Workforce Event

Welcome

29 June 2023

Orlando Hampton

Associate Head of Workforce Transformation, NHS England

Workforce Transformation:

What, why and how?

Presented by:
Orlando Hampton, Associate Head of Workforce Transformation

What do we mean by workforce transformation?

“Transformation is a process of profound and radical change, that takes an organisation in a new direction and to an entirely different level of effectiveness.”

From a workforce perspective, this requires us to:

Understand the current context

Understand the future of work

More, or different?

Explore the broader skills requirement, beyond traditional competencies and roles

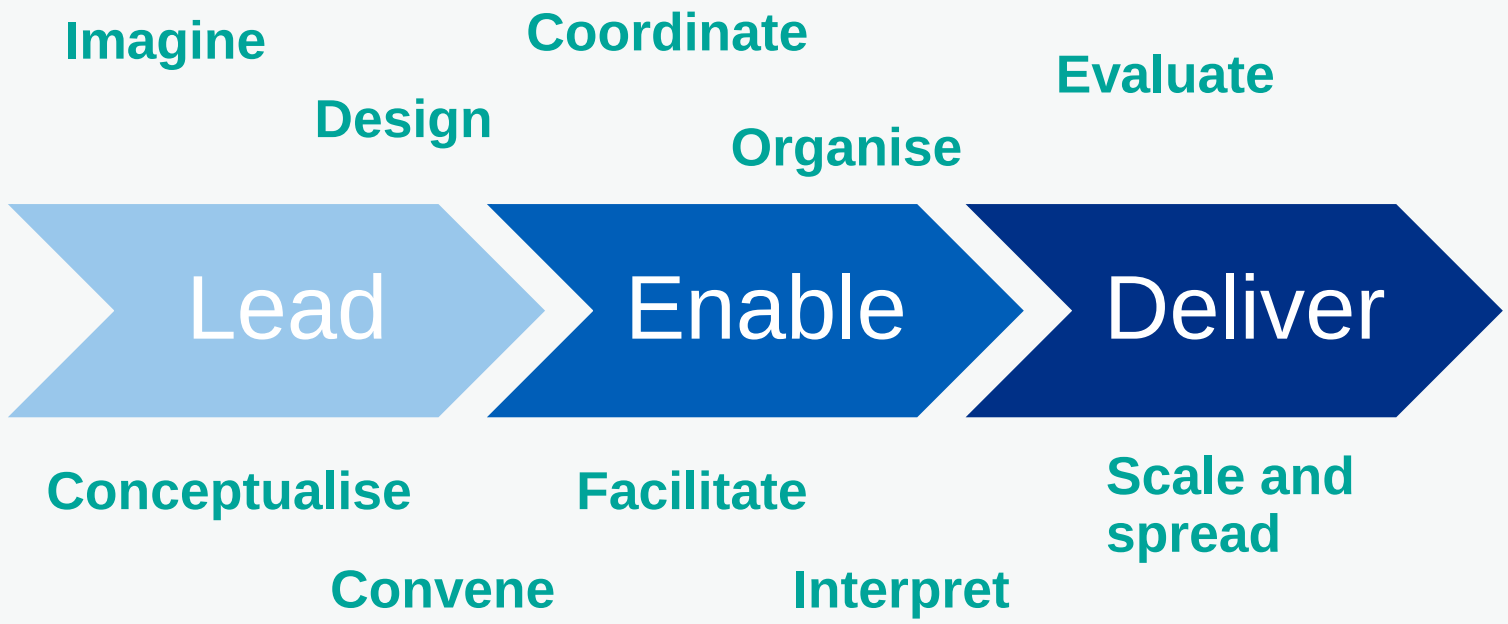
Nurture a future integrated workforce that is more agile/flexible

Support leaders and talent at all levels

Adoption of workforce transformation

Challenges	Opportunities
A lot of health and care pressures and priorities Little standardisation of processes and limited capacity for service and workforce transformation, all compromising the development and delivery of workforce transformation plans	**Collaborative working across health and care providers** Integrating workforce transformation alongside service transformation and digital enablers, reducing duplication and variation, maximise collective expertise
Partnerships/governance/cultures in their infancy Limited understanding of workforce transformation models, where to start and what's needed to deliver locally driven changes (more of the same considered 'easier' and safer, than doing differently)	**Common goals** Needing to attract and retain, fill difficult gaps and grow their own across the system footprint and our universal offer to co-produce progressive workforce transformation investment plans with every ICS
Capacity to capture impact The time and focus to evaluate work and build a workforce transformation evidence base, sufficient to inspire spread and adoption	**A single place to source best practice** To accelerate spread of what works, as well as tools and frameworks to support the process end to end, including the culture of change
Persistent imbalance between workforce demand and supply, exacerbated by new service models, limited focus on prevention and advances which have boosted demand	**Wider workforce transformation potential** including social care, third sector, volunteers, carers…

Our purpose in workforce transformation



Workforce of the future

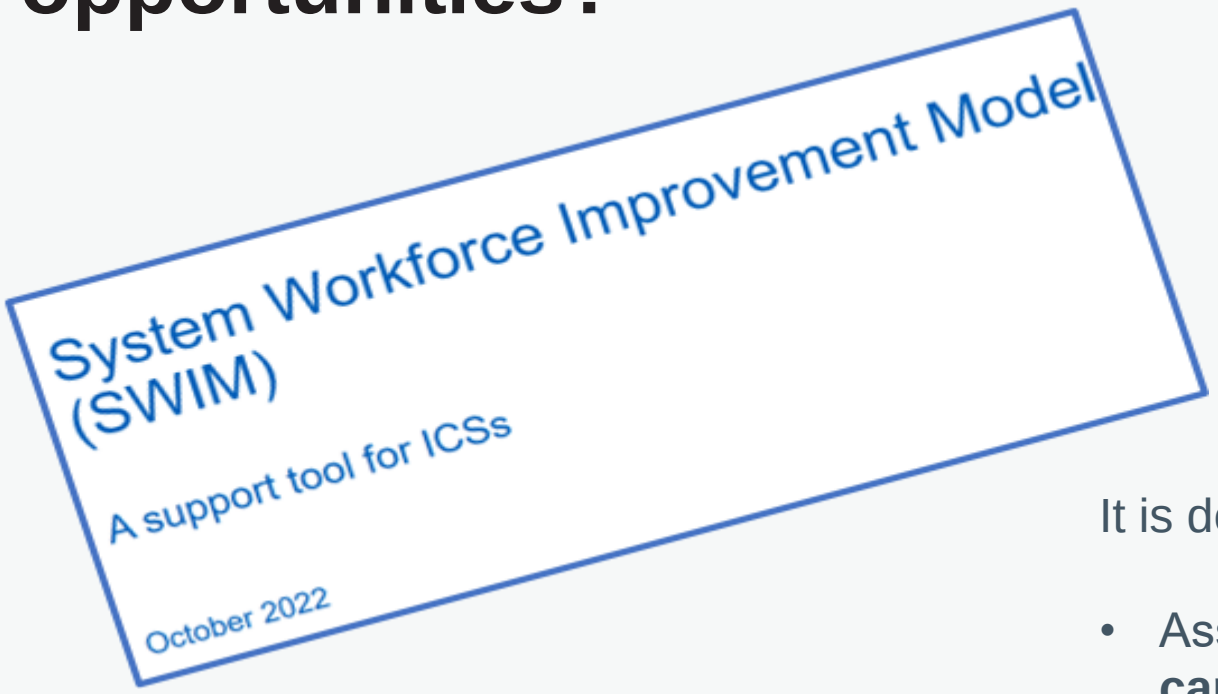
Multi-disciplinary teams with the optimal skills mix

Integrated working

Embracing technology

Personalised and holistic care

How do you measure your current state and future opportunities?



It is designed to support ICS leaders to:

- Assess their system's **readiness, capacity and capability** to deliver the ICS people function, and develop plans for establishing it alongside other ICS functions
- Identify potential **gaps and support needs** that can be discussed with the ICB, the ICP, the ICS People Board and the regional team

Workforce redesign tools/enablers

Tool/enabler	Outline
HEE Star	An OD tool designed to distill and simplify complex workforce challenges and create a programme of tangible and realistic workforce solutions
	Also an **online directory** of existing solutions, readily available to access – including training materials, competency frameworks, template role descriptors etc.
CLEAR	*C*linically-*L*ed workforc*E* and *A*ctivity *R*edesign, equips front line clinicians with the skills to analyse service activity, design improved care models and establish the optimum skills mix for safe, effective delivery. Been used to great effect in U&EC, Critical Care and for staffing the Nightingale units and now being applied to Theatres and Anaesthesia, and Outpatients.
Roles Explorer	An on-line collection of resources to inspire alternative skills mix to traditional workforce models, explore the capabilities, training requirements and career frameworks for different roles and provide best practice when designing and implementing new roles
MDT Toolkit	A step by step, guide to progress team working and 'one workforce' approaches to enable systems to bridge workforce gaps and draw upon a broader range of skills and competencies
COM-B	Building capability through the **Health Psychology Workforce Transformation Programme**, to apply the COM-B model which explores the Capacity, Opportunity and Motivations required for successful cultural change in practice. See also **https://behaviourchange.hee.nhs.uk/toolkits**

What is the HEE Star?

1 **A simple, coherent framework to facilitate and guide workforce conversations.**

- The methodology is proven to be faster, less costly and of higher quality compared to alternative, similar approaches.
- Since 2020, almost 600 facilitators have been trained to use the Star methodology, covering all ICSs.

2 **A single ‘go to’ directory for providers and systems to access and explore a range of workforce transformation solutions.**

- There are more than 400 individual offers, products, and resources available through the Star

https://www.hee.nhs.uk/our-work/hee-star

Key enablers of workforce transformation

Supply

Identifying current and future workforce availability in terms of skills, capabilities and numbers, in order to identify the appropriate workforce interventions.

Up-skilling

To improve the aptitude for work of (a person) by additional training, the aim of which is to create:

- A competent workforce working to its maximum potential
- An agile workforce that may be flexibly deployed
- A capable workforce with future-facing knowledge and skills

New roles

Health and care roles designed to meet a defined workforce requirement, warranting a new job title; the likely ingredients including additionality to the workforce, a formal education and training requirement (whether that be vocational or academic), an agreed scope within the established Career Framework, and national recognition (although not necessarily regulatory) by clinical governing bodies.

New ways of working

Emphasis on developing an integrated workforce culture that empowers it to break through system barriers to deliver a practical response, resonating with ICS needs, to person centred care.

Leadership

The support of individuals, organisations and systems in their leadership development – ranging from individual behaviours and skills, to organisational development of systems through partnerships.

Examples of Star actions

SUPPLY: *current and future workforce capacity, capability and numbers*

- Baseline and benchmark agreements
- Integrated workforce plans
- Affordability, cost benefit analysis
- Retention actions
- Education and Training: planning, access and capacity
- Mapping through to different services need

UPSKILLING: *optimising and developing the current workforce*

- Professional development
- Upskilling to meet new ways of working and new services
- Career pathways – maximising individual opportunity (e.g. nursing)
- Apprenticeships
- Advanced / Enhanced roles

Examples of Star actions

NEW ROLES: *Adoption and spread of new roles in health and social care*

- Review vacancy gaps and identify if new roles could support
- Alternative roles programme in Primary Care
- New Roles in MH programme
- Capacity to develop and sustain new roles
- Showcase NHS new roles programmes – employer / employee

NEW WAYS OF WORKING: ***integrating the workforce, digital & technology opportunities***

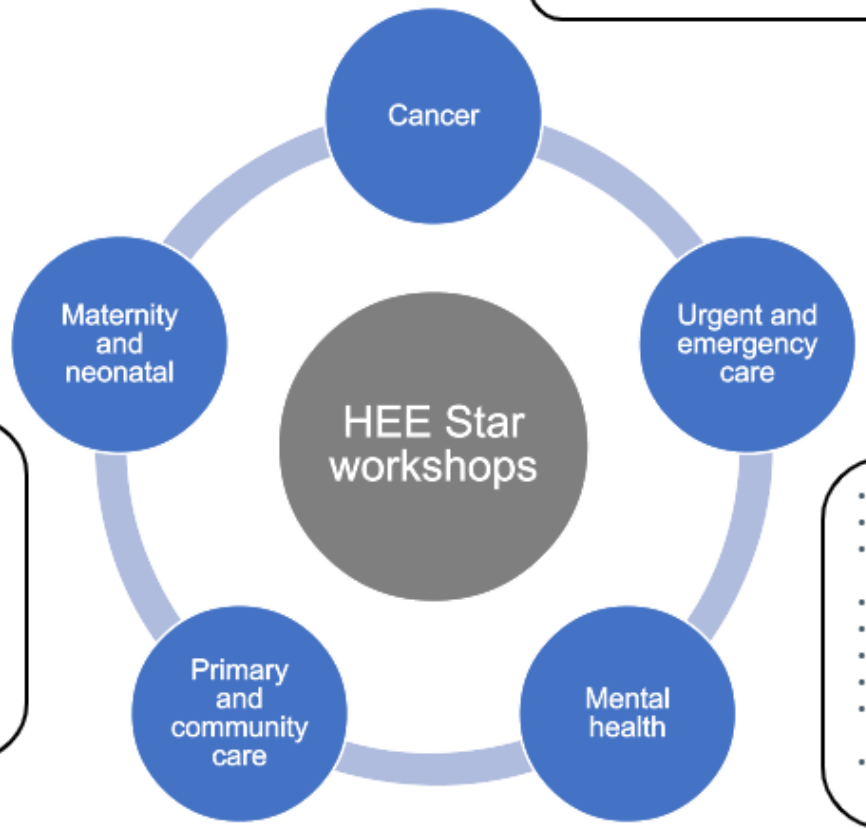
- New relationships between key employers
- Digital passports (?)
- Digital literacy and digital service
- National collaborations / pilots

LEADERSHIP: ***Capacity & capability, leadership of self and others***

- Talent management – leadership of self
- Organisational Development: the process and workforce change
- System Leadership representation and support

Examples of HEE Star Workshops

More than 50 Star workshops have been facilitated by the national workforce transformation team covering the breadth of priorities and pathways, and have collaborated with ALBs, Royal Colleges, systems, local networks, and Trusts in workshop delivery.



- Shortage of Cancer Nurse Specialists
- Maximising the potential of the palliative and end of life care workforce
- Shortage of reporting radiographers and sonographers
- Recruitment of clinical endoscopists

- Maximising the extended surgical team to support Improving Surgical Training across Wessex
- Addressing the shortage of respiratory nurses across Fylde coast
- Maximising the potential of nurses in frailty services in Morecambe
- Shortage of adequately staffed MDTs in Cardiac Rehab services
- Shortage of Echocardiographers
- Addressing the shortage of medical staff within Urology services across Hull and North Lincolnshire & Goole

- Spreading and adopting Physician Associates in MH
- Shortage of MH nurses
- Maximising psychological professions in MH
  Spreading and adopting Nursing Associates in MH
- Maximising the potential of social workers in MH
- Maximising peer support workers in MH
- Maximising the potential of AHPs in MH
- Maximising pharmacists in MH
- CAMHS - Optimising non-core professionals to increase access to talking therapies
- Addressing the shortage of PWPs in IAPT across Beds, Luton and Milton Keynes

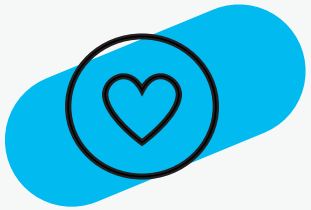
- Spreading and adopting Physician Associates in Primary Care
- Delivering the 26,000 multi-professional workforce in Primary Care
- Maximising the potential of the women's health workforce in the community to support delivery of services via women's hubs
- Maximising the potential of the community rehab support workers across Dorset ICS
- Maximising the potential of stroke workforce to apply Level 1 step care model across EoE

- Addressing the shortage of the Obstetrician and Gynaecologist workforce
- Maximising the potential of AHPs in neonatal services
- Maximising the potential of neonatal nurses
- Addressing the shortage of Neo natal medical workforce

CLEAR

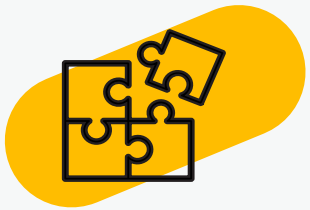
CLEAR stands for **Clinically-Led workforcE and Activity Redesign.** The national programme places **clinicians at the heart of healthcare decision making and innovation**. The integrated learning and working programme enables clinicians to develop new skills in data science, transformation and leadership while delivering live redesign projects in the NHS.

