitment and Employment Confederation, the biggest challenge was protecting the quality of staff to ensure that a “flexible and fit for purpose” workforce was retained.

“Whenever there are cuts and efficiency savings, if it’s not managed correctly it can impact on good quality, so we need to ensure that the quality of the workforce does not deteriorate,” he said. Revalidation will need to play a role in this for healthcare staff and needs “a bit more leadership”, he added.

Revalidation

“There is a huge possibility that organisations that start to tighten their grip on finances will use [revalidation] as a performance management metric for doctors,” said Dr Hilary Thomas, a partner in KPMG’s healthcare consultancy, adding that the rest of the world was watching with interest. “The UK is one of the only systems in the world where we have some correlation about what our medical workforce do and how we manage them. Revalidation is a potential way of tightening that even further.”

Dr Thomas added that cost-conscious organisations would be looking at staff numbers. Turning to offshoring – more outsourcing and private sector provision – could have a dramatic impact on the local economy in areas such as Norfolk, where the NHS was one of the biggest employers.

Health professionals were tending to see the south east as a more likely place to find work if they or their partner were unemployed, said Steve Lucas, managing director of Skillstream, and this caused “an imbalance in the ability to access talent” elsewhere.

Specialty shortages

New technology was seen as a mechanism for generating efficiency savings but, depending on how it was introduced, technology could also be seen as an opportunity or a threat to the workforce. Mr Taylor said there was a real opportunity to use technology to integrate trusts’ e-rostering system and purchasing to improve workforce planning, especially for hard to fill areas. But Liz Bickley, managing director of HCL Doctors, said there was also an awful lot of slow outdated technology out there that didn’t enable a flexible workforce.

While there were shortages of doctors in emergency medicine and paediatrics in particular, Ms Bickley said that in some other disciplines a future glut of consultants was expected. “There is a real opportunity for us to look at those doctors who are going into training and what areas they are going into, perhaps looking more into multiskilled doctors,” she said, so that they could work across more than one area as required.

Changes to immigration policy had deterred doctors from the Indian subcontinent coming to the UK and that had had a profound impact on the availability of medical staff in emergency medicine. Ms Bickley wanted to work with the Border Agency to address this. “Europe doesn’t do emergency medicine like we do in the UK and those countries [India and Pakistan] have a real contribution to give to our workforce,” she said.

In the future Health Education England would provide a real opportunity for employers to influence the future workforce, according to Dean Royles, director of NHS Employers, enabling more investment in developing Agenda for Change bands one to four – those who have the greatest patient contact. The view had been that professional bodies best understood what staff and patients need and that employers could not be trusted training development money, because they would “use [it] unwisely on other aspects of patient care,” Mr Royles said.

Regional pay

The public sector had now had an effective pay freeze for too long and the current “pendulum approach” needed to be replaced with something more sustainable to stop fluctuations in staff morale and motivation, Mr Royles said.

“Pay in the public sector is driven down until we reach a crisis, and we haemorrhage staff. We can’t recruit and we have to do something about it. We have an agreement that then swings the pendulum the other way and people say public sector pay is too high, etc,” he added. HSJ editor Alastair McLellan asked Mr Royles for his view on regional rather than national pay awards. Although there was a logic to labour markets paying differently by region, Mr Royles believed that getting it right would be very difficult.

“Do you have staff at the same bands paid differently because of the localities of supply?” he asked. “We can do something by allowing more flexibility to employers locally, saying, ‘you know your labour markets. How can you use
Moving care from hospitals into the community is one of the biggest challenges facing the NHS over the next few years.’

Dr Hilary Thomas pointed out that, despite proximity to potential staff, hospitals in outer London struggled to attract staff. ‘That is an example of regional/local distortions that those organisations can’t overcome because of the current pay structures, which actually disadvantages them and their population,’ she said.

Mr Royles says that moving care from hospitals into the community was one of the biggest challenges facing the NHS over the next few years. In the 1960s, the NHS had built and staffed district general hospitals and encouraged the public to come to them, he explained. ‘It was more efficient than having a doctor out on a bicycle visiting people, there was a rise in elective operations and these were big utilitarian efficient ways to do things.’

However, the last few governments had recognised that in future it would be more efficient to support the rising numbers of people with long term conditions at home.

Dr Thomas said that a lot of tasks currently delivered by highly qualified people in hospitals could instead be delivered in the community by somebody at NVQ level but who had had appropriate training. ‘That would help us “reach that holy grail of shifting more care out of our outmoded 20th-century model of care based around hospital”.’

