SECTION SIXTEEN
STAFFING AND STAFF MANAGEMENT

This section considers:

- the extent to which a common sense of identity and belonging extends across the PCT staff community
- the need for a comprehensive clinical workforce strategy
- supporting the provision of high quality clinical care through ensuring the adequacy of the PCT's own management and administrative infrastructure.

The challenge of creating an effective workforce

A PCT is a 'workforce-intensive' organisation where key outputs are created by people rather than by buildings, machinery or automated systems. The quality of clinical and other outputs is intimately related to the quality and morale of the staff – and the ways in which they are managed and supported. Attention to staffing and to staff management is, therefore, a significant part of a Board and PEC's clinical governance responsibility.

The ultimate aim is a staff group that is:

- highly motivated
- fully 'fit for purpose' in relation to current needs and demands
- flexible enough to respond positively to changing need and patterns of care.

To forge a cohesive and effective workforce across a professionally diverse and geographically dispersed community presents a significant challenge to the leaders of PCTs. This is especially true where:

- some staff have often been 'inherited' from one or more predecessor organisations
- some staff are directly employed while others are employed by the practices which provide an independently contracted service
- the inherited management (and/or administrative) infrastructure does not reflect the scale and extent of the duties and responsibilities of PCTs

CHI reviews across all NHS sectors indicate that many organisations have not approached workforce planning systematically, involving all disciplines and ideally the whole local health community.

Key learning from the pilot programme

Although most PCTs express general satisfaction with the capability of their staff groups, and have paid significant and serious attention to Improving Working Lives initiatives for all but their own senior managers, few have undertaken a systematic analysis to map their inherited staff groups' capacities and competencies against their current, and future, core clinical and business priorities. Many, therefore, lack a comprehensive and robust staff recruitment, retention and development strategy. All, however, recognise both the opportunity and the challenge presented by the new General Medical Services (nGMS).

Across all PCTs in the pilot programme, the section on Staffing and Staff Management was the third highest scoring at 5.5 on the progress scale (range 3.9 to 7.5).

Predictably, the more recently formed PCTs were significantly less confident about these issues than were their older contemporaries. Those under a year old when they completed the questions scored an average of 5.0 whilst the remainder scored an average of 6.0.

Although the CEOs and senior executives and managers of PCTs did not themselves complain of an excessive workload, it was often clear to their non-executive colleagues that they laboured under pressures that cannot be sustained indefinitely.

It was clear that there was no correlation between the scale of the challenge confronting a particular PCT and the management capacity it had at its disposal to deal with the resultant proliferation of issues. If anything the reverse seemed to be the case, with those PCTs that were serving the most disadvantaged communities facing the greatest downward pressure on their management cost base.

In general, PCTs have a very small middle management tier. Senior executives are pre-occupied with short-term operational crises and have little opportunity to give sustained energy and time to strategic issues. Where senior managers and the Board do devise longer-term visions and strategies, they are not systematically implemented due to lack of management resource.

Clearly, many Clinical Governance leads, PEC Chairs and other PEC members make heroic contributions to their organisation and its patient populations, often at a significant personal cost. However, a small number of PEC Chairs or senior PEC members are still significantly, and occasionally overtly, detached from the clinical governance agenda with the result that (or perhaps because) the GP community views the PCT as a source of difficulties and problems, rather than an ally in their resolution.

Almost all PCTs recognise the opportunity and challenge presented by the new GMS contract but express concerns about the HR workload which local-level implementation will cause.

Equally, those PCTs that fall within the orbit of first-wave Foundation Trusts express concern about the contracting burdens that will fall upon them, particularly the requirement to 'double-run' commissioning alongside new contracting systems.

So far as the grass roots clinical and administrative workforce are concerned many PCTs, not only the newest, had not undertaken a detailed analysis of 'fitness for purpose' in the light of the PCTs clinical governance and other key priorities. As a result they had not developed robust, forward-looking, recruitment and retention strategies. Most appreciated the need to wrestle with the 'Changing Workforce' agenda, but few could identify well-evidenced gaps in capacity or capability (with significant implications for their approach to Education and Training — an issue that is explored in more depth in Section 13).