With its unique methodology, CLEAR delivers solutions that are clinically owned, increase control of clinical teams in healthcare delivery and provides an efficient solution to complex change programmes.



Clinically-led culture

Increasing the control of clinicians and clinical teams in the design and operations of front-line health care delivery, improving morale, well-being and staff retention and recruitment.



New skills

Increasing the control of clinicians and clinical teams in the design and operations of front-line health care delivery, improving morale, well-being and staff retention and recruitment.

New ways of working

Increasing the control of clinicians and clinical teams in the design and operations of front-line health care delivery, improving morale, well-being and staff retention and recruitment.

Clinical ownership

Increasing the control of clinicians and clinical teams in the design and operations of front-line health care delivery, improving morale, well-being and staff retention and recruitment.

There are four stages to the CLEAR methodology: Clinical engagement, Digital visualisation, Innovation, and Recommendations.

https://www.hee.nhs.uk/our-work/workforce-transformation/clinically-led-workforce-activity-redesign-clear

CLEAR – Project Impact in Eye Care

Challenge: Demand for ophthalmic services is significantly outweighing capacity, which can lead to avoidable disease advancement requiring model of care and workforce redesign.

Solutions:
Outpatients: Optimised referral refinement, phased integration of cross hospital-community glaucoma services, on-site diagnostic hub, MDT working, diversification of workforce, streamlining of clinics
Cataracts: Optimised theatre efficiency through risk stratification, nurse led consent clinics, last minute lists, case managers, and options for two dedicated theatres in appropriate estates

Potential outcome: New models of care for glaucoma and outpatients would be **£870k less than scaling the current model with 50% fewer consultants** (costs covered by cataracts savings).

- **Clear backlog and waiting lists**, eliminating need for support from private sector for cataracts.
- **Reduced cataracts lists,** from 29 to 19 pcm, saving >£1m pa whilst meeting cataracts service demand.
- **~£250k savings avoiding lost theatre time** due to last minute cancellations.
- **Lower imaging costs** with up to £27k savings.
- **Diversification and workforce optimisation** supporting recruitment and retention

Roles Explorer

- A collection of resources to support those responsible for planning and delivering workforce redesign.
- The resources are for use when introducing new roles, or innovative adaptations to existing roles already being deployed within a service or system.
- For those delivering workforce redesign, the Roles Explorer is designed to:

Provide inspiration and alternatives when designing the optimum skill mix

Explore the capabilities, training requirements and career frameworks for different roles

Support to choose the best fit for the service model

Develop new staffing models to fit new ways of delivering care.

Provide a range of resources to support the introduction of new roles including case studies of how roles are being deployed in each of the core system priorities

https://www.hee.nhs.uk/our-work/workforce-transformation/hee-roles-explorer

Multidisciplinary Team (MDT) Toolkit

- Interactive toolkit presenting a collation of evidence distilled into six enablers and associated success factors, supported by related resources
- Designed to be relevant in any setting, to any objective, to progress a ‘one workforce’ approach
- Inputs provided by ALBs and Think Tanks, and literature searches conducted by KLS team
- Supplemented by a development plan for MDT working
- Launched in Autumn 2021 alongside the Roles Explorer as a suite of resources to support workforce redesign

https://www.hee.nhs.uk/our-work/workforce-transformation/multidisciplinary-team-mdt-toolkit

Multidisciplinary Team Toolkit

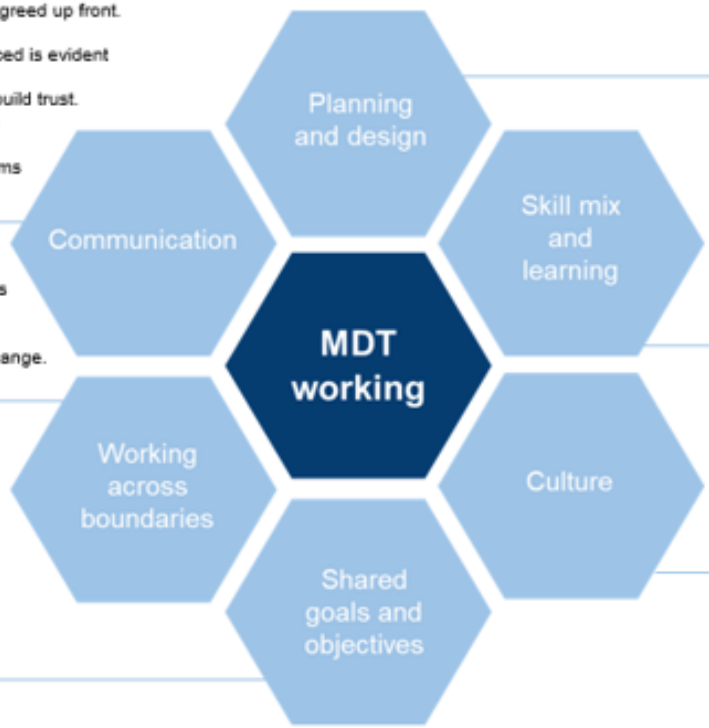
NHS
Health Education England

Six key enablers for successful MDT working

Communication
- Approach to engagement and communications is inclusive and embedded.
- Frequency, timing and methods of communications within the MDT are agreed up front.
- Systematic approach adopted to continuous relationship building.
- Shared vision and narrative being continuously implemented and reinforced is evident and supported.
- Open, transparent and two-way engagement approaches embedded to build trust.
- Engaging and communications driven leadership, capacity and expertise developed.
- MDT approach, with use of patient stories, is well articulated to other teams and organisations.

Working across boundaries
- Shared space or co-location is agreed and all physical and human factors have been identified.
- Leadership is committed to shared records.
- Technology to support MDT is enabled, with efficient, effective data exchange.
- Information governance is clear and well defined.

Shared goals and objectives
- Safe space created on a defined basis to discuss and agree shared goals.
- Commonalities are recognised, welcomed and recorded.
- Shared goals and objectives are designed together, across professions and leadership.
- Shared decision making, governance and accountability process are agreed.
- Approach to evaluate the effectiveness of the MDT is agreed.



Planning and design
- Design of the team is based on population need.
- HEE Star has been used as a methodology to plan workforce change.
- Approach to risk stratification is agreed.
- Personalised care plans are co-developed with patients/ service users.

Skill mix and learning
- The team has the right skills and membership.
- SMART development plans in place for individuals and the team.
- Roles and professional. backgrounds are shared as part of a team development plan.
- Clear understanding of how other services operate.
- Mentoring is an active part of the MDT's ways of working.
- Organisation changes and developments are routinely shared and discussed.
- Time is dedicated to allow MDT to learn together.

Culture
- Support from the organisation is evident and well documented.
- Support, training and supervision for shared leadership is evident and well documented.
- Cross leadership and multi professional training takes place.
- Non-work (socialising) is included in development time to progress relationships.

Applying health psychology to workforce redesign

Programme: National programme commenced December 2022, employing trainee health psychologists in host organisations to enable a psychological approach to changing NHS workforce practices. Trainees are utilising health psychology and behavioural science to drive change, specifically using the Behaviour Change Wheel which incorporates the COM-B framework (capability, opportunity, motivation, and behaviour).

Aims: Build capacity and capability for workforce redesign within NHS organisations, supporting and facilitating change and enabling new ways of working. Trainees are undertaking work to support locally identified workforce priorities including supporting the design and delivery of health and wellbeing initiatives, upskilling of health and care staff, and integration of new roles into MDTs.

Expected outputs and impact:

- Increased knowledge, understanding, and application of behaviour change within teams and organisations hosting trainees, and within wider systems/regions.
- Behaviour change theory embedded within workforce transformation and redesign activities, enabling and sustaining workforce change.
- Greater understanding of the unique contribution of the health psychologist role, and creation of suite of evidence based projects/publications linked to the role for sharing and future spread and adoption.
- Workforce improvements (e.g. more integrated working and person-centered approaches) aligned to strategic plans and leading to improved standards of care for populations.

Host organisations:

North West: East Lancashire Hospitals NHS Trust

North East and Yorkshire: Hull University Teaching Hospitals NHS Trust

Midlands: Derbyshire Community Health Services NHS Trust

East of England: East Suffolk and North Essex NHS Foundation Trust

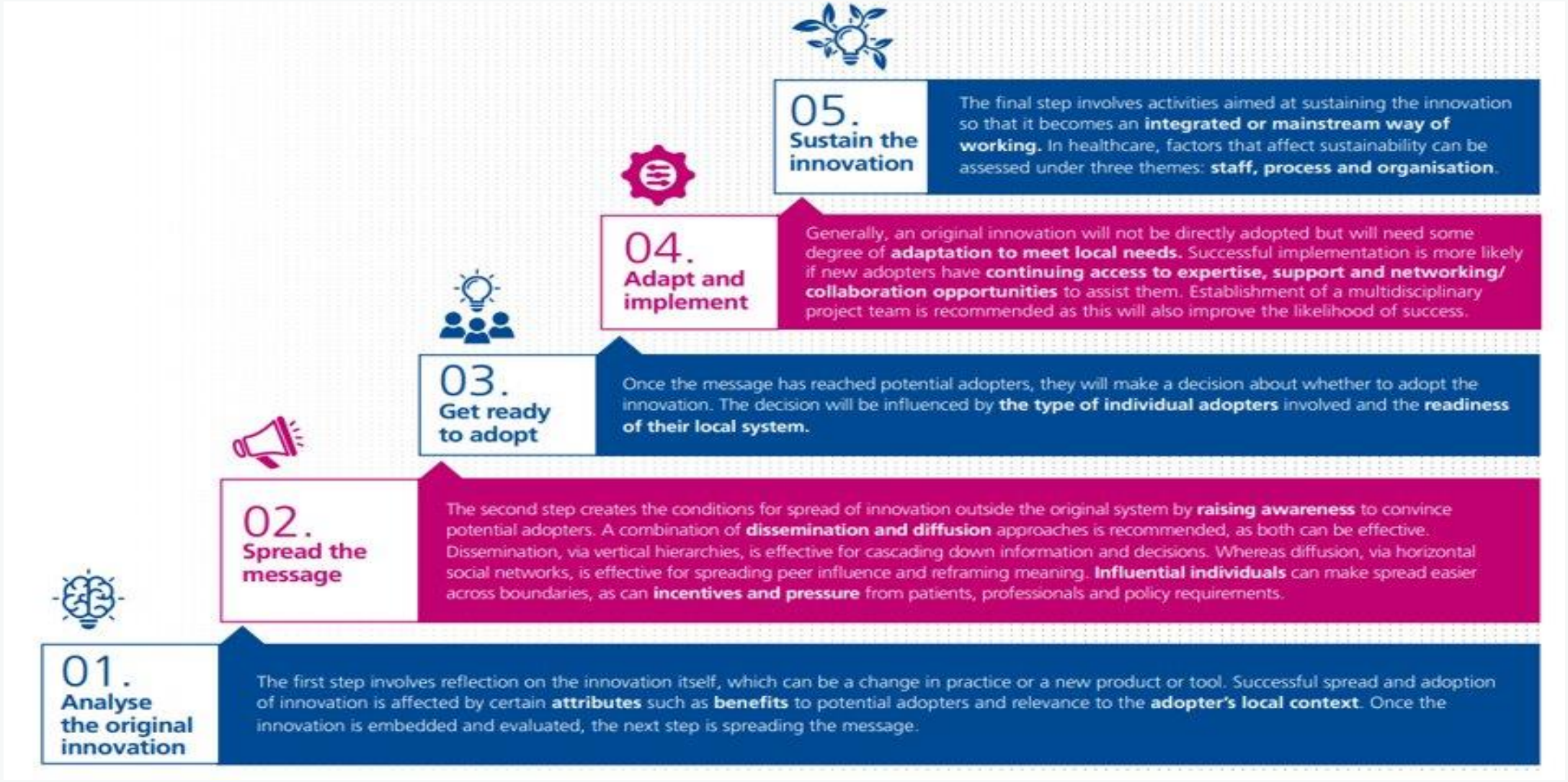
London: The Tavistock and Portman NHS Foundation Trust

South East: Kent and Medway Primary Care Training Hub

South West: Devon Partnership NHS Trust

https://www.hee.nhs.uk/our-work/workforce-transformation/health-psychology-workforce-transformation-programme/further-com-b-information

Spread and adoption of workforce innovation



https://www.hee.nhs.uk/our-work/workforce-transformation/spread-adoption

General Practice Assistant

Why GPAs? In 2018, the General Practice Assistant was introduced as a national spread and adoption programme, responding to the challenges faced in GP practices such as rise in patient expectations, recruitment issues and increased GP workload.

Their purpose: To support General Practitioners in their day-to-day management of patients, specifically aimed at reducing the administrative burden and making best use of consultation time.

The programme: Created a consistent approach to developing the role, underpinned by a defined job description, competency framework, on the job training and associated accreditation.

The result: To date 450 GPAs have completed the programme, and role now included in the Additional Roles Reimbursement Scheme.

The impact: Where GPAs have been introduced, GP practices have reported:

- Administrative tasks previously undertaken by GPs and now completed by GPAs, can support in releasing GPs' time to care, and result in **significant savings**
- GPAs undertaking insurance proposal reports, could potentially save £425 per week/£22,100 per annum
- GPAs undertaking other reports, could potentially save £813 per week/£42,250 per annum.
- **Enhanced team working** where GPAs felt more integrated into the team and able to provide cross cover for other team members (e.g. phlebotomy clinics and covering practice manager workload)
- **Improved turnaround** for Personal Independence Payments (PIPS) and Employment and Support Allowance (ESA) which helped to improve population health.

"In the absence of a GPA role, the practice would probably have trained more HCAs. However, the GPA role was seen as better, because of the breadth of the course, the formal qualification offered, and the ***ability to flex between administrative and clinical support"***

https://www.hee.nhs.uk/our-work/gp-assistant

Systematic approach to designing pathway ‘blueprints’

Data Analysis – service demand, population health and workforce supply

CLEAR (Clinically-Led workforcE and Activity Redesign)

Workforce redesign workshops held over time

HEE resources – HEE Star online directory, Roles Explorer, MDT Toolkit, COM-B

- Working across all key stakeholders
- NHS resources e.g. SWIM

0 months | 3 months | 6 months | 9 months

Data - Provides insight for focus of service and workforce transformation
Training programme which equips clinicians with the skills to model optimum workforce skills mix to deliver service improvements
HEE Star methodology used to explore workforce challenges and determine realistic workforce interventions/solutions
HEE tools, approaches and capacity to facilitate workforce redesign at regional and ICS level

Elective recovery and reform

Application of workforce redesign tools and expertise including:

In eye care:

- Using **CLEAR methodology**, identified a number of interventions with potential to help reduce waiting lists and make financial savings within Outpatients department at Sussex Eye Hospital, University Hospitals Sussex NHS Foundation Trust
- **Upskilling Guide** developed to highlight upskilling journeys in the eyecare workforce, including Optometrist, Orthoptist, Nursing Associate and Nurse.
- Ophthalmology section added to **Roles Explorer**, describing the roles in the team, supported by case studies, to inspire new ways of working.
- A range of standardised learning outcomes have been identified to form the basis of the first national **curriculum framework** for ophthalmic nurses.

HEE Star workshops held to support workforce challenges in priority areas with funding allocated to deliver range of projects:

- In **Cardiac Rehab**, projects included development of wider MDT roles, career pathways and workforce planning.
- In **Echocardiography**, projects included upskilling, prioritisation approaches, exploring training/supervision roles, retention, and digital.

Supporting the Medical Education Reform Programme to support ICSs impacted by changes in **distribution of medical training places.** Current focus within Cardiology, Haematology and Obstetrics and Gynaecology specialties.

Underpinned by development of workforce transformation toolkit, a suite of resources to support with workforce redesign.

Theatres

Leadership for Skills Mix and Competencies Working Group (workstream 2) of the Building Outstanding Theatre Teams Programme.

Objectives to:

- Utilise current and new ways of working to develop skills across professions, enhance staff's capabilities and increase theatres productivity
- Define competencies across the whole theatre team and establishing the training required to deliver them (with GIRFT team)

Deliverables for 23/24 include:

- Create three inspiring workforce redesign case studies using the CLEAR Compact approach. The focus will be on perioperative, adult elective care in trauma and orthopaedics within urban, rural and coastal settings.
- Create a skills toolkit to support organisations with understanding their operating theatres workforce.
- Develop competency frameworks for four theatre practitioner roles (Anaesthetic Practitioner, Recovery Practitioner, Scrub Practitioner and Circulator).