However, Mr Lucas injected a word of caution. ‘We can get influenced by the fact that we are orientated around a large city [London] here,’ he said. ‘We have to be careful that the concept of decentralisation is considered in the reality of the needs of all the population, not just for subsets of it.’

Chris Wilford, senior policy adviser at the Recruitment and Employment Confederation, agreed that trying to shift and adapt the service from acute to community with an ageing population would be a challenge, with one of the biggest issues being staff morale and retention because of concerns about job security. But he said: ‘The shift from the hospital to home represents a massive opportunity not only for the development of the workforce but also for the provision of care.’
As an example, Mr Wilford pointed to the reconfiguration of stroke services in London from “a very disparate and spread network” of care opportunities and outlets to a number of outreach centres that lead into centralised hubs. As a result, he said: “The workforce is incredibly motivated, a lot more flexible, a lot more adaptable too.”

“Staff being motivated and really seeing that what they’re doing is making a difference is going to be key to delivering those changes,” Mr Wilford said, and he recognised that it would not be easy to achieve that, because staff were likely to see the shift of care into the community as “a smokescreen for cutting and getting rid of the quality aspect.”

Emma Morrow, HR business partner at the Co-operative Pharmacy, said more collaborative working between primary and secondary care was needed to make sure that both sides were operating as effectively as they could from a workforce perspective. “While some decisions can be made at a national level, that actually can’t be seen to be of benefit unless action is ticked off at a local level. That’s about education and training working collaboratively and building relationships.”

The ability of clinical commissioning groups to look at new models of care and manage patients differently could have real implications for the workforce, Dr Thomas said. She explained how the leader of one CCG had told her that knee replacement surgery would come under scrutiny because 40 per cent of patients in that area had procedures without any improved clinical outcomes in terms of increased mobility or reduced symptoms. “Putting primary care opposite secondary and tertiary care in that way creates an opportunity to actually force the pace of change for workforce models.”

However, there was the risk that staff would become disengaged by reorganisation if it was not managed properly. “Lurching from the apparent crisis to reorganisation to crisis to reorganisation; that can have an adverse impact,” she said, not only on organisational culture and staff attitude, but on patient experience and functionality.

Procurement frameworks
Mr McLellan asked the group what actions were needed either nationally or locally to help realise workforce opportunities. Mr Taylor said that, historically, general practice and primary care staffing had not fallen under procurement frameworks, but the north west had been using a framework recently to deliver continuity of care for their patients using a pool of general practitioners migrating around a controlled area. “I would like to see that come more into the other regions, especially around London where in that general practice market at the moment there is a complete lack of continuity of care and we see GP locums voting with their feet as to where they can get the best revenue,” he said.

Mr McLellan asked him whether the frameworks, but the north west had been using a framework recently to deliver continuity of care for their patients using a pool of general practitioners migrating around a controlled area. “I would like to see that come more into the other regions, especially around London where in that general practice market at the moment there is a complete lack of continuity of care and we see GP locums voting with their feet as to where they can get the best revenue,” he said.

However, Mr Lucas said that some of the frameworks neither operated effectively nor generated real benefits. Mr McLellan asked him whether the frameworks should be scrapped or changed? Mr Lucas’s view was they should be scrapped, as they did not represent best value and were not responsive enough to the marketplace. Many large corporate companies considerably outperformed the health service in terms of value, Mr Lucas explained. “I can supply secretarial staff in Canary Wharf at approximately half the price I supply secretarial staff to surrounding trusts.”

He would like local organisations to be able to customise what they offer according to the market needs, which would see the value of some roles fluctuate as they align themselves more closely to the rest of the market.

It was important to highlight such examples, Mr Royles said, because while frameworks could provide efficiencies at some level they were inflexible. Better collaborative working to create a local fit would deliver a better solution. He recalled being told he would get a better price on stationery by collaborating around a framework. “We were getting stationery delivered to the point of use. With the framework we were getting it delivered to the front door. We then have to invest hundreds and thousands of pounds to move it around the organisation. That is not cheaper for us at all and it’s a worse service.”

While taking criticism of frameworks for administrative and clerical staff on board, Mr Taylor said that, as well as...
delivering savings, they were important for maintaining the quality of clinical staff. Where trusts had used people from unregulated agencies outside the current framework, he had witnessed infectious Hepatitis B carriers working in exposure prone procedures, as well as doctors being employed who had been suspended from their substantive post on full pay. “The framework pre-employment screening would have stopped that,” he said. “[If] we move away from the framework, we need to ensure that whatever is put in place still focuses on ensuring those qualities are met.”