The importance of developing an HR strategy derived from the current and emergent clinical priorities of the PCT

'HR in the NHS Plan' is the strategy for growing and developing the workforce to meet the challenges of improved safety, quality and service transformation. PCTs are workforce-intensive organisations. They must develop and implement a Human Resource Strategy proceeding from and supporting their overall strategic priorities. An organisation which fails to do so will be incapable of meeting its own objectives; over time it will become incapable of meeting performance targets and will fail the communities that it exists to serve.

In developing and implementing such a strategy, PCTs must work in a close and collaborative partnership with:

- their own staff groups
- trades unions
- local professional representative bodies.

In addition PCTs must address some transactional HR issues (appointments, disciplinary procedures, etc) and, not least where these are dealt with on a shared services basis, Boards and PECS need to be satisfied that these policies and practices are fully compliant with UK and, where appropriate, EU directives and best practice.

Creating a common identity in 'merged' organisations

PCTs are, without exception, an aggregation of many discrete parts, sometimes scattered over a wide geographical area. Staff bring to PCTs a range of differing experiences, cultures, feelings and expectations.

General Practitioners may feel that their independence and professional autonomy has been eroded by the advent first of PCGs, then of PCTs. Dentists, pharmacists and optometrists may still be exploring what it means to become part of the PCT community.

Community nursing staff (like many PCT managers) may have experienced a number of structural re-organisations and changes of employer in recent years.

The Boards of PCTs need to forge a common sense of belonging and shared purpose from the disparate elements of this often still-new community. Evidence from industry and from the acute NHS sector demonstrates that mergers of historically distinct organisations – each with their own culture, history, traditions and informal patterns of working – can create traumatic disruption to the process and to the quality of care, even where the merger was welcomed.

'Coping with the impact of constant structural change, at the same time as they wrestle with the unchanging nature of human need, can leave professionals feeling 'lost in familiar places.'

Shapiro and Carr, 1991

REFLECTION

What evidence is there to indicate the extent to which all staff feel that they 'belong' to the PCT community?

Unless the practical and emotional challenges of structural change and merger are recognised and actively and sensitively managed, 'after shocks' can rumble through an organisation for years. Disharmony, fragmentation and alienation become almost inevitable.

Depending upon their origin and their stage of development, PCT Boards may need to develop a strategy for generating a sense of community and of belonging. They must pay attention to managing the psychological as well as the practical impact of change.

Developing staffing accountabilities and structures

Boards must assure themselves that they have appropriate structures and processes in place to:

- recruit/retain
- manage
- monitor
- support the workforce.

The total list of workforce accountabilities and duties is a daunting one. Overall, NHSTs need to give appropriate attention to all of the following:

'Improving Working Lives'

Human resources performance framework

Human resources capability and capacity

'NHS Professionals'

Childcare development

'Vital Connection'

'Positively Diverse'

'Zero Tolerance'

Continuing Professional Development

Organisational development

Leadership programme development

Recruitment and retention'

Department of Health, 2002a

As part of their overall corporate governance responsibilities, NHSTs must ensure that a PCT's HR strategies address all elements of UK (and relevant EU) employment law. Strategies must:

- include appropriate disciplinary and grievance procedures, equal opportunities and race relations policies
- promote action to achieve the targets set in *Working Together and Improving Working Lives.*
- support proactive and full compliance with the requirements of Health and Safety legislation
- provide for a full range of employee support services (e.g. occupational health and independent advice and counselling services).

PCTs will be supported in these tasks by Workforce Development Confederations, which themselves have recently been re-positioned with strategic health authorities.

'The Confederation will take the lead in developing a shared approach to HR policy and practice.'

Department of Health, 2002a

So far as their clinical governance duties are concerned, the Boards and PECs of PCTs must ensure that they have taken appropriate steps to:

- map the skill mix of the workforce and match this against the current and future clinical needs of the PCT (including the skills of 'commissioning for quality')
- develop appraisal systems for all groups of staff
- develop clinical accountability, supervision and mentoring systems
- develop transparent and effective processes to identify and address 'poor performance'
- ensure that they actively monitor the implementation of all of these systems.