Rural and coastal: overview

Background

Chief Medical Officer's Annual Report 2021 highlighting serious health challenges = preventable ill health which will get worse as current populations age.

Global health research – learning from workforce and digital approaches.

Education and training interventions that impact on social determinants of health.

Pilot sites selected in four ICS footprints: Lincolnshire, Norfolk & Waveney, Suffolk & North East Essex, Kent & Medway, based on having highest indices of multiple deprivation and lowest workforce per head of population. These sites also experience lower than average levels of health literacy.

Delivery approach

- Led by NHSE Regional Workforce Transformation Teams in conjunction with the ICS Workforce leads and other key ICS partners based on local determined priorities.
- Multi-directorate collaboration across Workforce, Training and Education directorate and more widely, overseen by a small representative steering group.
- Brings together existing workforce, education and training programmes and initiatives across a focussed and targeted geography.
- Investment funded through ICS, Workforce Development and other programme funds.

https://www.hee.nhs.uk/news-blogs-events/news/hee-unveils-programme-help-tackle-health-inequalities-rural-coastal-areas

Rural and coastal: priorities and levers

Medical education:

- Widening access and increasing local recruitment
- Learning experiences and support in rural settings
- Medical Doctor Apprenticeship
- Redistributing specialty training posts
- Enhancing generalist skills programme

Clinical workforce:

- Enhanced, advanced and consultant practice
- Clinical placement expansion, including civic placements
- Expansion and adoption of technological opportunities including XR/Sim deployment

Health and digital literacy:

- Pilots through partnership with CILIP, Libraries Connected and Arts Council England
- Local projects including digital ambassadors/champions

Apprenticeships and widening participation:

- Development of apprenticeship strategies aligned to rural and coastal needs
- Engagement and promotion of health career opportunities

Workforce transformation:

- Utilisation of transformation approaches and resources (HEE Star, MDT Toolkit, Roles Explorer)

What next?

- Long Term workforce plan (Summer 2023)
- Framework 15 (Summer 2023)
- Digital Data and Technology Workforce Plan (Autumn 2023)

Useful links

- Find out more about our work: https://www.hee.nhs.uk/our-work/workforce-transformation
- Email us: transformation@hee.nhs.uk

Thank You

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england.nhs.uk

Jayne Adamson and Rachel Baillie-Smith

Executive Director of People and Deputy Director of People – Humber and North Yorkshire ICB

Humber and North Yorkshire
Health and Care Partnership

180 Days and beyond

Innovation in system-led workforce transformation in Humber and North Yorkshire

Jayne Adamson, Executive Director for People
Rachel Baillie Smith, Deputy Director for People

July 2023

Collaboration machinery

We needed to help our system community move along the **collaboration spectrum**:

Competing → Co-existing → Cooperating → Collaborating

Principles from the **System Workforce Improvement Model** (SWIM) prompted focus in three practical areas:

- Collective understanding and ambition
- Collective action planning and delivery
- Measurable impact

Humber and North Yorkshire Health and Care Partnership

Our **People Strategy** establishes a shared architecture for the People challenge

Our **iterative transformation programme** enables collaborative planning and delivery

Using these collaboration tools, we aim to:

- Make progress on priority system workforce challenges
- Establish a real system leadership team with the power to sustain complex long-term change
- Catalyse a change movement in People and Workforce to generate hope and build confidence

Humber and North Yorkshire
Health and Care Partnership

Video:
https://youtu.be/TgQmeRDx_A8

Building blocks

Storytelling generates empathy to catalyse change

Equal voice in design from each part of our system via a workforce summit

A strong and public commitment to **dispersed leadership** of activities across our programme, building organically towards a true system leadership team for People

‘All welcome’ task and finish groups – creating the opportunity for different conversations by involving colleagues in new combinations

The story continues in our **180 Days storybook** here:

Humber and North Yorkshire Health and Care Partnership

"The creation of Rani helped to bring more realism and empathy into the discussion and kept us focused on the person and what their needs might be."

180 Days participant

“Putting people at the heart of our conversations, mixed groups of people and organisations and identifying opportunities for integration and solving some workforce wicked issues”

180 Days participant

Living system leadership

One of our key aims was to establish a **dispersed system leadership team** for the People agenda

We are building in **system leadership development,** creating space for our emerging leadership team to test, learn, challenge and debate

Our leadership team also includes and is enabled by our **system convenors**, provided by the ICB People Team

We are paying attention to team relationships and identity and celebrating team success

Humber and North Yorkshire
Health and Care Partnership

Our dispersed system leadership team for People is drawn from across our system and includes:

- Members of our Workforce Board
- Our transformation programme SROs
- Chairs of groups adopted within our People governance structure

Humber and North Yorkshire
Health and Care Partnership

Video:
https://youtu.be/NzTHwbFrfJs

What's next …

BREAKTHROUGH HNY

Our Workforce Transformation Programme 2023/24

We are continuing to deploy and evolve the new way of working we have road tested in 180 Days:

- Working in the **big picture,** using **narrative as catalyst**
- **Sprinting** for quick wins, then regrouping for the next phase
- **Developing and caring** for the change team
- **Evolving our aspirations** over time

Humber and North Yorkshire
Health and Care Partnership

Summary methodology

1. Use data and stakeholder insight to establish a core narrative for change
2. Define programme outline collaboratively with partners, ensuring equal voice
3. Invite colleagues from across the system to own and lead priorities
4. Create broad interest and participation through 'all welcome' task and finish groups
5. Provide each group with a convenor from the ICB People team
6. Convenors and SROs target additional key participants and put in place steering arrangements as appropriate to the task
7. Plan objectives and measures and assess EDI impacts and risks within the programme period, with clarity on contribution to longer term goals
8. Report progress, challenges and solutions monthly to the Workforce Board

BREAKTHROUGH HNY

Our Workforce Transformation Programme 2023/24

Humber and North Yorkshire Health and Care Partnership

Inclusive health and care careers	Flexible workforce: agency and bank	Leadership, talent and succession	Stay and thrive: retaining our staff	OD Lab for system effectiveness	Care at Home workforce redesign	Children's and young people's workforce redesign	Oral health workforce redesign	Volunteers at the heart of the system	Enabling colleague movement	One system, recruiting together
Careers support menu in deprived schools Work experience placements bank, employer toolkit and virtual offer Disability confident Veterans	Design HNY system collaborative bank Deliver 23/24 NHSE bank and agency objectives Create HNY bank and agency dashboard	Create best practice programmes for leaders at all levels Explore common induction Deliver career progression curriculum Work with region 4+1 on senior level talent	Co-design and launch flexible working strategies New starter attrition prevention tools Exit intelligence Stay conver-sations	Create cutting edge OD toolkit to support system effectiveness, involving and developing Place, Collaborative and Function leaders and teams	Map VCSE Care at Home workforce at Place Streamline Care at Home roles Amplify direct care provider voice Care at Home digital vision	*To be developed with Directors of Children's Services*	*To be developed with Dental commiss-ioners and profession leaders*	Apply 180 Days research findings Design and progress HNY volunteer hub Research volunteering in social care	Define and negotiate portability agreement and process Employee passports	HNY attraction campaign and front door Shared recruitment Charter and principles Pilot joint recruitment campaign and recruitment innovation

23/24 programme in context

Humber and North Yorkshire Health and Care Partnership

Our shared goal

Making Humber and North Yorkshire a better place to live and work

Our People strategy

Be the Best Place to Work		Grow and train our workforce		Demonstrate system leadership		Embrace new ways of working		Building strong foundations	
Supporting staff health and wellbeing	Supporting inclusion and belonging	Growing the workforce of the future and ensuring adequate workforce supply	Educating, training and developing people and managing talent	Valuing and supporting leadership at all levels	Supporting system design and development	All sectors workforce transformation including VCSE	Carers and volunteers	Transforming People Services and supporting the People profession	Leading coordinated workforce planning using analysis and intelligence

Our 2023/24 workforce transformation programme

New for 2023/24

- **Inclusive health and care careers**
- **Flexible workforce: agency and bank**
- **Leadership, talent and succession**
- **OD Lab for system effectiveness**
- **Children's and young people's workforce redesign**
- **Oral health workforce redesign**
- **Enabling colleague movement**

Continuing from 2022/23

- **Stay and thrive: retaining our staff**
- **Care at Home workforce redesign**
- **Volunteers at the heart of the system**
- **One system, recruiting together**

Our core workforce governance

- Workforce Health and Wellbeing Sub-committee
- Whole system intersectional Inclusion Assembly
- Ethical International Recruitment Sub-Committee
- Education and Training Sub-Committee
- York and North Yorkshire Workforce Group
- Humber Workforce Group
- People Story Sub-Committee

Professor Vari Drennan

Professor of Health Care and Policy Research – Kingston University

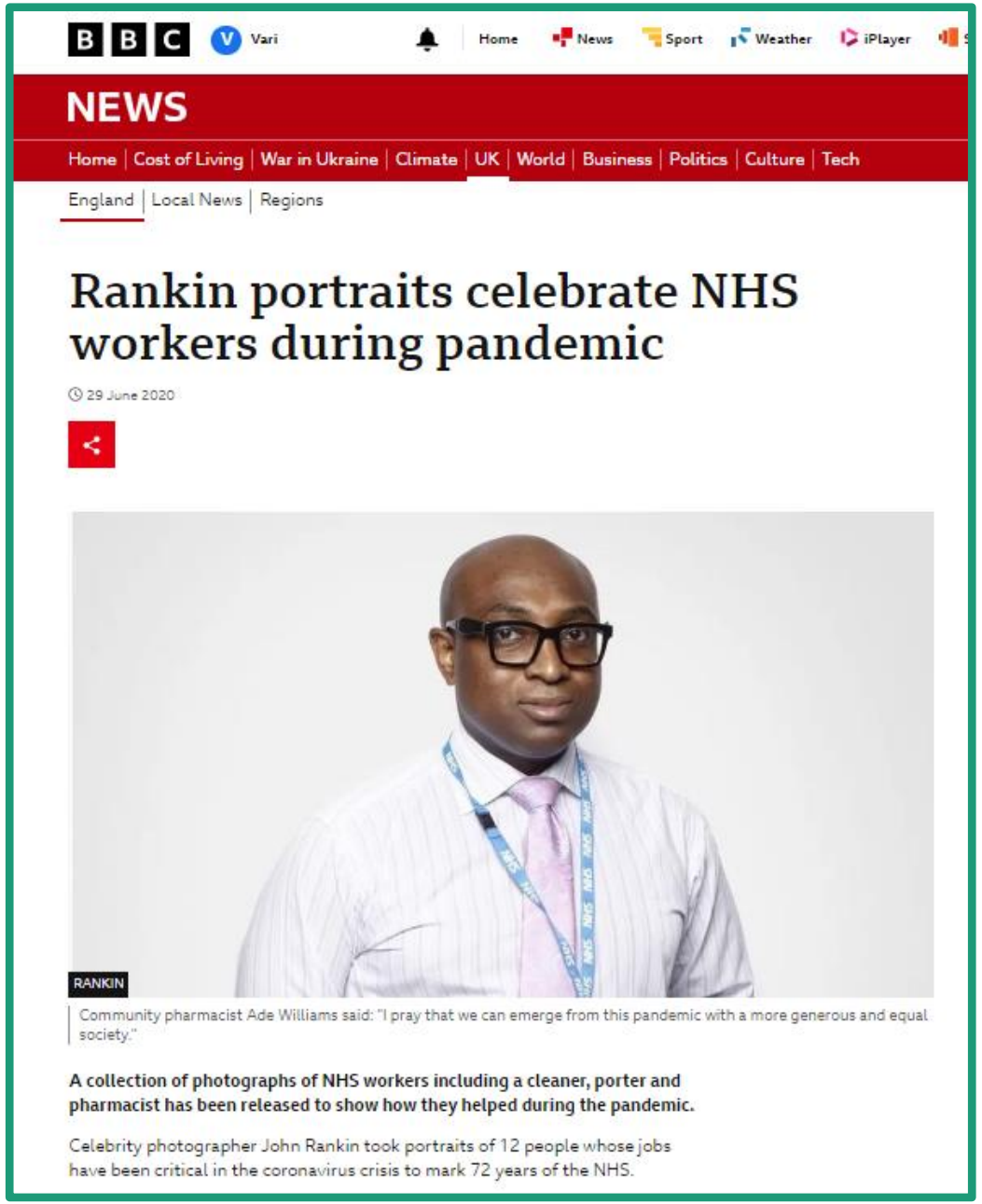
Kingston University London

The changing NHS workforce and new roles : factors influencing introduction and sustainability

Professor Vari Drennan

Centre for Applied Health & Social Care Research

June 2023



https://www.bbc.co.uk/news/uk-england-53220340

Today :

I will :

- Set the scene on health ‘work’ and new roles,
- Invite you to share your expertise on new roles in table top discussions and feedback,
- Provide some ways of framing and understanding the impact of new roles,
- Draw together some key points from the session,
- Invite comments and questions.

NHS Nurse Photo by Luke Jones on Unsplash

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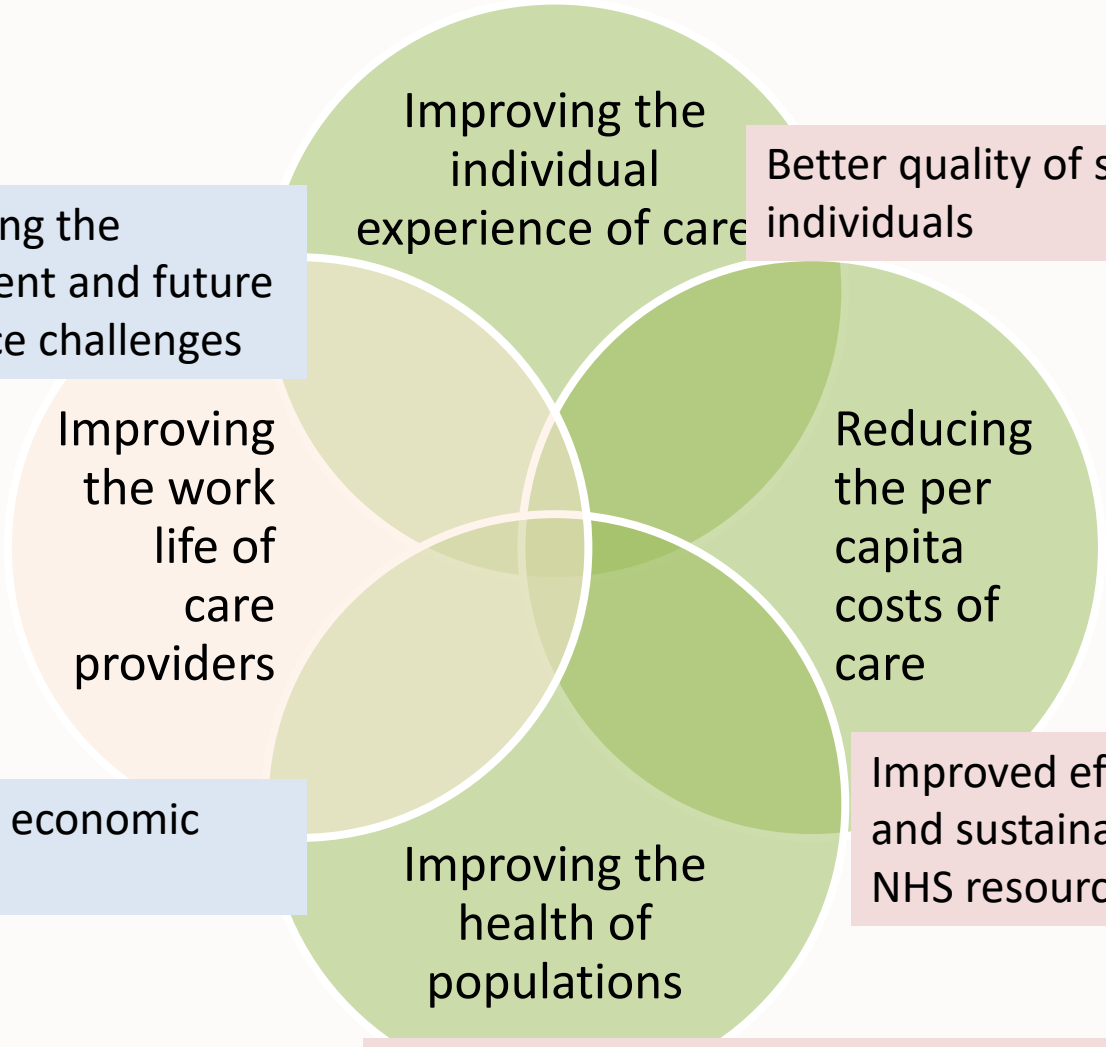
Aims of any health & social care system



Addressing the *(re-)*current and future workforce challenges

Better quality of services for individuals

Promote economic growth

Improved efficiency and sustainable use of NHS resources

Better population health and well being , including reduce health disparities

References

- Berwick DM, Nolan TW, Whittington J. The Triple Aim: Care, health, and cost. Health Affairs. 2008 May/June;27(3):759-769.
- Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. Ann Fam Med. 2014 Nov-Dec;12(6):573-6. doi: 10.1370/afm.1713.
- Health and Care Act 2022 https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted

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World Health Organization

"The COVID-19 pandemic has placed unprecedented pressure on health systems' capacities, particularly health workforces.

