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How do we Change Today’s Workforce for Tomorrow’s World?
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Objectives

- To understand the wider future strategic operating context for tomorrow’s workforce
- To explore the impact of potential operational changes on the workforce
- To identify the key themes around which to build major workforce initiatives
- To propose how we should work together across the region to ensure an integrated infrastructure for workforce
Opening Objectives and Expectations

Presentation by Katherine Fenton – Director of Clinical Standards and Workforce

Key Points
- £5.8 billion – Health budget NHSSC
- 60-70% - Spend on workforce
- Forecast – 4,700 reduction in FTE per year for three years
- Demographic changes
- Commissioning more of the same
- Planning to have more not less in the workforce
- Projections exceeding current financial envelopes

Strategic Context: The New Reality

Talk by Ben Lloyd – Director of Finance and Investment
Dreams and Nightmares
Reflection - Dreams

“Lean efficient thoroughbred”

“Challenge underlying assumptions”

“Workforce motivated to deliver”

“Self management and personal care planning is the norm”

“Just do it!” – Partnership working
# Dreams

| Integration | • Fully integrated health and social care system – joined up services, statutory, private, 3rd sector  
|            | • Partnership  
|            | • No barriers  
|            | • Opportunity to interchange roles, inter-professional working, breaking down traditional walls/values |
| Culture    | • Freedom to change things that really need to change  
|            | • Honesty and shared values  
|            | • Reality - hard choices e.g. payment  
|            | • Focus on what works, ‘can do’ attitude  
|            | • Culture change – safety, quality, EBM |
| Structure and Processes | • Services reconfigured around patients  
|            | • Home and people will be in charge - self management and personal care planning is the norm  
|            | • Structures – commissioning  
|            | • Processes – care pathways around patients  
|            | • An episode of unplanned care is rare |
| People     | • Right skills, right place – appropriately trained staff delivering care  
|            | • Clear leadership  
|            | • Staff enjoy NHS service |
| Effectiveness and Efficiency | • A more effective NHS whose staff know why we’re doing what we do  
|            | • Waste and variation removed  
|            | • Agreement on priorities for the way ahead  
|            | • Better value healthcare |
Reflection - Nightmares

“An end of ‘free at the point of delivery’”

“Slash and burn without rationale”

“No money – 0% - flat cash 2010 – 2011”

“Operations – two year waits!”
Nightmares

Service Delivery
- No services for family when dying
- Operations – two year waits
- Trolley waits for hours
- Can’t get care needed quickly and locally on the NHS
- Patients poorly treated or not treated
- Threaten quality of life or life itself

Structure
- PCT’s/SHA’s merged and re-organised again and again
- No NHS in the future

Staff
- Return to the dole queue
- Workforce reductions in the NHS not aligned with service changes

Education
- 35% reduction in NPET commissions £ per annum equals a major income loss to HEI’s and threat to long term sustainability of health care education provision
- Wanting to produce workforce cheaply ignoring pedagogic principles and purpose of HEI then blaming HEI for non/low functioning workforce in a complex environment
Perspectives on the Impact on the Workforce

1. Service Commissioner
2. Service Provider
3. Social Care
4. Education Commissioner
5. Education Provider
6. HR/OD
7. Patient/Public
Key Points

- Initially miserable about being perceived as the “bad person” – however moved to feeling positive.
- Key is getting public to understand – “managing the message”
- Primary Care – Levers for change – PMS/GMS important.
- Look at tendering, integrating teams.
- Secondary care – not about massive redundancies, more about managing wastage, variation, aligning productivity with incentives, working towards integrated & managed care.