Mr Lucas disputed this. “What part of a framework ensures those people comply to that?” he asked.

Mr Taylor pointed to the policy audits at the start of the frameworks and the threat of the audit team coming in to check that providers are delivering to the frameworks. Mr Lucas replied: “None of those things need a framework they just need best practice.”

Mr Taylor agreed, but said that when trusts engaged outside those frameworks, that didn’t happen at the moment. If the cost of that framework could be put back in to the trust to support those procedures within the trust “wouldn’t that be to some extent be achieving the same goal?” Mr Lucas asked.

Mr Taylor responded that staffing and procurement departments within trusts that did not use frameworks did not make the active choice to go through those checks and vetting processes. “That’s why those two situations that I’ve just mentioned occur,” he said.

Mr Taylor said that the NHS could learn a lot from councils’ flexible staffing models, and how they had engaged with neutral vendors’ solutions to deliver a flexible fit for purpose workforce and efficiency savings. Mr Lucas agreed but pointed out that councils don’t use frameworks. That was because the quality measures required were different for a secretary working in a council and a doctor carrying out an invasive procedure, Mr Taylor replied.

Although Mr Lucas did not dispute this fact, he argued it was important to ensure that a social worker working in child protection had the right set of skills. “What I’m saying is that from my perspective there are examples where those standards can be maintained outside frameworks,” he asserted.

Increased co-operation
Ms Bickley agreed that the frameworks got in the way of suppliers’ ability to influence pay, so trusts ended up competing on pay, which was “ludicrous”. “They should work together much more closely.”

Mr McLellan asked whether, in an environment where there was meant to be contestability, choice and competition, NHS organisations could co-operate on pay when effectively they might be competing for demand. Would there not be a danger of being brought to the attention of the competition commission for creating a pay cartel, he asked.

Ms Bickley explained that this was about moving away from “candidates holding the NHS to ransom”.

“Competition shouldn’t just be around pay, it should be on the working environment, the opportunities, the support network, the offer of flexibility in terms of working,” she said.

To improve procurement, more joined up thinking on strategic management of the workforce was needed, Mr Wilford said.

He gave two good examples of this – the Chartered Institute of Purchasing and Supply’s procurement academies to educate organisations about procurement and what tools are available, and the NHS Employers’ flexible staffing forum, which promotes collaboration.

There are many good examples in the corporate world illustrating that a collaborative approach doesn’t penalise the worker, infringe people’s rights or threaten a competition review, Mr Lucas emphasised.

For example, his organisation manages the contract population for 16 banks at Canary Wharf. “There is a huge collaborative effort to share information across those 16 banks about what the market is doing,” Mr Lucas said. Staff are paid good competitive rates, but it stops small imbalances between organisations in the order of 50p an hour encouraging staff to move round.

Mr Royles said that, at a national level, politicians needed to show a similar level of bravery to that displayed by their predecessors in the 1970s, who went ahead with the closure of mental institutions and moved patients into the community, despite scaremongering from the press of the time. And, at a local level, foundation trust governors needed to really be driving the changes and the expectations of staff.
Lessons from outside the NHS

Mr McLellan asked what the NHS could learn from other sectors in terms of delivering a quality flexible and responsive workforce.

Mr Lucas said the NHS should value flexible workers more highly. His organisation works with some of the large supermarkets, which have outlets across the whole of the UK, in excess of 500,000 workers and face many of the same challenges in terms of supplying staff and keeping services open over ever increasing hours. He said they were doing it very effectively with an increasing volume of flexible staff.

“I’m not necessarily sure that the marketplace within the NHS is recognising that flexibility can be one of those characteristics that we can accommodate, work with and encourage you back into the workplace, even if you are looking at doing five hours a day,” he said.

Companies such as BT had the vast majority of their staff working flexibly around core hours, Mr Wilford said, and this had had a direct impact on the efficiency of their work. “Maybe we could think about how that could work for back-office functions,” he said.

Dr Thomas recalled that there had been a shortage of therapy radiographers when she worked in the NHS and the mindset had been that nobody would want certain hours because nobody then employed in the organisation worked them. Actually, she said: “There were people out there who were perfectly happy to work for us in the evening because that would work with childcare when their partner was home to look after the children.”

Activity data

A good appraisal system should involve collating data about that clinical staff member’s activity, such as their personal readmissions rates and length of stay for different procedures and the reasons for those, Dr Thomas said. “Most clinicians want to see how they are performing compared with their peers, you don’t have to do it in a threatening named way, you just see where you sit within the pack,” she said.