In their reviews across all NHS sectors CHI have identified a failure to address workforce planning systematically, across all disciplines and across the whole health community. Most of CHI's concerns about staffing and staff management in PCTs relate to forming PCT-wide policies and strategies.

'In at least half of reviewed PCTs, CHI is concerned that management of clinical staff employed by the PCT directly and by practices be better integrated.'

Commission for Health Improvement, 2003

Regional Workforce Confederations have been established to help PCTs and other NHSTs deal with a complex workforce agenda.

REFLECTION

What evidence is there to suggest that the PCT is forging a strong and effective partnership with the local Workforce Confederation?

Mapping and matching the skill mix of the clinical workforce

The skill mix of a PCT's clinical staff group is initially determined by:

- the pattern and mix of staff inherited from predecessor organisations (e.g. community trusts)
- the composition of the constituent GP practices and other community paramedical provision which have come (or been brought) together to form the clinical nucleus of the PCT.

Given the size, professional diversity and geographical dispersal of these staff, it is not easy for a Board or PEC to reach an informed judgement of their 'fitness for current purpose' (in terms of numbers and skill mix) to deliver the PCT's immediate priority clinical agenda. Careful and systematic mapping and analysis are required to identify duplication, overlap and key shortages, whether in the numbers of personnel or in their range and level of competence.

Such a gap analysis should inform a clear and comprehensive work-force strategy that will, in the short term at least, drive both the workforce development/education and training and the recruitment agendas. There are already significant problems in recruitment and retention of many key professional disciplines. Particular attention has recently been paid to concerns about the recruitment and retention of General Practitioners. The DoH has launched a number of strategies to respond to these issues, including the following schemes:

- Golden Hello
- GP Returners
- GP Flexible Careers.

The response to these schemes to date has been mixed, and an appraisal of differential success factors may help to shape subsequent national strategies in relation to other professional groups. In the meantime, there are excellent examples of pro-active recruitment strategies targeted at the specific needs of particular health communities, such as the promotional and recruitment activities of the South West London WDC.

In the medium term, it will be necessary to pay attention to the age profile of the workforce and systematic and periodic exploration of staff turnover intentions. Mapped against changing pattern, processes and locations of care, these will enable Boards to identify and manage workforce trends which, if left un-addressed, will generate longer term problems or crises.

REFLECTION

What evidence is there to suggest that the PCT has a clear picture of the skill mix of the clinical workforce? Does it match the clinical service demands?

Mapping and matching the skill mix of key management and support staff

High quality clinical services need to be underpinned by effective management and administrative structures and processes. The scale of this management challenge is now being widely recognised.

'Modernisation of the NHS and the delivery of *The NHS Plan* constitute not only the biggest health care project in the world, they add up to the toughest management task as well.'

Department of Health, 2002b

PCTs have inherited management and administrative infrastructures that often do not map against the new range of responsibilities and demands placed upon them as a result of Shifting the Balance of Power. Nor do they map against the demands of clinical governance and the investment of time and energy in co-ordinating and implementing the constituent components of the quality agenda (e.g. clinical risk management, clinical audit).

'Over the past year, the average number of managerial, financial and administrative staff employed by PCGs increased from 6.8 to 11.3, and from 15.8 to 31.5 in PCTs, but 61% of chief executives felt that current staffing levels were inadequate.'

National Primary Care Resource and Development Centre, 2002

Each new clinical duty inescapably imposes upon an organisation a demand for the investment of management and administrative time, as well as for clinical staff time. If this time is not available from within the management or administrative infrastructure, clinical staff are inappropriately deflected from their key caring tasks in order to make good this shortfall. In addition, key staff may find themselves occupying multiple roles, to the detriment of their own well being and that of the PCT as a whole.

PCTs need to identify the nature and scope of the management and administrative infrastructure necessary to support high-quality care. In order to determine this, the PCT needs to map the nature and extent of the management and administrative demands upon it. This must be done with the same systematic and analytical rigour it uses to define the profile of the clinical workforce. There can then be a realistic comparison between the demand and the capacity of the current management and administrative team.

'CHI is concerned about management capacity and clarity of management roles in PCTs.'