Impact Summary

- Public, Primary Care, Secondary Care, Managed Care
- Concerned about becoming service decommissioners.
- Use of Language needs careful consideration e.g. £1.2b reduction = 2 x DGH’s – NHS interpretation is service reduction – public will wonder which hospitals will close.
- Privatisation – Job Loss and Service Loss concerns.
- Current environment is difficult – pre-election lull – being politically cautious.
- Investigate growing other workforces e.g. 3rd Sector (e.g. Oxfordshire Age Concern increasing volunteers)
- Commissioning less and managing consequences – creating/maintaining sustainable providers.
- Align behaviours with incentives e.g. tariff / better care, better value (confidence in figures to use?) -> ½ billion released.
- Use public pressure for service change - shouldn’t go in early for surgery, or be invited back to be informed of test result
- Levers for productivity: - Remove variation e.g. GMS GPs £65/head, PMS GPs £75 - £120/head (tender PMS contract)
- Encourage GP Practices to work differently – integration with community teams.
Service Provider
Robert Crouch, Suzanne Cunningham, Anne Owen, Stephen Richards, Ros Tolcher

Key Points
• Staff morale – impact on frontline staff who will have to manage any changes on a daily basis.
• Technology may deliver productivity gains.
• Clinical Staff must be drivers for change – want to deliver sustainable care.
• Discussed WF profile change risks e.g. fewer but more highly skilled vs. more but with lower level of skills.
• Need to avoid confrontation with 3rd Sector – work in partnership.

Impact Summary
• Morale – managing message, fear etc
• Focus on productivity, Value for Money, Innovation and Tele-Med etc
• Thresholds: clinically determined, safety & quality, sustainability
• Changing work profiles
• Partnerships & Org Culture
Social Care
Nikki Griffiths, Sue Harriman, Jonathan Horbury, David SInes

Key Points
• Transformation, Personalisation agenda– NHS squeeze and impact on Personal Care raised
• Dementia Focus – possibly up skill social care workers – described as lower end NHS skills, upper end of social care.
• Patients managing own budgets – will this migrate to traditional healthcare delivery models? What would be impact on Social Care?
• Concerns expressed over loss of Professional Identity
• Green paper over funding – implications for NHS – Free at Point of Delivery vs. Means Testing/Top up contributions
• Social care has 680 orgs 25000 Workforce in Hampshire alone. Need to work together

Impact Summary
• Quality & Safeguarding are common denominators
• NHS cuts squeeze social care
• Demographics don’t change
• Prevention at risk (if its there now) - links to dementia demographic, medicines management, skills for social care workforce from NHS
• Cost shifting – gaps in care : patients fall through
• Personalisation & Transformation – diverse workforce & providers, 3rd sector challenge. No single employer in social care – 100’s of regulated providers
• True ‘Personal Budgets’ – is the Government & the NHS ‘risk ready’?
• Heightened tension between free NHS vs. means tested social care (Green Paper Options) – could expectations squeeze the NHS?
• Can’t afford to run two parallel systems (NHS in steady state, dramatic shift in social care workforce)
• Risk of skills gap
• Professional identity for social work & health professions – what’s the future?
Education Commissioners
Jessica Corner, Allan Jolly, Peter Lees

Key Points
- Need to be smarter, not engage in slash & burn.
- Must engage Education Commissioners with Service Design. Change levers - Joint H&S commissioning.
- Workforce - where is the waste? Need to create workforce which is adaptable and flexible. If creating new environment will need to run in parallel – overlap & duplication costs need to be accepted.

Impact Summary
- Engage commissioners in service delivery
- Dramatic shift
- Careful about assumptions
- Smarter – must not be slash & burn
- Staff employed at system level – Intelligent
- Better Info - workforce now, variation and waste
- Change the levers – joint health & social care commissioning
- Engage commissioners from beginning – design new system
- Run new + old in parallel
- Flexible, adaptable new workforce
Education Providers
Jeannette Bartholomew, Stuart Carney, Sue Duke, Ann Ewens, Vicky Osgood

Key Points
• Need to be aware of impacts on HEIs – if courses close, redundancies in HEIs. Also if HEIs decide to close courses due to low numbers, capacity may be permanently lost
• Committed to partnership working. Need to review what training is done in HEIs and what training is done in service
• Is current Xmas tree model (workforce profile) right? Especially with regard to associate practitioners which has not had sufficient time to embed in many organisations.