Even prior to the pandemic, the capacity to deliver essential health services in many countries was limited due to persistent health workforce shortages.

Already, in 2016, WHO had projected a global shortfall of 18 million health care workers by 2030, especially in the WHO African and South-East Asia regions. Notably, the African Region, which bears almost one quarter (24%) of the world's disease burden, had only 3% of the world's health care workers." page ix

https://www.who.int/data/gho/publications/world-health-statistics Accessed last 30-11-2022

The problems

- Shortages,
- Skill-mix imbalances,
- Maldistribution,
- Barriers to inter-professional collaboration,
- Inefficient use of resources,
- Poor working conditions,
- A skewed gender distribution,
- Limited availability of health workforce data,
- All these persist, with an ageing workforce further complicating the picture in many cases.

One of the recommended solutions

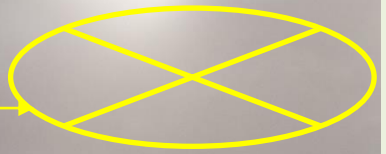
"implementation of health-care delivery models with an appropriate and sustainable skills mix in order to meet population
health needs equitably"

https://www.who.int/publications/i/item/9789241511131 Accessed last 30-11-2022

WHO 2016

Health care activity – an irregular and changing shaped cloud

Health work provided by a health service



Division of labour i.e. who does what in health care provision

Photo by [Mladen Borisov](#) on [Unsplash](#)

Photo by [Dallas Reedy](#) on [Unsplash](#)

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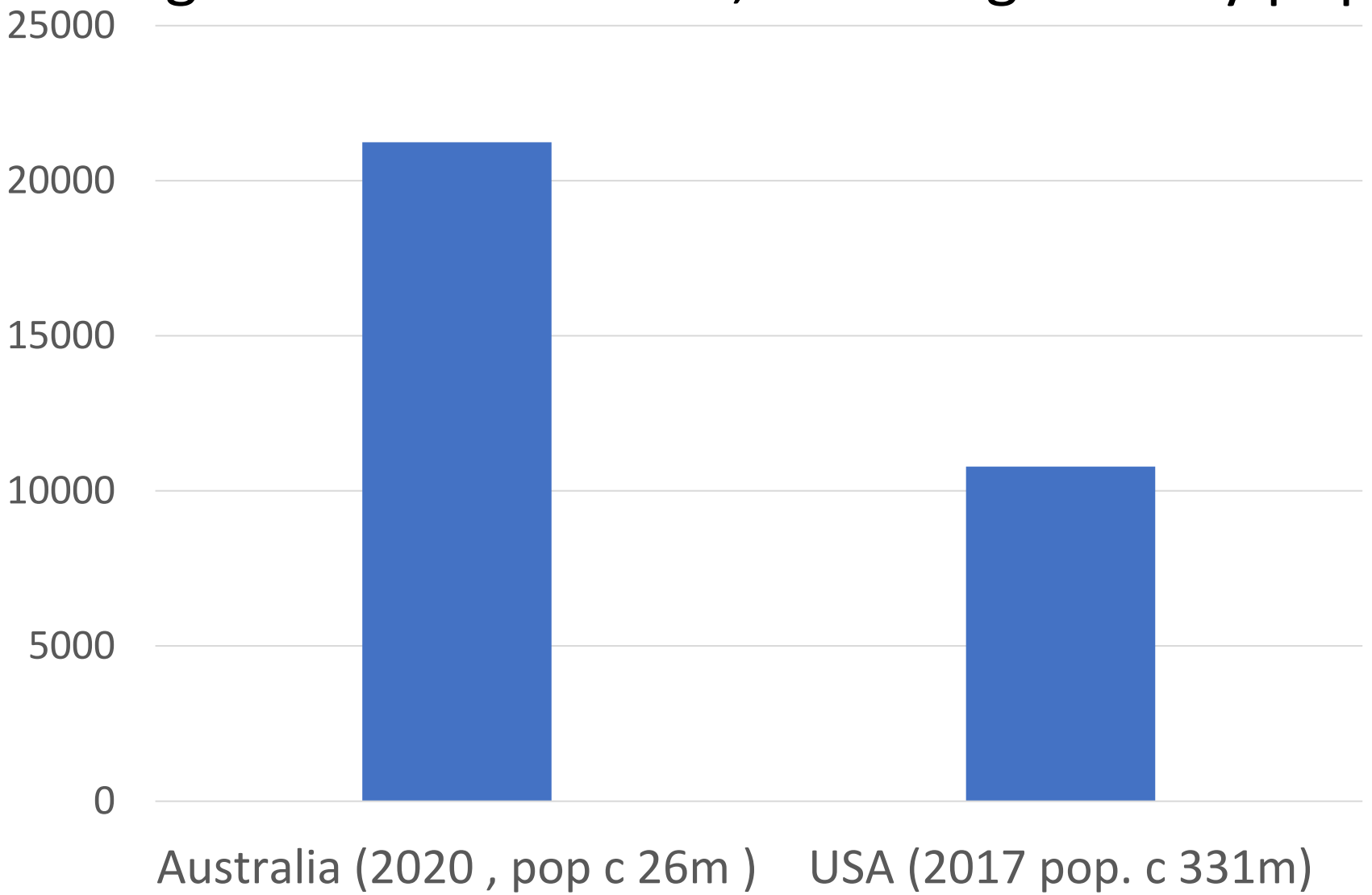
Examples of differences in number of midwives between selected high income countries, including country population.



https://www.who.int/data/gho/data/themes/topics/health-workforce

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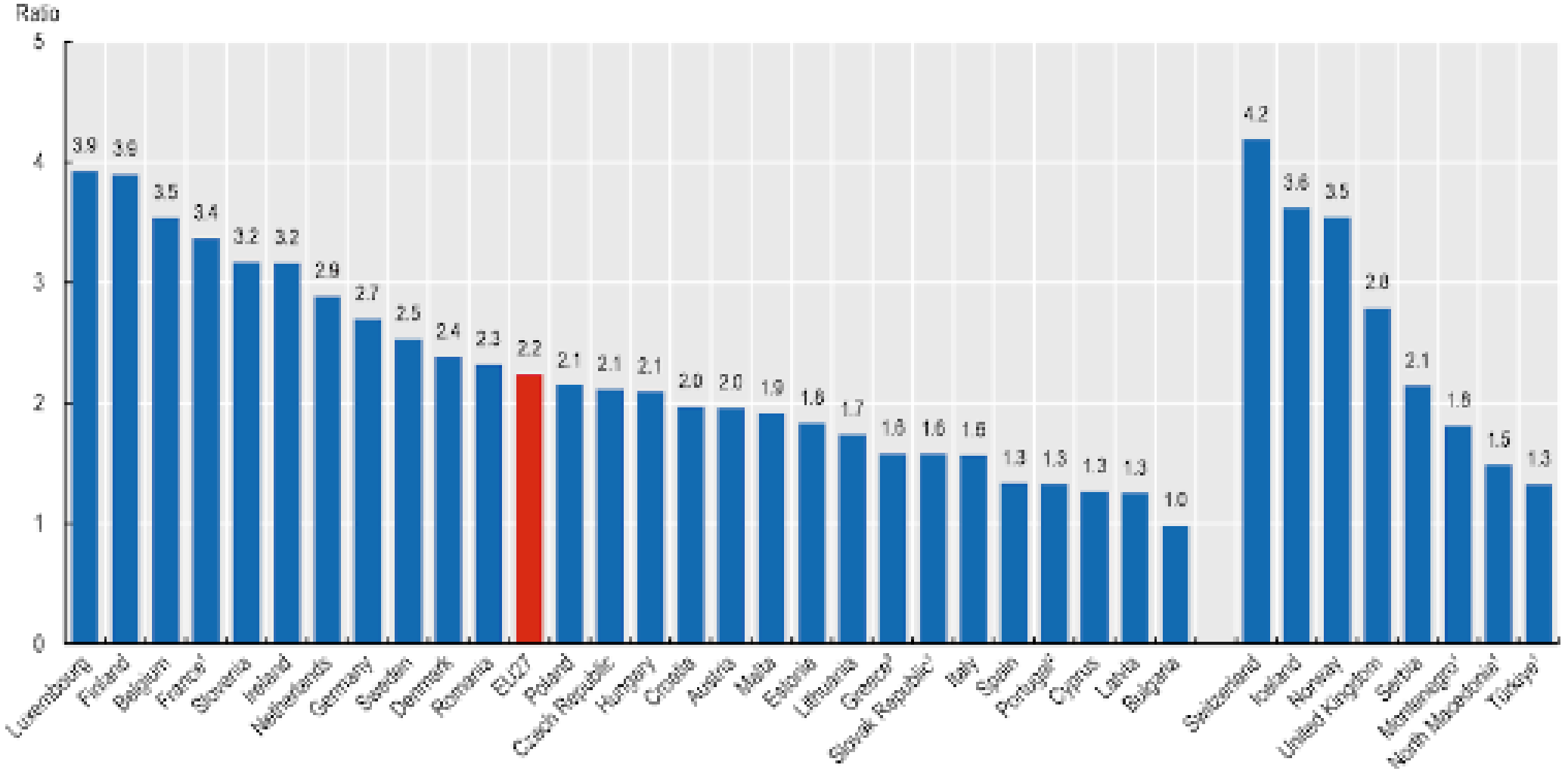
Figure 7.17. **Ratio of nurses to doctors, 2020 (or nearest year)**

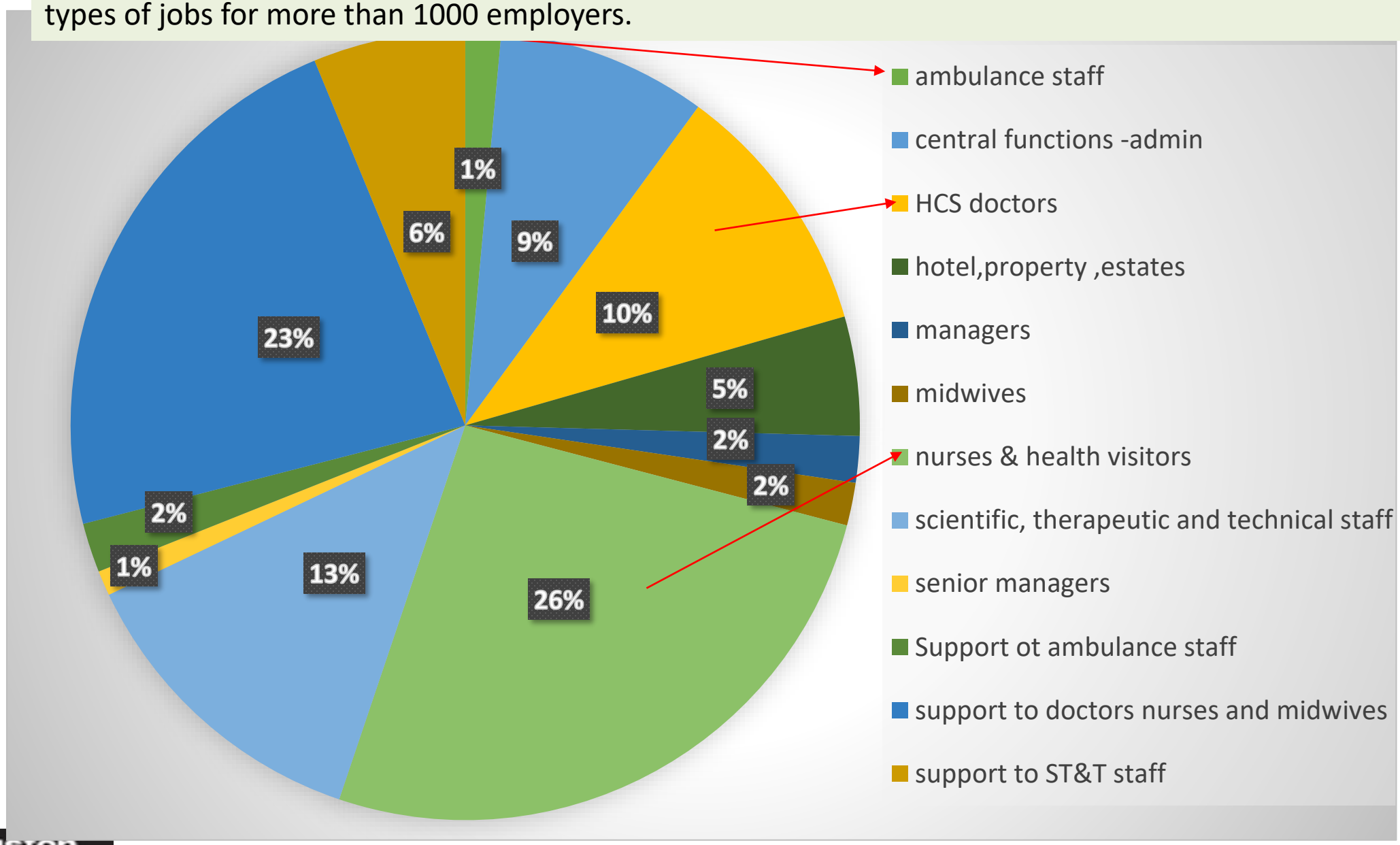


Note: The EU average is unweighted. 1. For countries that have not provided data for practising nurses and/or practising doctors, the numbers relate to "professionally active" nurses and doctors. 2. The ratio for Portugal is underestimated (professionally active nurses / all doctors licensed to practise). 3. For Greece, the data refer to nurses and doctors employed in hospitals.

Source: OECD Health Statistics 2022; Eurostat Database.

StatLink https://stat.link/2goj0t

NHS England Hospital and community Services employs over 1.3 million staff, working in around 300 different types of jobs for more than 1000 employers.



Source : https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/january-2023

New roles examples from NHS Jobs in Yorkshire & the Humber this week

Care Flow Navigator - Emergency Department

Primary Care Mental Health Clinical Practitioner

Advanced Clinical Pharmacist
Pharmacy

Nurse Associate
General Medicine

Triage Clinician
Community Health Services

Advanced Practitioner MSK FCP
Physiotherapy

Advanced Critical Care Practitioner
Critical Care

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Altering '*who*' does '*what*' in health services –

- Task shifting from one occupational group to another ,
- Jurisdiction shifting (an area of activity to have authority over) between occupational groups,
  - **Substituting for another occupational group**
  - **Complementing the work of existing occupations**

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Who does what , and in what context ?

- The taking of blood samples – 'a task' :

Hospital inpatients

  - visiting central phlebotomy service, ward staff (RNs only or HCAs, nursing associates), foundation year doctors, physician associates,

- Hospital outpatients
  - central department, in clinic provision

General practice ambulatory patients

  - practice nurse, health care assistants, hospital /centralised phlebotomy service,

General practice housebound /care home patients

  - district nursing service (RN, HCA) - part of nursing care or a dedicated HCA/phlebotomist service .