Commission for Health Improvement, 2002

To impose new tasks or functions upon a management or administrative infrastructure that is already over-burdened by the scale of existing responsibilities constitutes corporate negligence. Boards (and not least their non-Executive members) have a clear duty to ensure that the burden that falls upon their management and administrative systems is not an unmanageable one.

REFLECTION

What evidence is there that the PCT's management and administrative infrastructure is able to support the delivery and development of high quality clinical care?

In doing so, they may need to devise new patterns of organisational structure. These should not be based on old-fashioned bureaucratic models but rather on the more flexible and organic forms emerging in some parts of the voluntary and commercial sectors.

Paying due attention to 'Improving Working Lives'

The Improving Working Lives Standard is integral to the Performance Management Framework against which PCTs will be judged.. The standards that it sets out are designed to ensure that the duty of care that an organisation has to its workforce are given concrete and flexible expression – so that the workforce can achieve and sustain high levels of performance.

'It is the people in the NHS who will deliver improvements. The Improving Working Lives makes it clear that every member of staff in the NHS is entitled to work in an organisation which can demonstrate its commitment to more flexible working conditions and gives staff more control over their own time.'

Department of Health, 2001a

The Improving Working Lives National Audit Instrument is based on the Improving Working Lives Standard, which has the following key criteria:

'
- Recognises that modern health services require modern employment practices.
- Understands that staff work best for patients when they can strike a healthy balance between work and other aspects of their outside work.
- Accepts a joint responsibility with staff to develop a range of working arrangements that balance the needs of patients and services.
- Values and supports staff according to the contribution they make to patient care and meeting the needs of the service.
- Provides personal and professional development and training opportunities that are accessible and open to all staff irrespective of their working patterns.
- Has a range of policies and practices that enable staff to manage a healthy balance between work and their commitments outside work.'

Department of Health, 2001a

It will require sustained commitment and investment from Boards and PECs if they are to achieve these standards and make real and tangible improvements in the working lives of all of their staff:

'improvements that are effective, improvements that are embedded, and improvements that deliver better working lives for staff and better patient care'.

Department of Health, 2001a

In doing so, they will be in a stronger position to recruit and retain staff whose expertise is becoming ever scarcer in an increasingly diverse and competitive employment market.

Fitness to respond to emerging clinical and organisational demand

Clinical governance is a transformational agenda, designed to move the health service from being predominantly provision-led to an organisation whose provision is led by the changing needs of changing patients and communities. Boards and PECs of PCTs need to develop flexible clinical and organisational capacity in collaboration with professional staff groups and in those of their constituent GP practices.

'Nursing in primary care has to change to deliver *The NHS Plan* and that change will be determined locally by PCTs controlling 75% of the NHS budget. We need strong nurse leadership from PCTs to help make it happen.'

Kate Billingham, Department of Health Assistant Chief Nursing Officer

Liberating the Talents, launched in November 2002, contains practical examples of how nurses are pushing forward the boundaries of their work and implementing aspects of the framework that the document sets out. Concrete examples already exist within the primary care arena itself

'The Collaborative has demonstrated the effectiveness of nurses in managing patients with chronic disease such as CHD. The majority of Collaborative practices have chosen to transfer much of the work to practice nurses, often in tailor-made CHD clinics.'

National Primary Care Development Team, 2002

Through their partnership and commissioning arrangements (in collaboration with the SHA), PCT Boards and PECs can foster and support the development of flexible capacity across the local health economy. There are already a number of powerful examples of the ways in which more flexible and imaginative approaches to the deployment of the expertise of the inter-organisational workforce can deliver improvements in patient care alongside improvements in efficiency and in staff satisfaction.

'Many of the initiatives to reduce delays between primary and secondary care, like the examples included from the NPCC, look at new and appropriate ways of handling demand in primary care. GPwSIs, specialist nurses and PAMs are delivering care in partnership with secondary care colleagues, often in primary care or community facilities, improving access for patients. Eastleigh Surgery, a Wave 3 practice in West Wiltshire PCT with over 15,000 patients, looked at how they might improve care for patients with mental health problems within the practice. As a result, they reduced referrals to secondary care by 83%.'