Impact Summary
Impacts on HEIs
• Courses closing
• Redundancies
• Potential loss/reduction of capacity (VCs)

Opportunities
• Breaking down the silos
• Potential new models of education & training
• Partnership working
• Skill Mix revisit and commissioning? - Associate Practitioner
Human Resources & Org Development
Caroline Crabtree, Sue Donaldson, Ruth Monger, Judy Saunders

Key Points
• Short term agenda is key focus to drive down costs. More work needed on Sickness, turn over. Need to align WF to service plans. Role limitations, HR directors need to challenge professional groups to overcome this & engage & empower staff to want to work & stay in NHS.
• Looking to work across sectors, trying to improve productivity & quality. Redundancies are an expensive method of making any change

Impact Summary
• NOW: Opportunistic headcount control (downwards) – Managed:
  - absence, turnover, agency, headcount
• TOMORROW:
  - Mergers / TUPE
  - Leadership
  - Alignment of workforce planning with service planning
  - Role redesign- challenge demarcation lines
  - Challenge national terms & conditions
  - Staff engagement and empowerment
  - Don’t lose sight of rewarding careers
• Short Term (already happening) - Finesse HR Best Practice, Absence Management, Turnover, Agency
• Medium Term - Demand reduction (carer and voluntary workforce), Integrated Planning, Radical planning of service changes across health economies and sectors
Patients & Public
Heather Aldridge, Nadia Chambers, Elizabeth Hale, Fizz Thompson

Key Points
- P&P hugely fearful of what may be coming – will I be able to access services, and how quickly – who will be there to deliver them. Expect enormous pressure on certain aspects of NHS – lobbying groups may exert undue pull/influence?
- If people cannot access services in time, Ambulance and primary sector may become pinch point. Politics – rationing of services, challenges over perceived waste, duplication, inconsistencies, - the NHS only as good as the patients last encounter!

NHS approach to Swine Flu – internet access to drugs, will this influence future delivery mechanisms?

Impact Summary

Technology

Lobby Groups

Replication
Inconsistency

Challenges over waste

Rationing

Demand

Pressure

Politics/Policy Direction

FEAR
Skills
Access
Speed
Who?
Themes for Strategy

1. Managed Change
2. Design the Future – Integration
3. Productivity and Information
4. Leadership
5. Engagement
6. Workforce – Professional demarcation, T&C’s
### Plenary Verbal – Key Points on Themes for Strategy

#### Leadership
- Leadership – to take change forward
- Aligning Incentives
- Quality – clinicians view

#### Change
- Brave decisions based on intelligence and evidence
- Fundamental change
- Do the ‘brave’ stuff
- Plan for the future now

#### Patient
- Managed Care (where is patient in this?)
- Patient managing own care -> control and choice
- People ‘owning’ their destiny
- Personalisation agenda

#### Education
- Maintain educational provision & plan new programmes for future
- Cutting education budget will prevent future innovation
- New models of education
- Partnership with services

#### Public
- Narrative with Public, e.g. use of technology => impersonal
- Public taking charge of their own healthcare, part of ‘workforce’- empower e.g. Tamiflu
- Current expectations
- Proactive – social shift
- Social movement
Plenary Verbal – Key Points of Themes for Strategy 2

Integration
• One organisation / series of organisations - certainty around what we're building for the future
• Organisational boundaries - different in terms of considering workforce & services
• Health & Social Care vision - shared interests, economies of scale, opportunity – mutual benefits
• Scale – too many individual organisations (24)
• Consolidation -> De-commissioning
• Break down professional silos
• Engage Royal Colleges, regulators
• Align service & workforce
• Thresholds – ownership, public expectations, commissioner, provider

System
• Consider “wider system”
• Do we use what we already have in place - look at whole pathway (systems & operating models)
• Do what is easy to do
• Keep system going for future
• Productivity – still a lot to do