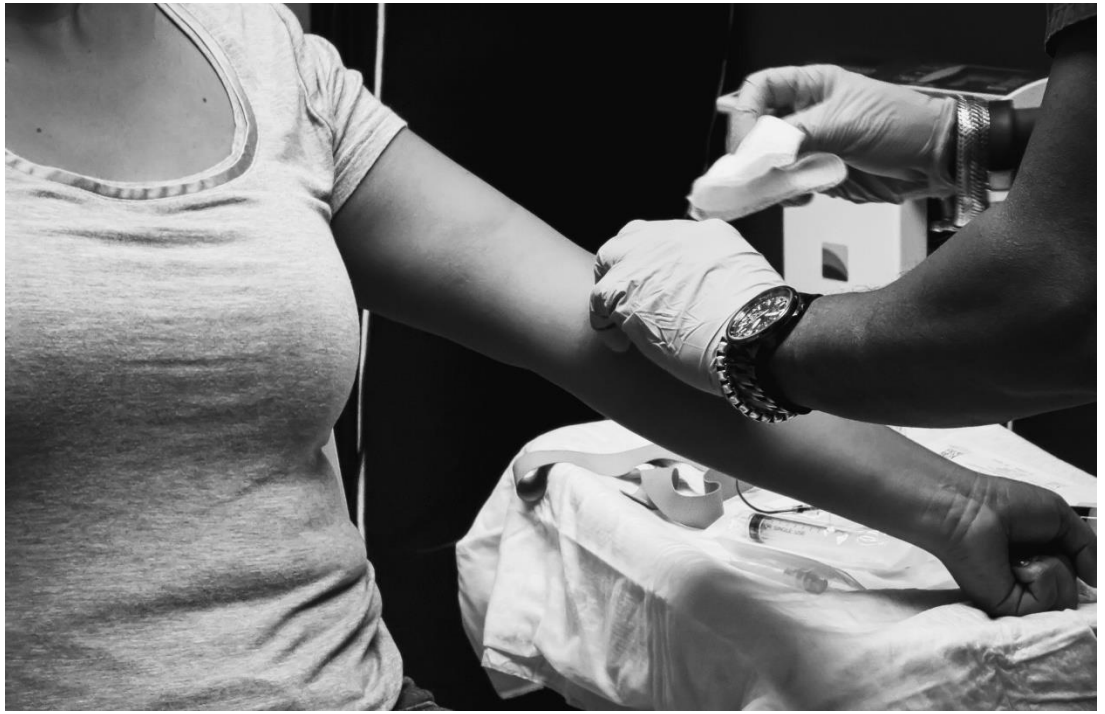

Photo by Obi - @pixel7propix on Unsplash

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The problems

- Shortages,
- Skill-mix imbalances,
- Maldistribution,
- Barriers to inter-professional collaboration,
- Inefficient use of resources,
- Poor working conditions,
- A skewed gender distribution,
- Limited availability of health workforce data,
- All these persist, with an ageing workforce further complicating the picture in many cases.

One of the recommended solutions

"implementation of health-care delivery models with an appropriate and sustainable skills mix in order to meet population health needs equitably"

"the skill-mix should be community-based and include a variety of different health professions from different educational levels and backgrounds, **including mid-level health workers** in interprofessional Teams".

https://www.who.int/publications/i/item/9789241511131 Accessed last 30-11-2022

WHO 2016

Jurisdiction shift example “mid-level providers”

- No agreement on collective term,
- Will have received shorter training than doctors but will perform some of the same tasks as doctors,
- Not a medical doctor, but provides clinical care (may diagnose, manage and treat illness, disease and impairments)
- E.g. Advanced nurse practitioner, physician associates/assistants, medical assistant, surgical technician, nurse anaesthetist (or associate)

WHO Mid-level health workers: a review of UHC Technical brief the evidence 2017

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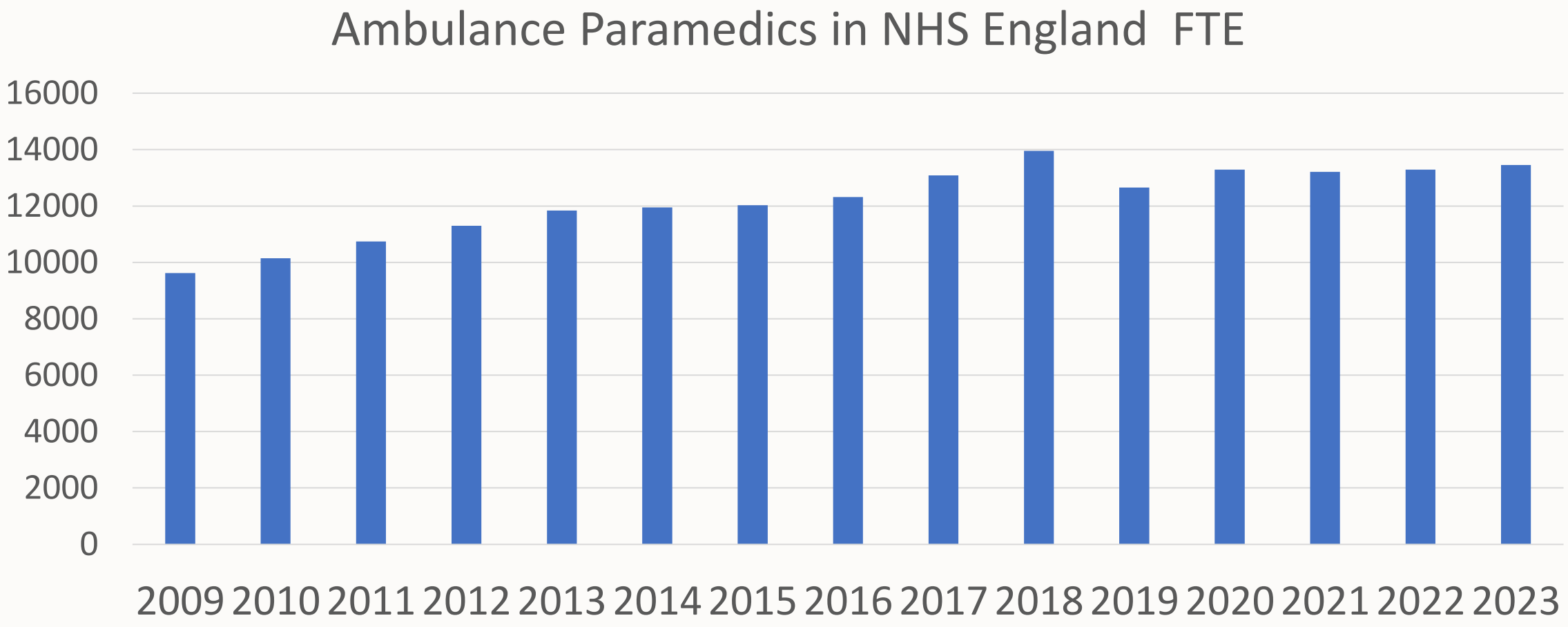
New roles over time example 1



https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/january-2023

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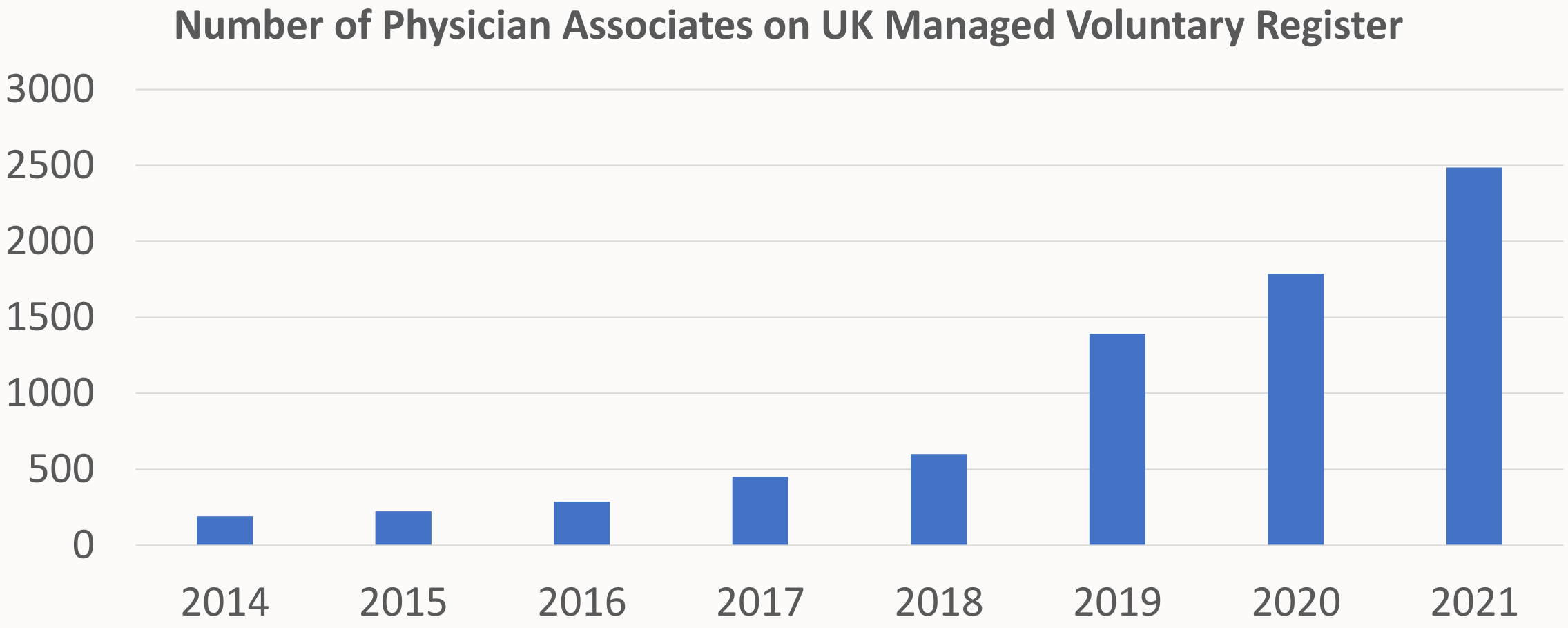
New roles over time example 2



Source of Data https://www.fparcp.co.uk/about-fpa/fpa-census

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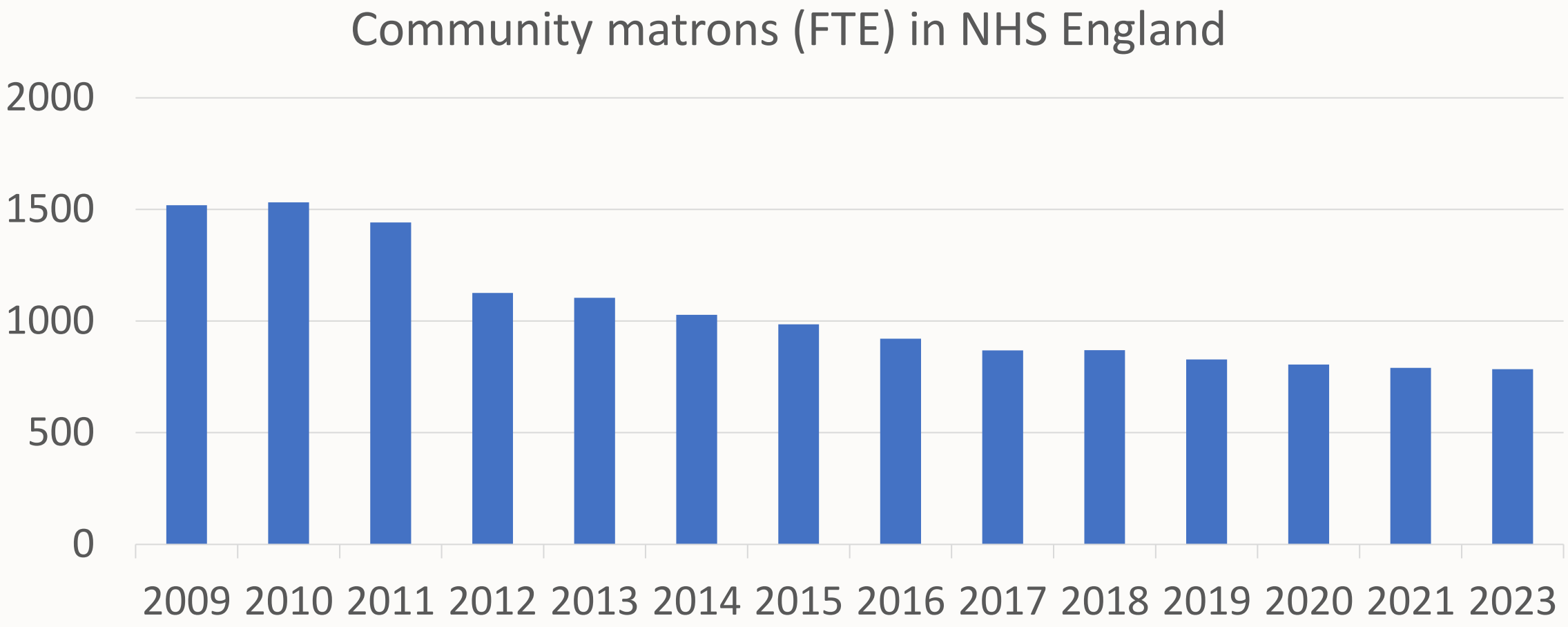
New roles over time example 3



https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/january-2023

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Your experience of introducing new roles (25 minutes)

At your table please share some key points on your experience of a health organisation introducing new roles:

- What new roles and why?
- What went well or less well?
- What criteria were used to judge success or otherwise?

Please agree someone to feedback main points to all of us .

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The research studies I am primarily drawing on in this presentation

*The non-medical practitioner workforce contribution in the emergency and urgent care system skill-mix (in progress)

**Advanced Clinical Practitioners in Secondary Care. 2019

*The role of physician associates in secondary care: the PA-SCER mixed-methods study. NIHR Journals Library. 2019

** The contribution of the medical associate professions. 2018

**The physician associates expansion programme : evaluation. 2018

*Investigating the contribution of physician assistants to primary care in England: a mixed-methods study. NIHR Journals Library. 2014

- Disclaimers
- *Independent research funded by the National Institute for Health Research (NIHR Health Services and Delivery Research, The views expressed in this presentation are those of the author(s) and not necessarily those of the NHS, the National Institute for Health Research or the Department of Health and Social Care."

- **Independent research funded by Health Education England and other NHS bodies. The views expressed in this presentation are those of the author(s) and not necessarily those of the NHS, Health Education England or the Department of Health and Social Care."

Why introduce new roles ?

- Drawing on our research studies, the driving motives:
  - Workforce shortages – primarily of doctors, but also nurses in general practice,
  - Provide continuity in staffing and reduce costs in comparison to locum doctors,
  - Improve the quality of the health service provision and experience for patients and staff,
  - Retain experienced health professionals, such as senior nurses.

Photo by Nick Fewings on Unsplash

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What are the dimensions that new roles are judged on?

Same dimensions as ‘quality’ in health care is judged on :

- Clinically safe?
- Acceptable?
- Appropriate?
- Equitable (fair) service?
- Clinically effective?
- Cost effective?

(From Donabedian, A., 1988. The quality of care: how can it be assessed? Jama, 260(12), pp.1743-1748).