The NHS also did not take a long term view of people’s personal development, although that had huge potential as a carrot for staff, she added. “Some people get stuck and they have to take charge of their own responsibility to develop and it is often by moving on,” Dr Thomas said.

The teaching profession was a skilled workforce the NHS could adopt some practices from, Ms Bickley suggested. Over the past 10 to 20 years teaching had adapted to try and meet demand by ensuring that teachers trained in at least two areas of education, sometimes three. Although this would not be appropriate for some of areas of medicine because they were highly specialised, “in some cases the NHS could learn from that and people could be trying to exploit different avenues as and if the need arises”.

There was much that could be learned from supermarket chains in particular, Mr Royles said, because supermarkets, like other private enterprises, were much more willing to embrace a good idea when they saw one. For example, once one chain introduced self-checkouts, soon everyone had them. “I can’t imagine that they collaborated and said that in June we’re all going to introduce that,” he said. Whereas in the NHS, there were innovative ideas, such as redesign of stroke services and organisations could not give them away.

As an example of this, Mr Taylor described a GP surgery where every patient who called had a telephone consultation prior to getting an appointment booked and that this had reduced the number of people
needing appointments, attending walk-in centres or requiring GP out of hours services. That had reduced appointment waiting times so that everyone was now seen within 24 hours or, at worst, 48 hours. “I was just gobsmacked it is not used more widely,” he said.

Mr Royles recounted how, after his local supermarket was bought out by another chain, they shut on a Friday, rebranded, changed the layout and put in new shelves and equipment. “It was fantastic. Over a weekend [there was] a complete transition, we never had the chance to do that in the NHS,” he said.

Ms Morrow described how the Co-operative Group had improved staff engagement through establishing clear organisational goals and running a series of engagement events to ensure staff understood them, how they fitted in and what they had to do, so there was a shared purpose. “I have a clear line of sight to those organisational goals and can attach my objectives and my responsibilities to [them]. It starts to bring your objectives and my responsibilities and the needs that organisation will have placed on it in about 15 years time,” he said.

But Dr Thomas disagreed over the necessity to expand the level of staffing. The workforce would only be insufficient for the challenge if care continued to be delivered in the same way as it was now, she said. What was needed was some disruptive innovation. For example, not every hospital needed to have a 24/7 paediatric service and there would not be enough paediatricians to staff the 200-plus units that existed now anyway.

A dramatic process redesign was needed to change the way in which care is delivered. It should shift the workforce into being far more productive, delivering what they absolutely had to do, rather than the menial tasks that added no value and could be done in other ways using new technology, Dr Thomas said.

“I’d love to see even a handful of hospitals out there having a much smaller footprint, where their back office is managed potentially overseas let alone somewhere in a hub in that region, but where the core elements of what you need in the acute emergency hospital can be provided as streamlined as possible,” she said.

Elective procedures would not be done on site and long term conditions would be managed proactively and involving the patient more. That community element of caring for patients outside hospital had been long needed, Ms Bickley said, and would have the added advantage of reducing secondary infection in hospital trusts. But she added that this and an increased focus on commercialism and the power of choice would bring “whole new headaches”, because many patients, especially the vulnerable, would not understand and would need to be supported through the process.

Mr Royles predicted that organisations would start to see support staff, who provide much of the direct patient care, as central to that patient experience as patients rated services and their expectations rose.

He also expected a complete transformation in the way that people learn, with social media playing an increasing role and many staff doing learning on the way into work.

“Just that kind of explosion that we had when Tony Blair came to office in 1997, when people weren’t using emails and things were stored on ‘C’ drives on office computers,” he said. “This is the same sort of fundamental technology change and it will affect learning and development, understanding, and engagement of staff over the next five years and we will then wonder how we got by without it.”

Mr Wilford expected that, “like it or lump it”, frameworks were here to stay and that there would be a massive expansion in them. “The sheer growth in the framework market is going to be quite amazing to witness and I think every major curatorium and every local area will have specific procurement providers coming under staffing frameworks.” As a result pay would be reformed and be market facing, he said.

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Nicolson challenge and after the next general election.

With the ageing population bringing with it a rise in long term conditions, Mr Lucas said that this demographic change had to be recognised in the next five years so that the workforce could be expanded and trained to deal with it. “The biggest surprise would be someone grasping the nettle and saying we’re actually going to recognise that challenge and start to fund and deal with the training issues and the needs that organisation will have placed on it in about 15 years time,” he said.

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