Workforce
• Reduce workforce – maintain productivity
• Workforce generalists vs. specialists - Autonomy & specialist practitioners, What do we want?
• Workforce redesign/change - shape of service, flexibility, challenge
• Staff engagement & empowerment
• Role of Carer -> as a member of the workforce

Staff Side and Representation
• Engage staff side - Local vs. National
• Local representative committees - psychological influence

Commissioning
• Commissioning Strategy – shared & aligned, involvement, co-produced
• Clear commissioning objectives
• What is commissioner wanting us to deliver –> skills?
• What works locally but is commissioned from centre?
Synthesis – Agreement on Themes for Strategy

Emerging Themes

**Managed Change:**
Short term and long term strategies, risks, phasing, benefits realisation, pace and scale

**Design the Future – Integration:**
Integration of health and social care workforce, integrate workforce service an financial planning, design the future

**Productivity and Information:**
Incentives for performance

**Leadership:**
Leadership, ownership and engagement, belonging and the psychological contract

**Engagement:**
Public as partners

**Workforce - Professional Demarcation, T&C’s:**
Prepare and develop the workforce for what the future may bring, includes engagement

Exam Questions

1. What is your theme about?
2. What are the benefits of getting it right?
3. If we could only do one thing to make an appreciable difference, what would it be?
4. What could we do relatively quickly (say within a year)?
5. What else could we do (max three things)?
Managed Change

John Newton, Judy Saunders, Nadia Chambers, Ros Tolcher, Allan Jolly

1. What is the Theme About?
   • Planning for the future
   • “Planting shade trees” – from risk to resilience
   • Enhance board role?
   • Protecting resources for strategic areas
   • Common long term objectives at all levels – clinical/finance/organisational

2. Benefits of Getting it Right
   • Plan gets delivered – rhetoric to reality
   • Sustainability
   • User “buy-in”
   • Patient outcomes and solidarity increases

3. One Thing to Make an Appreciable Difference
   a) Boards have workforce as a standing item?
   b) Multiple Inputs:
      Operating plans, HEI's, Policy, Trust Based Groups, Coms

   Strategic Workforce Alliance at regional level

   Outputs:
   Coherent strategic vision – risks, benefits, dependencies
   Mandated Actions
Managed Change

4. What Could Be Done Quickly?
• Establish a Framework of Accountability for workforce – command and control system for crisis/steady state Accountabilities – specifying need, delivering training, pathway change, commissioning, oversight/scrutiny, VFM/equity

5. What Else Could We Do?
• Consider Workforce Early – ensure that workforce is considered early in all discussions about service change
• Rebalance Training Spend – towards generic staff
• Clarity and Leadership on National Issues – e.g. terms and conditions, public messages, working with the Royal Colleges
Design The Future - Integration
Jonathan Horbury, Sue Donaldson, Jessica Corner, David Sines, Katherine Fenton

1. What is the Theme About?
   • Creating a more solid and thought through picture of the future that is:
     - Affordable, phased and designed with all parts of the system
   • Fresh look and build from where we are

2. Benefits of Getting it Right
   • Transformational rather than incremental change
   • Sustainable finances and educational commissioning
   • Make change happen beyond organisational boundaries

3. One Thing to Make an Appreciable Difference
   • Workforce Plan Across Health and Social Care

4. What Could Be Done Quickly?
   • Pragmatic Change e.g.:
     - Band 4 Associate Practitioner and decommission others
     - Local policies and contracts: enable easier redeployment
     - Get staff involvement underway

5. What Else Could We Do?
   • Understand and Protect the Supply Side
   • Different/Multiple Careers
Productivity and Information