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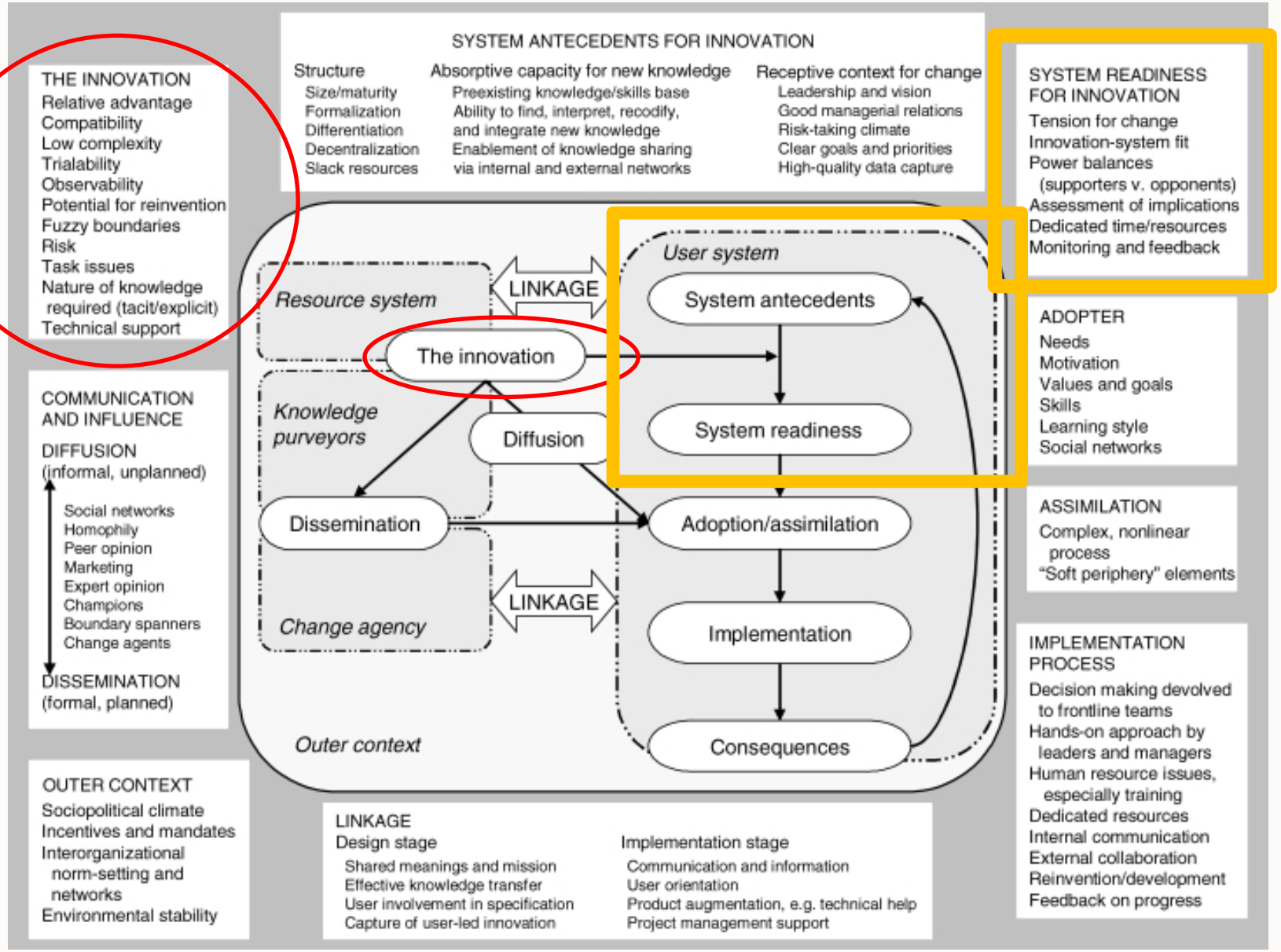

Conceptual Model for Considering the Determinants of Diffusion, Dissemination, and Implementation of Innovations in Health Service Delivery and Organization, Based on a Systematic Review of Empirical Research Studies Greenhalgh et al. 2004

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Physician Associates in primary care - mixed methods investigation

6 general practices currently employing PAs and 6 matched practices not including PAs in their staffing

Multiple types of data collection

1. Prospective consultation record review and linked patient survey
2. Patient interviews
3. Interviews of PAs, GPs, practice staff
4. PA work activity diaries
5. Video observation of PA and GP consultations
6. Ethnographic observation of clinical meetings

*Independent research funded by the National Institute for Health Research (NIHR Health Services and Delivery Research, The views expressed in this presentation are those of the author(s) and not necessarily those of the NHS, the National Institute for Health Research or the Department of Health and Social Care."

Prospective consultation record review and linked patient survey

- *n* = 2068 patient anon. electronic records of same day/urgent consultations (PA *n* = 932 - GP *n* = 1154)
- A classification was assigned to each patient consultation based on a) patient and b) medical acuity of each presenting problem:
  - acute (that is, medically defined as something with a rapid onset sometimes representing severe disease);
  - chronic;
  - minor problem or symptoms;
  - prevention (for example, malaria protection advice for travel); or
  - process of care (for example, provision of a medical certificate).

Analysis

- Primary Outcome – Unplanned consultation for the same problem within 14 days
- Secondary outcomes – processes within the consultation
- Clinical record review by independent group of GPs for those re-consulting (unplanned) for the same problem within 14 days

Outcome of care – PA and GP comparison

Consultation outcome measure	Rate ratio	95% CI	p
Re-consultation within 14 days for a condition the same as the index consultation at the practice or an urgent care facility	1.314	0.843, 2.049	0.228

From patient survey – High levels of satisfaction and no difference for consultations with PAs or those with GPs.

Published
Vari M Drennan, Mary Halter, Louise Joly, Heather Gage, Robert L Grant, Jonathan Gabe, Sally Brearley, Wilfred Carneiro and Simon de Lusignan. Physician associates and GPs in primary care: a comparison Br J Gen Pract 2015; 65 (634): e344-e350. DOI: https://doi.org/10.3399/bjgp15X684877

Synthesis of findings from overall study

- PAs were found to be an *acceptable* group of health professionals to contribute to primary care teams,
- No indication that the distribution of more complex cases to GPs was *inequitable* (unfair) to any group of patients,
- Demonstrated PAs' *effectiveness* in providing appropriate and safe care at the same time as not increasing costs to the wider health care system,
- The analysis of *cost* demonstrated that they deliver care more cheaply to the patient case mix they work with than GPs (although not all costs such as supervision could be accounted for).

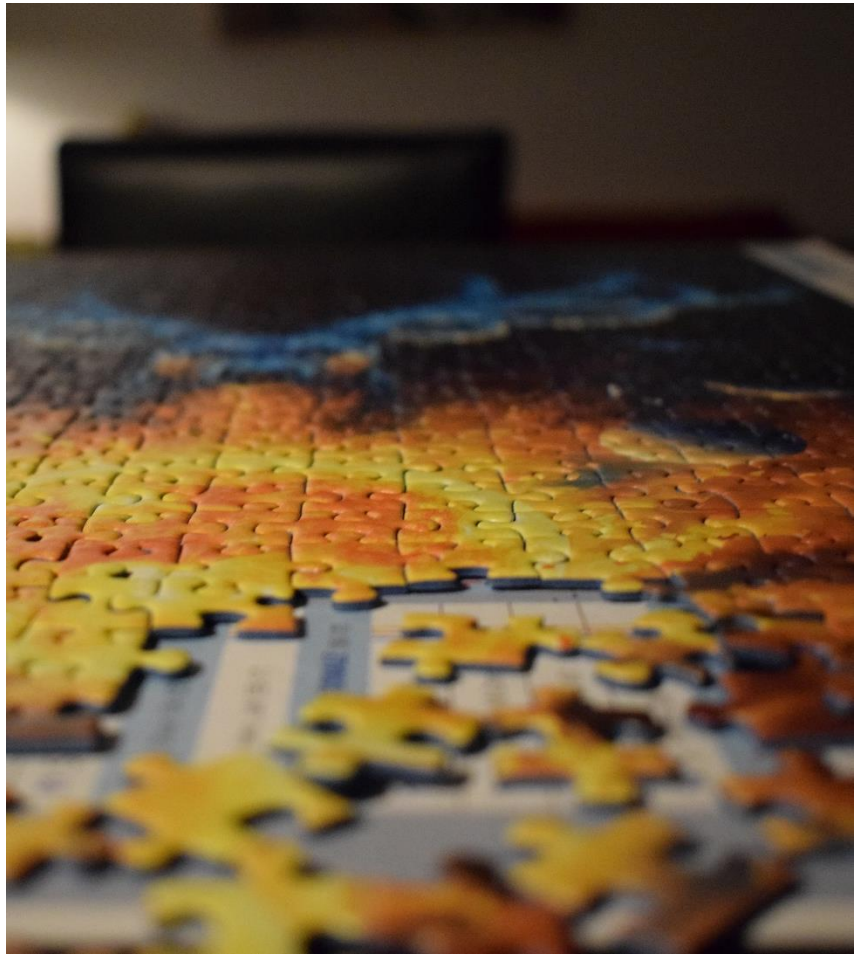
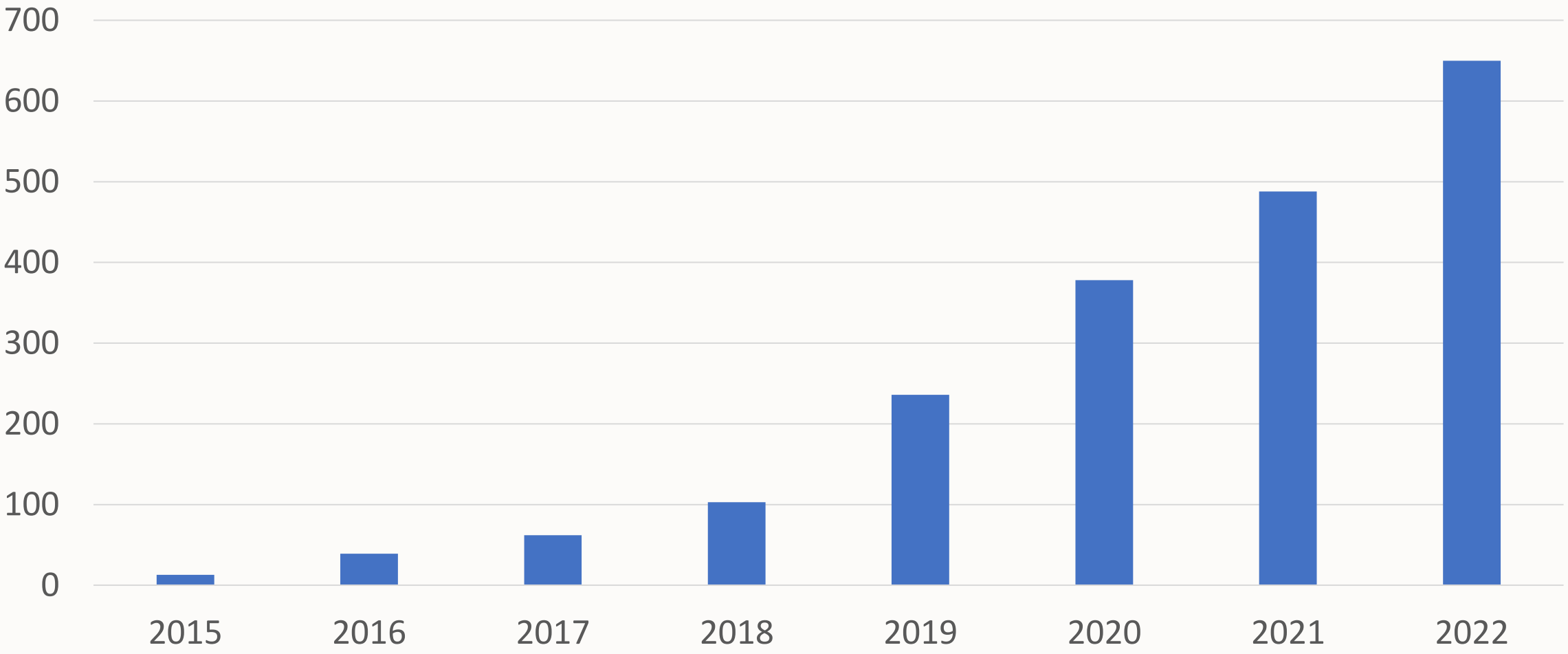


Photo by Mor THIAM on Unsplash

Physician Associates (number) in general practice in England



Data source : General Practice Workforce - NHS Digital

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NIHR | National Institute for Health and Care Research

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[Physician associates appear to make a positive contribution to inpatient care (nihr.ac.uk)]

Homepage > Alert >

Physician associates appear to make a positive contribution to inpatient care

Physician associates appear to make a positive contribution to inpatient care

HEALTH AND SOCIAL CARE SERVICES RESEARCH | 15.08.19 | doi: 10.3310/signal-000807

This is a plain English summary of an original research article

Physician associates improve continuity of care and patient experience within the hospital setting. This first evaluation of the new role in the NHS suggests they could provide safe and equivalent care on defined tasks, freeing up time for doctors, and help with patient flow. However, some say that the actual and perceived potential is being held back by a lack of professional statutory regulation and the ability to prescribe.

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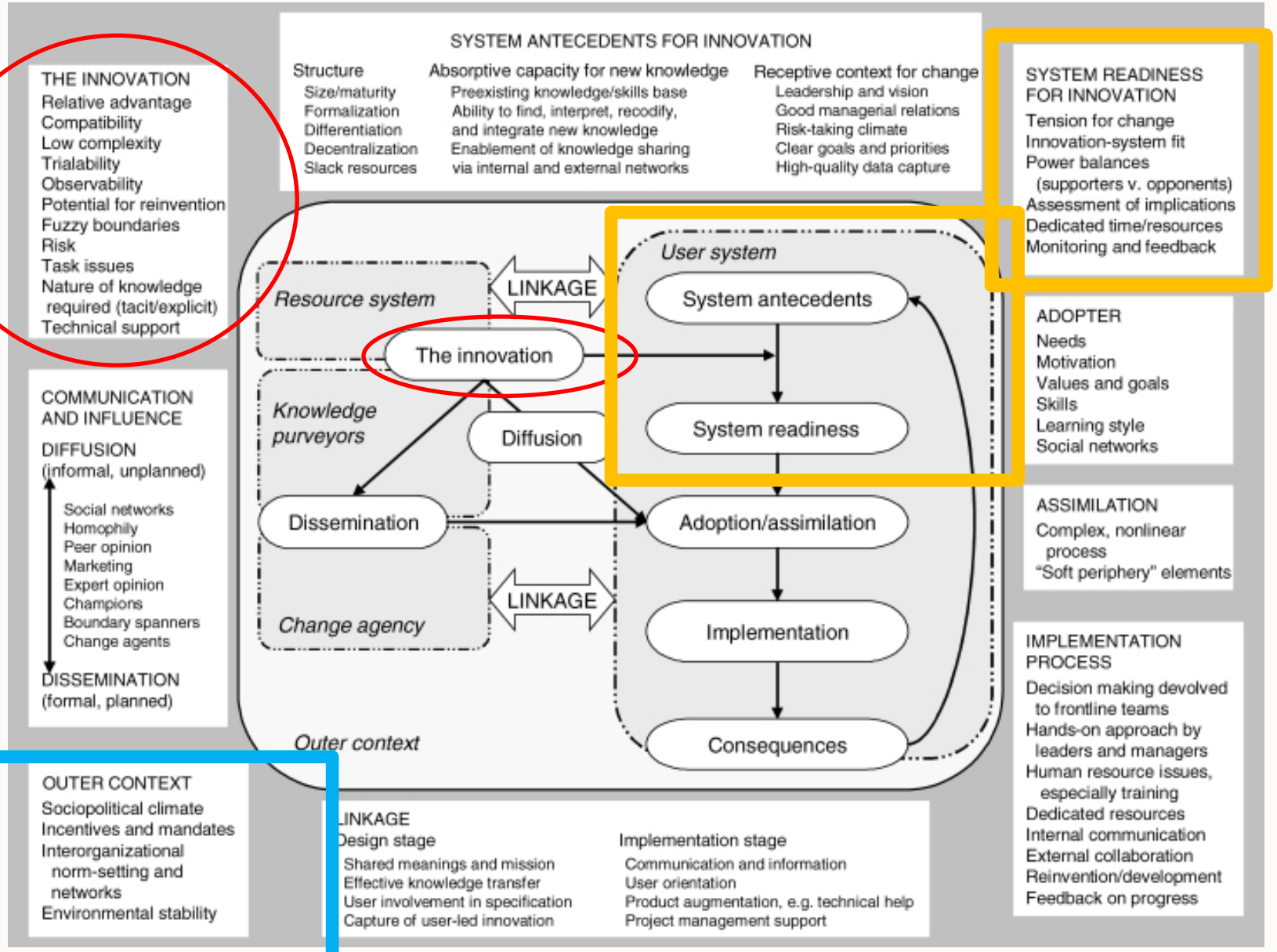

Conceptual Model for Considering the Determinants of Diffusion, Dissemination, and Implementation of Innovations in Health Service Delivery and Organization, Based on a Systematic Review of Empirical Research Studies Greenhalgh et al. 2004

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How to divide the labour in health care services?

- Doctor first (most senior clinician) – delegate work and tasks
- Segment the patient population – and stream to differently experienced /clinically knowledgeable practitioners
- Combination of the two approaches

- *Drennan VM, Gabe J, Halter M, de Lusignan S, Levenson R. Physician associates in primary health care in England: A challenge to professional boundaries? Soc Sci Med. 2017 May;181:9-16. doi: 10.1016/j.socscimed.2017.03.045. Epub 2017 Mar 23. PMID: 28364578.*

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The System of Professions (Abbott 1988)

Health professions are part of an interdependent system in which the activities and developments of one occupational group impact on others and are tied up with issues of status, rewards, power and control.