National Primary Care Development Team, 2002

A longer-term developmental agenda needs to run in parallel with activity designed to address current workforce demands. PCTs can draw upon support and help from the regional Workforce Confederation.

'The Confederation will take a leading role in visioning the future healthcare workforce.

The Confederation will develop and lead an integrated approach to workforce planning for health and social care communities.

The Confederation will have overall responsibility for developing the existing and future healthcare workforce.'

Department of Health, 2002a

This enhanced flexibility can, in part, be achieved through the promotion of a culture that is confident, learning focussed and supportive.

Priorities for action

Now that you have finished reading through this section, please identify three priorities for the PCT in relation to staffing and staff management.

1

2

3

References

Commission for Health Improvement 2002. *Emerging Themes* August. www.chi.nhs.uk

Department of Health 2002. *HR in the NHS Plan: More staff working differently*, London: DH

Department of Health 2001. *Working Together, Learning Together*, London: The Stationery Office

Department of Health 2001 *Shifting the Balance of Power within the NH: Securing delivery*. London: DH

Department of Health 2002a. *Workforce Development Confederations Guidance* London: DH

Department of Health 2002b. *Liberating the Talents: helping Primary care trusts and nurses to deliver The NHS Plan*, London: DH

Department of Health 2000. *Improving Working Lives Standard*, London: DH

Department of Health 2001a. *Improving Working Lives National Audit Instrument*, London: DH

Department of Health 2002b. *Managing for Excellence in the NHS*, London: DH

National Primary Care Development Team 2002 *The National Primary Care Collaborative: The First Two Years*, Manchester: NPCD

National Primary Care Resource and Development Centre 2002. *National Tracker Survey of Primary Care Groups and Trusts 2001/2002: Taking Responsibility?* Manchester: NPCRDC

Kate Billingham, Assistant Chief Nursing Officer, Department of Health

Shapiro, E and Carr, A. 1991 *Lost in Familiar Places* New Haven and London: Yale University Press

Resources

Commission for Health Improvement – CHI's aim is to improve the quality of patient care in the NHS
www.chi.nhs.uk

General practitioners – GP recruitment and Retention can be found at:
www.doh.gov.uk/stats/gprrvsurvey2002.htm

Details of the 'Golden Hello' scheme can be found at:
www.doh.gov.uk/pricare/goldenhello

Details of the GP Returners and the GP Flexible Careers Scheme can be found at:
www.doh.gov.uk/pricare/fcs

Department of Health Support includes: Involving staff in decision-making
www.doh.gov.uk/hrinthenhs/staffinvolvementworklifebalance

HR in the NHS Plan
www.doh.gov.uk/hrbulletin/nhs-qrt-plan-nov.pdf

Improving Working Lives
Publications associated with the Improving Working Lives initiative can be found at:
www.doh.gov.uk/iwl

Liberating the Talents, launched in November 2002, contains practical examples of how nurses are pushing forward the boundaries of their work and implementing aspects of this new framework. A comprehensive resource listing provides access to websites, publications and organisations to take this forward Copies can be obtained from the Department of Health, PO Box 777, London SE1 6XH or call the NHS Response Line on 08701 555 455. Fax 01623 724524 or e-mail doh@prolog.uk.com
It is also on the Chief Nursing Officer's website at
www.doh.gov.uk/cno/liberatingtalents.htm

Update for community practitioners at
www.doh.gov.uk/cno/liberatingtalentscphu.htm

NHS Alliance – has various publications including *Morale in PCTs: Colchester PCT's toolkit to assess morale in PCTs*
www.nhsalliance.org

Out of hours guidance on Department of Health website at www.out-of-hours.info/news

Rating the PCT's current stage of development

Please rate the PCT's current stage of development in relation to the following questions.

Remember to use the Response Sheet provided for your answers.

16.1 To what extent has the PCT undertaken a detailed analysis of the skill mix of all staff groups to assess their 'fitness for purpose '?

16.2 To what extent does the skill mix match the PCT's overall responsibilities?

16.3 To what extent is the management and administrative infrastructure sufficiently robust to ensure that strategies can be translated into reality?

16.4 To what extent do the Board and PEC keep their own development needs under active review?