Judy Curson, Bob Deans, Anne Owen, Ben Lloyd, Stephen Richards

1. What is the Theme About?
   • Our culture - leadership/empowerment. Is regulation stifling innovation?
   • S/B metrics driven? Incentives/barriers?
   • Addressing the variation we have known about for years
   • Important outcome metrics: ROI/benefit, patients, taxpayer, staff. E.g. ROI – category management, ROI – front line staff
   • Input efficiency – absence/sickness/turnover
   • Output efficiency – processes – don’t waste time because of the system, e.g. prescribing
   • Outcome efficiency (effectiveness) – better outcomes, same outcome for less skilled input, changing risk threshold

2. Benefits of Getting it Right
   • It is better for the patient – patient and taxpayer
   • “Concentrate on the first half of the game”
   • Taking away the places to hide

3. One Thing to Make an Appreciable Difference
   • Top Five Metrics – to take away the places to hide

4. What Could Be Done Quickly?
   • Top Five Metrics and Input and Output Efficiency – build into contracts with organisations.
   • Focus and Stop Doing Lower Priority Changes – changes/projects with leadership/ownership at health economy level

5. What Else Could We Do?
   • Outcome Efficiency
   • Delivery Rigour Through Local Individual Accountability
   • “Fire the Wasters”
Leadership

Peter Lees, Stuart Carney, Fizz Thompson, Ann Ewens

1. What is the Theme About?
   • Engagement at all levels and team working
   • Good leadership responsible for results and accountable
   • Clinical engagement
   • NHS Brand – units ‘us’ and the public, consistent, health and social care – the ‘S’ in NHS is Social Care
   • Communication Campaign – persuasive and positive
   • SONHS – Safeguarding – Save us. Protecting ‘free at the point of delivery’

2. Benefits of Getting it Right
   • Drive out waste/inconsistency
   • Vision – ‘best healthcare system in the world’ will efficiency and VFM

3. One Thing to Make an Appreciable Difference & 4. What Could Be Done Quickly
   • Sense or Belonging
   • Line Manager Makes a Huge Difference
   • Role Modelling – e.g. highest paid takes a 5% pay cut
   • Communication – Lines of Direct Report – generational differences need to be acknowledged
   • Organisational Culture – line managers, front line an support services

5. What Else Could We Do?
   • Create headroom, hold people to account, focus on outcome data,
   1. Structure Our Systems Built Up of Networks of Teams Around Patient Care Pathways
   2. Enable Line managers to Structure Teams Around Patient Care Pathways – give them skills/space, provide real time outcome data
   3. Monitor Service and Drive Further Development – NB need exemplars
1. What is the Theme About?
   • Public engaged with the “change” narrative – speed and local quality
   • Public as partners, what they want, shared responsibility, listen
   • Public as workforce - ownership

2. Benefits of Getting it Right
   • Change will be smooth
   • Less to deliver – know where the support is
   • Deliver what is needed – rights and responsibilities balance

3. One Thing to Make an Appreciable Difference
   • End of Life Pathway – public – confidence, choice, control and competent

4. What Could Be Done Quickly?
   • Every Health and Social Care Worker Can Tell The Positive Narrative
   • Help Public Make Choices

5. What Else Could We Do?
   • Implement a Strategy for Educating Public in Basics – e.g. driving test with first aid test, e.g. GP – educating parents with children under two, e.g. communication via email/phone,
   • Trust Public to Make Judgement
1. What is the Theme About?
   • Engaging and developing existing and future workforce – carers, health and social care staff, HE staff, GP’s etc.
   • Public engagement with workforce change
   • PSRB’s risk averse
   • Personal ownership

2. Benefits of Getting it Right
   • Future-proof, flexible workforce
   • Cost-effective
   • Effective team working and shared expertise – team leadership
   • Services need skill sets not disciplines
   • Flexible service delivery

3. One Thing to Make an Appreciable Difference
   • Enabling Pathways for Changing Roles – political, professional and sustained will

4. What Could Be Done Quickly?
   • Agree and Implement Unified Scope of Practice – what are the good pockets of innovation?