Reference
A. Abbott The System of Professions – a Study of the Division of Expert Labour. University of Chicago Press, London (1988)

Photo by Tolga Ahmetler on Unsplash

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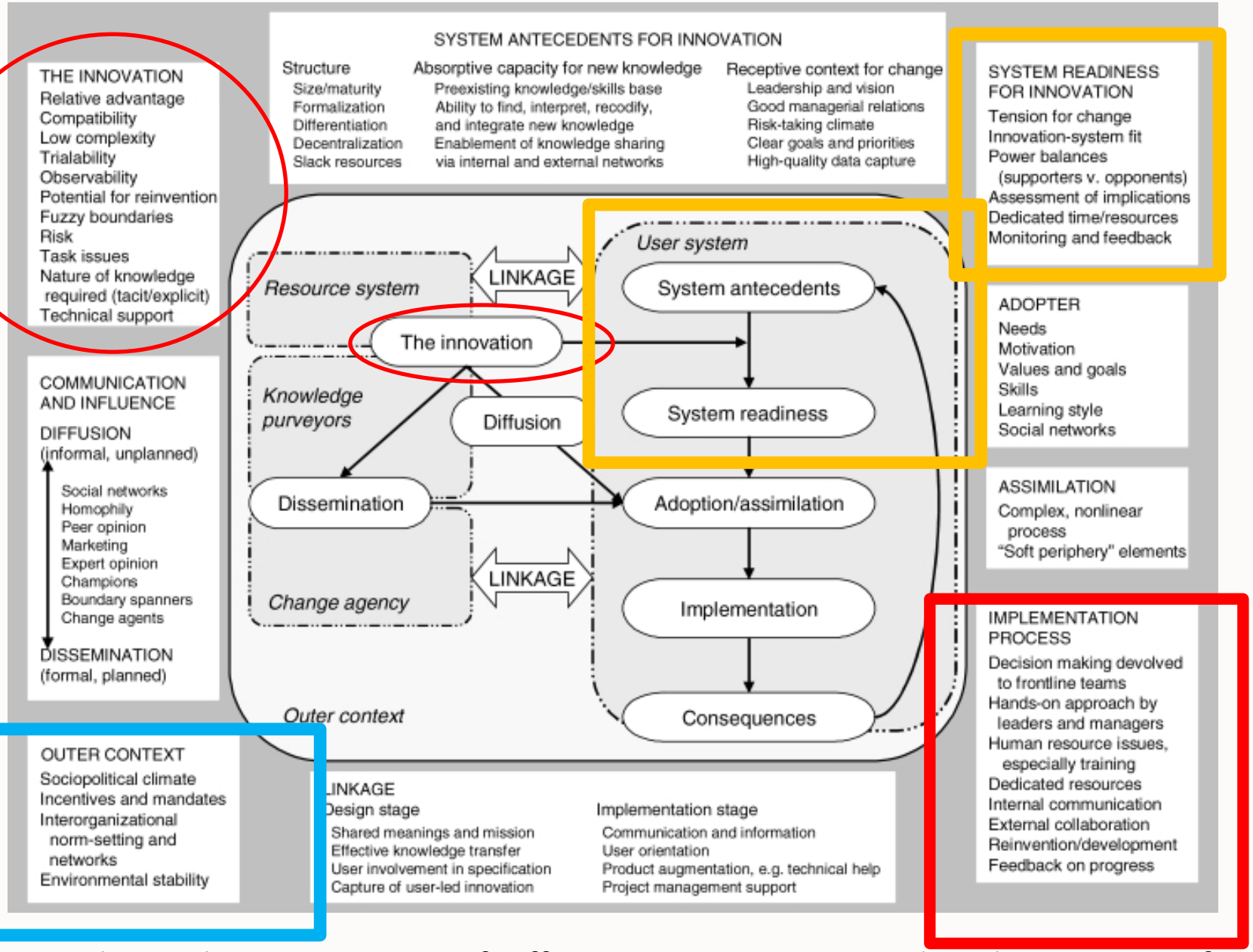

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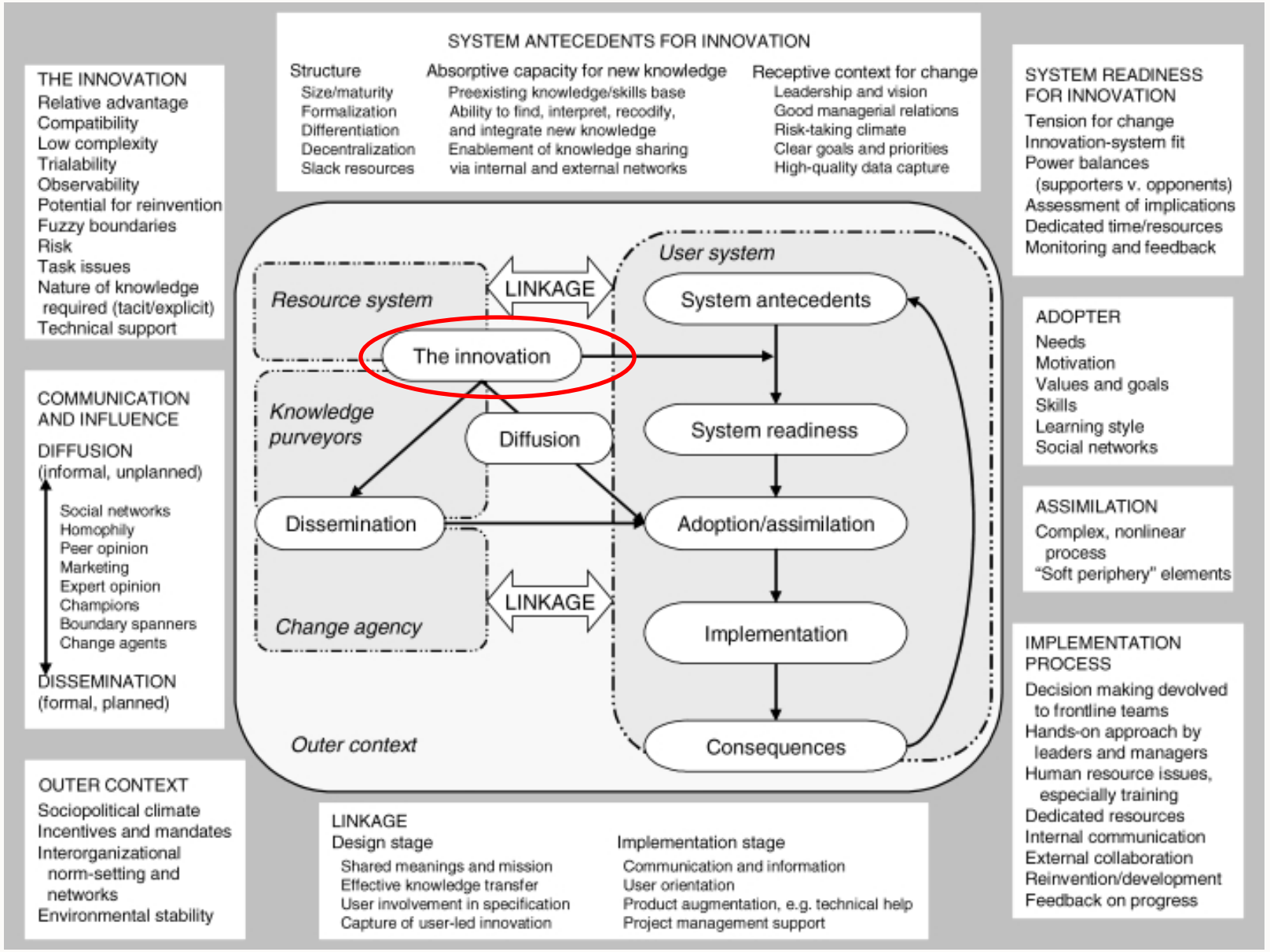
Advanced Clinical Practitioners in hospital services: qualitative research

- Conclusions: While the national policy was to promote advanced clinical practice roles, the evidence suggested there was and would continue to be limited implementation at the operational level.
- Development scenarios that introduced new monies for such roles reduced some of the inhibiting factors. However, where the introduction of roles required funding to move from one part of a service to another, and potentially from one staff group to another, the growth of these roles was and is likely to be contested.
- In such scenarios, research and business evidence of relative advantage will be important, as too will be supporters in powerful positions. The paucity of publicly available evidence on the effectiveness of advanced clinical practice roles across the specialties and professions in different contexts requires urgent attention.

Drennan, V.M., Collins, L., Allan, H., Brimblecombe, N., Halter, M. and Taylor, F., 2022. Are advanced clinical practice roles in England's National Health Service a remedy for workforce problems? A qualitative study of senior staff perspectives. Journal of health services research & policy, 27(2), pp.96-105.



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SkillMix-ED
Skill mix in the emergency department research

FUNDED BY NIHR | National Institute for Health Research

Principal investigator Associate Professor Mary Halter

What are we studying?

Increasing demand for emergency care has occurred alongside staffing shortage, particularly of doctors. Re-shaping of the workforce has resulted, including the introduction of non-medical practitioners, such as nurse practitioners and physician associates in Emergency Departments and Urgent Treatment Centres. These are qualified staff from other healthcare backgrounds who work at the same level as doctors. Despite 20 years of non-medical practitioners being employed in Emergency Departments, there is limited evidence of effectiveness of individual roles, and none as to appropriate skill-mix of staff, at what level of independence from senior medical staff.

The aim of this study is to explore the impact of different skill-mix including non-medical practitioners in Emergency Departments and Urgent Treatment Centres on patient experience, quality of care, clinical outcomes, activity, staff experience and costs in acute NHS trusts in England, in order to inform workforce decisions of clinicians, managers and commissioners.

SkillMix-ED, part of the Urgent and Emergency Health Care and Workforce Research Group - Kingston University London

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Some ‘take home’ points

- What is the ‘problem or issue’ the new role is addressing?
- What is the risk in the new roles and what are the governance structure for the new roles?
- How are the new roles being evaluated?
- Have you considered all dimensions of evaluation – including the did it solve the problem?
- Have you captured the unintended consequences?
- Have you considered how the new roles will be evaluated / monitored over time – not just the ‘pilot’ phase?

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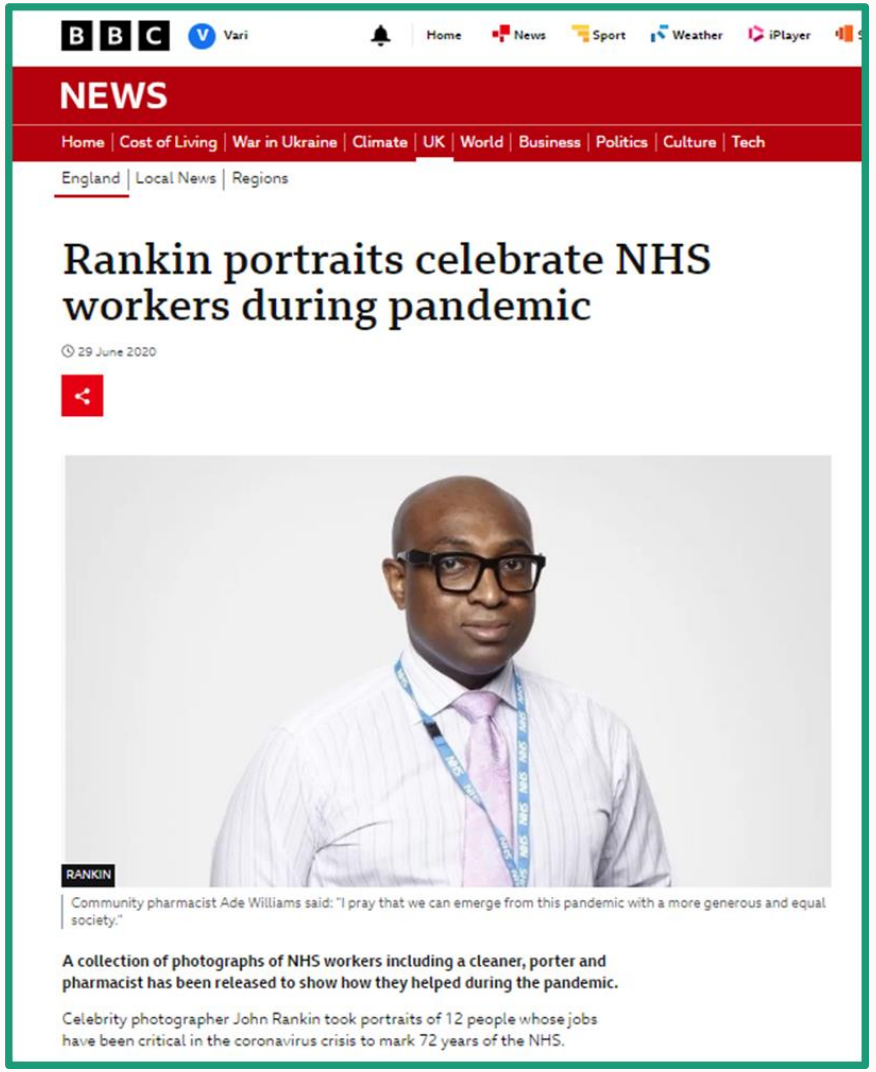
Thank you for engaging and listening

- Comments – observations ?

Contact

- V.Drennan@kingston.ac.uk



https://www.bbc.co.uk/news/uk-england-53220340

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Some additional references not on slides

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Karen Mechen and Nicola Buckle

Practice Development Matron and Senior Matron for IPC – Hull University Teaching Hospitals NHS Trust

Grow Your Own

NHS
Hull University Teaching Hospitals
NHS Trust

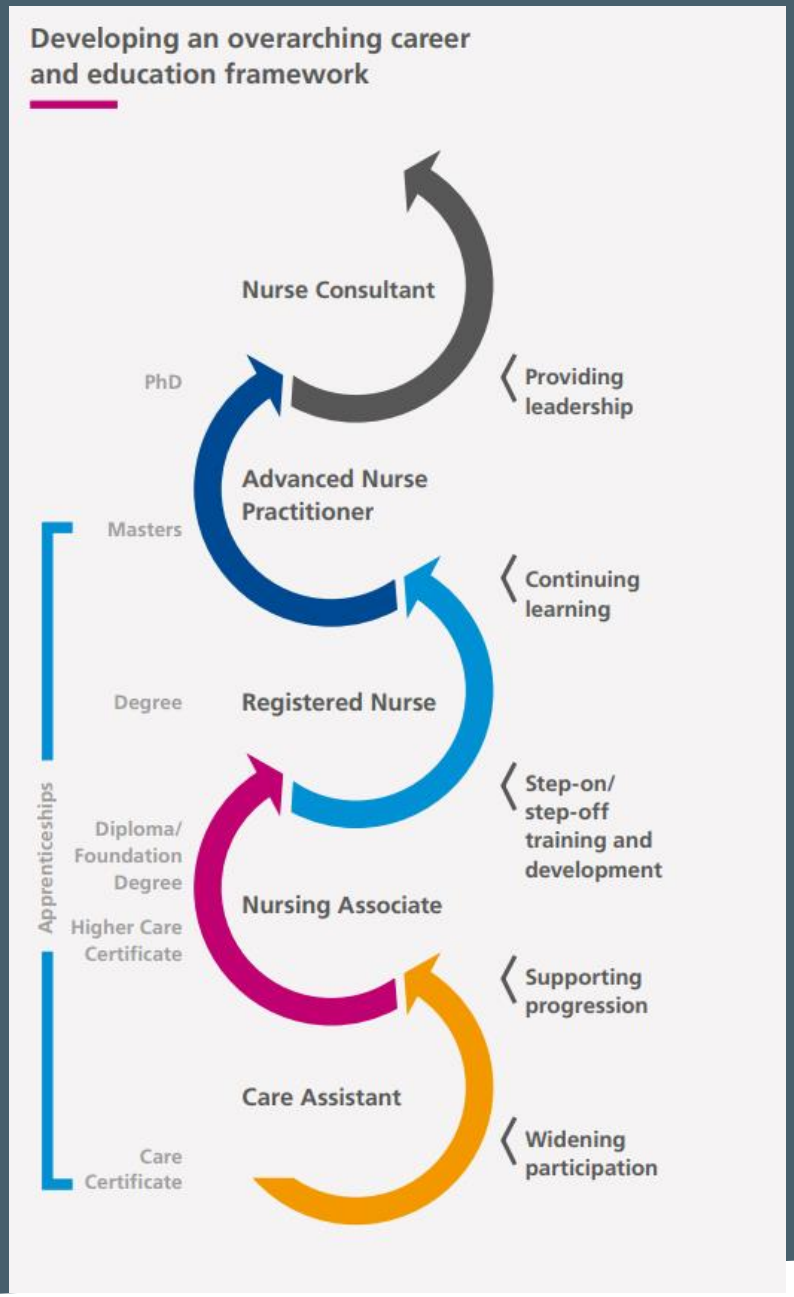
Education and Development

Remarkable people.
Extraordinary place.