5. What Else Could We Do?
   1. Cost Effectiveness of Current and Future Provision
   2. Re-examine What We Have and What Can Be Taken Forward
   3. Organisational Restructuring to Find Posts
How Should We Work Together?

1. Roles and Responsibilities Across the System
2. Leadership and Governance Including Decision Making
3. To Align Service Design and Redesign Including Decommissioning Services
4. To Deliver a Consistent Story (Narrative) to Public/Staff etc.
5. To Reflect National Priorities and Align With QIPP
6. To Encourage Regional Collaboration for Commissioning and Decommissioning
How Should We Work Together?

Roles and Responsibilities Across the System

To Align With Service Design and Redesign Including Decommissioning Services

To Reflect National Priorities and Align With QIPP

Leadership and Governance Including Decision Making

To Deliver a Consistent Story (Narrative) to Public, Staff etc.

To Encourage Regional Collaboration For Commissioning and Decommissioning (Education)

Exam Questions

1. What does ‘good’ look like?
2. How could we make it happen together?
3. What will get in our way?
4. What specifically are the top three things we can do to show we mean it?
Roles and Responsibilities Across the System
Fizz Thompson, Katherine Fenton, Ann Ewens, David Sines

1. What Does Good Look Like?
   • Clearly articulated system of accountability throughout the various levels in the system
   • CE of SHA - Clear on accountability for workforce, good narrative, joined up.
     - Sees workforce as a priority – mandate delegated workforce lead in PCT.
   • CE of PCT - Clear on accountability
     - Workforce lead in PCT and each PCT has a workforce plan (metrics, yearly review with SHA)
     - Commissioners (joint appointment with social care) – 3 commissioning clusters – COM (collaborative operating model)
   • Trust Level – work with Trusts to establish workforce plans
   • HEI’s – Roles at each level part of strategic alliance. Responsibilities – informing, responding, innovation
   • Issues – workforce has not been a nationally driven target

2. How Could We Make It Happen Together?
   • MUST DO – Clinical Care Strategy for each of the 8 care pathways
   • Developing people for workforce planning

3. What Will Get In Our Way?
   • Financial targets
   • Lack of national – local priority
   • Fragmentation – matrons etc
   • Lack of focus
   • Lack of capability

4. Top Three Things
   • Mandate from CEO to implement accountability structure
   • 8 clinical pathway workforce strategies to be integrated with the PCT workforce plans
Leadership and Governance Including Decision Making
Vicky Osgood, Allan Jolly, Ros Tolcher, Nadia Chambers

1. What Does Good Look Like?
   • Leaders identified and empowered to decide
   • Provided with good information
   • Transparency of process and visible collaboration

2. How Could We Make It Happen Together?
   Good practice

   Excellent patient care
   Education and Training

   Expert opinion and resource

   Service Commissioner – leadership and accountability for workforce

   Service Provider – Leadership and accountability for workforce

   Outcome behaviours

3. What Will Get In Our Way?
   • Barriers between organisations working
   • Perverse incentives of tariff

4. Top Three Things
   • Personal ego/agenda
   • H & SC different agendas
To Align With Service Design and Redesign including Decommissioning Services
Stuart Carney, Ben Lloyd, Ruth Monger

1. What Does Good Look Like & How Could We Make It Happen Together?
• Looks like (new trainees):
  - Around the table you have: - COM, Evidence analysis (PCT strategy, CD priorities), international, social care, provider board (Increase private sector?), workforce demand and supply co-ordinator (Rece to SHA Board about investment).
  - Good (existing): 67,000 FTE’s – alignment to service strategies/plan of existing workforce
Link to existing machinery and provide challenge to ambition

3. What Will Get In Our Way?
• Modelling – answer is never absolute
• Therefore risk based decision making

4. Top Three Things
• Do the “good” models above leading to Board decisions
To Deliver a Consistent Story (Narrative) to Public, Staff etc.
Jonathan Horbury, Suzanne Cunningham, Sue Duke, Nikki Griffiths