Grow Our Own Rationale

NHS
Hull University Teaching Hospitals
NHS Trust

- Reduction in workforce vacancies
- Patient safety
- Promotion of trust as a great place to work
- Developing career pathways
- Development opportunities
- Teaching hospital



NHS
Hull University Teaching Hospitals
NHS Trust

Policy into Practice: Shape of Caring

HEE (2015)

Education and Development

Remarkable people.
Extraordinary place.

NHS
Hull University Teaching Hospitals NHS Trust

3 reasons we won the Best UK Employer of the year for Nursing Staff 2022

1. Recruitment and Retention
2. Inclusivity
3. Well-Being

1. Recruitment and Retention

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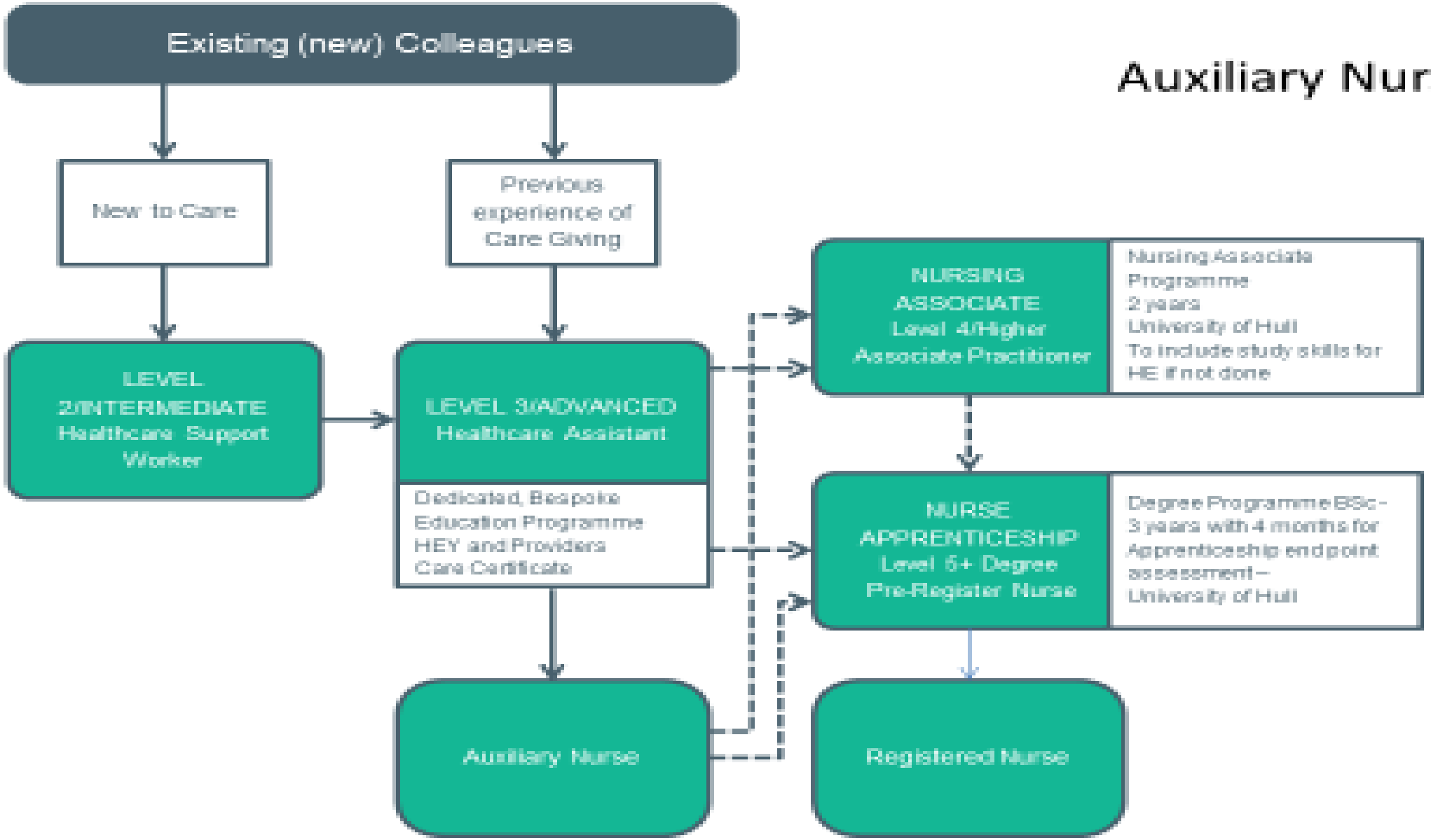
- Schools and College Engagement Days
- University Recruitment Programme
- OSCE Preparation Programme
- DWP Job Centre Initiative
- Recruitment Open Days - HCSW
- Application and Interview skills support
- NHSI/E Masterclass & Allocate Workforce Conference

1. Recruitment and Retention

- HCA Apprenticeships
- TNA Apprenticeships
- SNA (RNDA) Apprenticeships
- HCA IENs

Case Study
Ben, 27
Auxiliary Nurse @ HEY



Grow your own Workforce

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Year	HCA Apprentices	TNA Apprentices	SNA (RNDA) Apprentices	IENs Grow Your Own
2017	NA	20 17 Qualified NAs	NA	
2018	10 10 Finished Apprenticeship	15 10 Qualified NAs	14 13 Qualified RNs	
2019	13 9 Finished Apprenticeship	39 25 Qualified NAs	8 8 Qualified RNs	
2020	12 10 Finished Apprenticeship	20 18 Qualified NAs	12 TBC Qualified RNs	
2021	11 TBC Finishing Apprenticeship	19 TBC Qualified NAs	11 + 3 (Top-Up) TBC Qualified RNs	10 9 Qualified RNs
2022	15 TBC Finishing Apprenticeship	20 TBC Qualified NAs	12 + 3 (Top-Up) TBC Qualified RNs	
2023	Planned 15	Planned 15	Planned 15 (3 NAs Top-Up)	Planned 35
TOTAL	61 (+15) 29 Finished Apprenticeship	113 (+15) 70 TBC Qualified NAs	63 (+15) 13 Qualified RNs	10 (+35) 9 Qualified RNs

1. Recruitment and Retention

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- Recognition of skills
- Talent Spotting
- Development opportunities for HCSWs
- Equality in opportunities for BAME colleagues
- IEN Pastoral Nurse

Education and Development

Remarkable people.
Extraordinary place.

2. Inclusivity

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- Social Responsibility to local area, economy and sustainability
- Responsibility to Trust Staff and Teams
- Promoting Development for internal staff e.g. IENs, B2's
- Involvement from Apprentices in shaping the future workforce
- 'Buddy' scheme
- Career Clinics and Development support

2. Inclusivity

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- Trust Feedback to NMC Code of Practice - TNAs
- Strive and Thrive Committee
- Promotion of inclusivity agenda

3. Well-Being

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- Staff Well-Being Clinics
- Well- Being Champions
- Professional Nurse Advocate Programme
- Buddy Scheme for Apprentices
- Financial support in economic crisis
- IR Visa reimbursement and 0% interest loans for Indefinite Leave to Remain and Citizenship applications

3. Well-Being

Hull University Teaching Hospitals NHS Trust

Branded Preceptorship Programme and QIP

Aimed to:

- Consolidate learning
- Build confidence
- Develop resilience

Includes:

- Human Factors
- Clinical Skills & Simulation
- Consolidate Practice Theory
- Promote Professionalism

STaR
Supporting Transition and Retention of newly qualified nurses

LET'S GET STARTED....

Remarkable nurse.
Extraordinary place.

Grow Your Own

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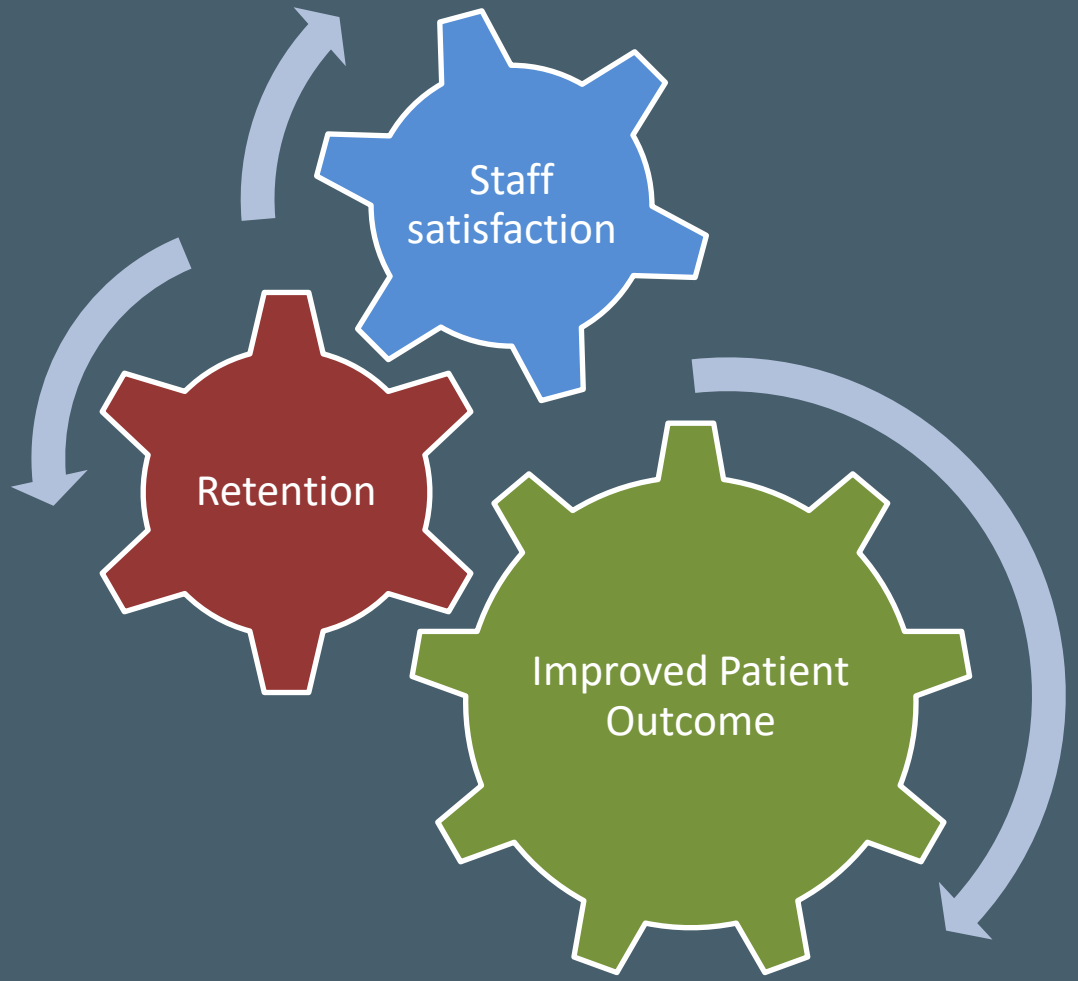

Education and Development

Remarkable people.
Extraordinary place.

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Great Staff - Great Care - Great Future

https://vimeo.com/74756446

Best Employer of the Year for Nursing Staff 2022 - HULL

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Education and Development

Remarkable people.
Extraordinary place.

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Remarkable people.
Extraordinary place.

Danny Mortimer

CEO – NHS Employers

Shilpa Ross

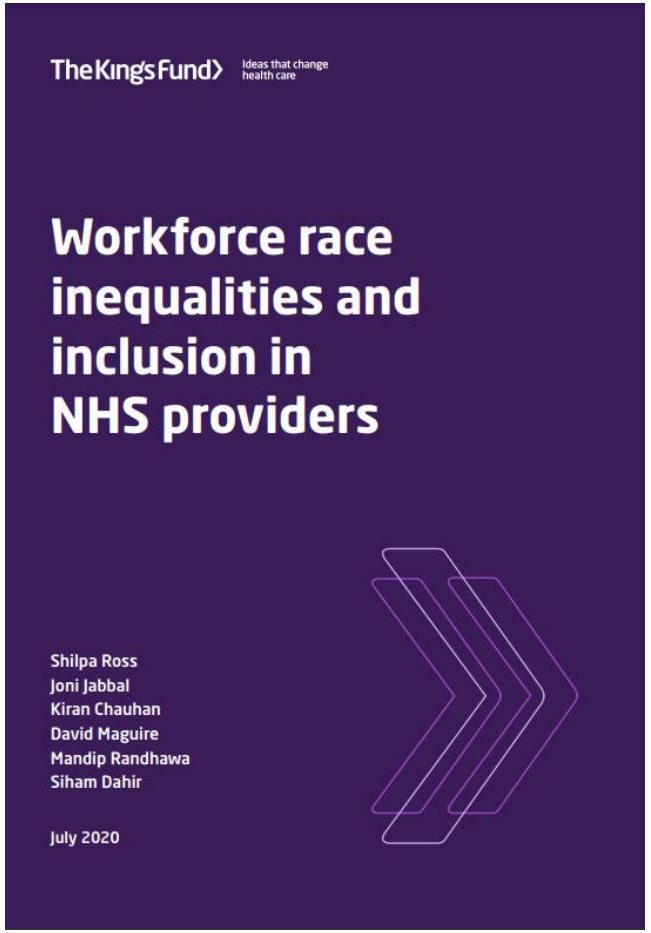
Fellow in Policy Team – King's Fund

NHS workforce race inequalities and inclusion

Shilpa Ross
Fellow
The King's Fund

The King's Fund

Our research



Ethnic diversity in the NHS workforce

	2016	2017	2018	2019	2020	2021	2022
% BME staff (overall)	17.7	18.1	19.1	19.9	21.1	22.4	24.2
% BME staff (VSM)	5.4	5.3	6.9	7.6	7.9	9.2	10.3
% BME board member ship	7.1	7.0	7.4	8.4	10.0	12.6	13.2

How equitable and inclusive is the NHS workforce? (WRES data)

	2016	2017	2018	2019	2020	2021	2022
Rel. likelihood short-listing (white)	1.57	1.60	1.45	1.46	1.61	1.61	1.54
Rel. likelihood CPD/ training (white)	1.11	1.22	1.15	1.15	1.14	1.14	1.12
Rel. likelihood disciplinary (BME)	1.56	1.37	1.24	1.22	1.16	1.14	1.14

How equitable and inclusive is the NHS workforce? (Lived experience)

Marginalisation

Lack of equal opportunities to progress

Why is diversity and inclusion important?

MORAL CASE

QUALITY OF CARE

BUSINESS CASE

What is being done to address inequality and inclusion in the workforce?

Case studies

- Case studies of three NHS providers
- Common interventions:
  - Making it safer to talk about race: ethnic minority staff networks and Freedom to Speak Up Guardian role
  - Career progression: development programmes
- Enablers:
  - Leadership and allyship
  - Removing obstacles.

What staff in the case studies told us…

- Signs of progress even if this doesn’t show up in WRES data
- Important to consider a range of data, including lived experiences
- Change was felt by staff in case studies (ripple effects, if not ‘big bang’):
  - Confidence in speaking up about race-related issues
  - Feeling valued
  - Raising awareness amongst colleagues
  - Changing conversations and relationships.

Key lessons to consider

No magic solutions

Approaches are not ‘one size fits all’

Approaches can make a difference –
with a sustained commitment, over time

Thank you

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The King's Fund

Future Events

Procurement
11 September
When: 12:30 – 4pm (approx.)
Where: MS Teams

System Working
5 December
When: 9:30 – 12:30pm (approx.)
Where: MS Teams

Thank you for coming