1. **What Does Good Look Like?**
   - Consistent message within local context – honest and deliverable

2. **How Could We Make It Happen Together?**
   - Engage – unions, staff, media, partners, politicians
   - Build political capital
   - Personal stories – “health talk online style”
   - Zero tolerance on “violence about NHS”
   - “Everyday we”

3. **What Will Get In Our Way?**
   - All of the above
   - Time

4. **Top Three Things**
   - Personal stories
   - SHA protection/cushion
   - Project outwards
To Reflect National Priorities and Align With QIPP

Judy Curson, Jeannette Bartholomew, Anne Owen

1. What Does Good Look Like?
   • Be deliverable in a realistic time frame
   • Locally relevant
   • Reduces cost and delivers services more efficiently
   • Has capacity to easily change in line with changing priorities
   • Can be seen to improve/maintain quality
   • Values people and their contribution
   • Doesn’t look like innovation for the sake of innovation
   • Builds on evidence based practice, learns from success elsewhere
   • Well communicated/disseminated and guides what we do
   • Facilitates personalisation

2. How Could We Make It Happen Together?
   • Holistic view of priorities – look at interdependence
   • Collaboration and co-ordination to ensure delivery
   • Integrate priorities with plans for service redesign/reduction
   • Plan ahead for right education and training packages
   • Engagement of regulators and professional bodies at an early stage
   • SHA upward influence to regulators/professional bodies
   • Taking individual accountability to make it happen
To Reflect National Priorities and Align With QIPP

3. What Will Get In Our Way?
   • Lack of belief in national priorities – are they right for our local populations?
   • Too many national targets that are often competing
   • Education targets (HEI restrictions on growth)
   • General election – paralysis of decision making
   • Regulation of education
   • Placement capacity and supervision

4. Top Three Things
   • Make the workforce strategy number one priority and align national priorities and QIPP to it
   • Engage whole economy in design and delivery
   • Implementation plan with clear accountability and time frames
     - Introduce ways for individual focus e.g. objective in all leaders’ profiles
To Encourage Regional Collaboration For Commissioning and Decommissioning (Education)
Jessica Corner, Sue Donaldson, Bob Deans, Heather Aldridge

1. **What Does Good Look Like?**
   - Effective leadership/governance
   - Clear vision to make it happen
   - Having understanding of current state and future regulation
   - Healthy challenge of ‘menu’ available from education providers
   - Better value response from our education providers – VFM, critical mass

2. **How Could We Make It Happen Together?**
   - Use opportunity of HIEC
   - Exploit current networks
   - Focus on innovation
   - Make it worth it for individual organisations
   - Collaborate with current providers – if responsive to change
   - Encourage provider to collaborate themselves – especially in new areas
   - National input
To Encourage Regional Collaboration For Commissioning and Decommissioning (Education)

3. What Will Get In Our Way?
   • HEI not willing – what’s in it for them?
   • Current provider/commissioner split
   • Funding
   • Vested interests (professional bodies in decommissioning scenario)
   • Political resistance

4. Top Three Things
   • Get sign up from key organisations – memorandum of activity, link to HIEC (focus on accountability/governance) – SHA or PCT to facilitate? Proper sign off from organisations collaboratively. Step change in SA role.
   • Be clear about influence local collaboration can have vs. national collaboration
   • Early dialogue with key influencers e.g. Royal Colleges, professional bodies and regulators
Next Steps and Support Going Forward

• Newsletter and feedback
  - CE, DON, Trust Leads

• Workforce Strategy Reference Group “Critical friends”
  - Real and virtual – opt out option
  - 2<sup>nd</sup> Nov, 2pm – Southern House, Otterbourne - First draft review

• Regional Health & Social Care workshop
  - 12<sup>th</sup> Nov

• “Pathway” strategies

• CE group/provider group

• Workforce Strategy Conference
  - 7<sup>th</sup> Dec – Wide consultation and further discussion on implementation
To contribute further to the South Central workforce strategy contact:

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