1. Workforce Governance Arrangements

Workforce is defined as an enabling workstream within the STP governance and portfolio programme management arrangements. Kathy Thomson, CEO of Liverpool Women's FT was appointed as CM STP Workforce SRO in September 2016, and has a seat on the overarching STP Working Group.

This workstream benefits from two main existing cross CM networks that have been in place for a number of years. The stakeholder engagement mechanism previously known as the CM Local Workforce and Education Group was set up by HEE in 2013 as one of three in the NW, to enable senior stakeholder engagement in the main functions of HEE under the previous NW LETB arrangements. Stakeholders include CEs, Medical Directors, Directors of Nursing, Directors of Finance, Directors of HR/ Workforce, Primary Care/ CCG representatives, Public Health, to recognize the system wide responsibility for workforce and education. This group has become the CM Local Workforce Action Board (LWAB) and the membership and Terms of Reference are designed to ensure it is fit for purpose as the place for strategic STP wide workforce discussions, development of priority plans, and assurance of actions associated with those plans. The remit of 'workforce' includes strategic and operational HR and leadership.

The CM LWAB is accountable to the CM STP Working Group as part of the overall STP Governance arrangements. The MoU between CM stakeholders which will set out principles and processes for decision making at the different levels within the STP (STP, LDS, sub-LDS, individual organization) will apply to decisions about workforce as any other function or theme within the STP. The membership of the LWAB has been developed to ensure social care/ LA representation, NW Leadership Academy representation; that there is a workforce 'voice' in and out of each of the other enabling functions, CCTs and critical decision areas (through stakeholder and/or HEE officer links), and that there is sufficient equity of LDS representation, given the anticipated focus of planning and delivery at that level.

The CM Human Resources Director network, a subgroup of the NHS Employers supported NW HRD network has also been in place for a similar period. As part of the STP process, three HRDs have been nominated in late September/ early October 2016 to act as the workforce lead within each LDS. These are: Rachael Charlton, East Cheshire Hospital NHS Trust (for Unified Cheshire); Roger Wilson, Warrington Hospitals NHS FT (for Alliance), with the North Mersey Lead to be determined. Those HRDs are active participants within the CM HRD Network, with Rachael Charlton also leading the NW Workforce Streamlining Programme (supported by HEE – see below). In addition, there are two HRDs on the CM LWAB, Anne Marie Stretch, St Helens and Knowsley NHS FT (Alliance) and Amanda Oates, Mersey Care NHS FT.

At LDS level, the recent appointment of lead HRDs (see above) for the workforce workstream will help ensure the centrality of the workforce 'voice' in each of the three LDS level governance arrangements. As much of the delivery of the STP is anticipated to be at or within LDSs, this is a critical step and one which can build on existing and developing LD/ sub LDS level networks of workforce leaders and wider work in such delivery. For example

in Cheshire and Wirral, a HRD group has been established to oversee the HR back office collaboration reporting via a lead CE to the Cheshire and Wirral CE group.

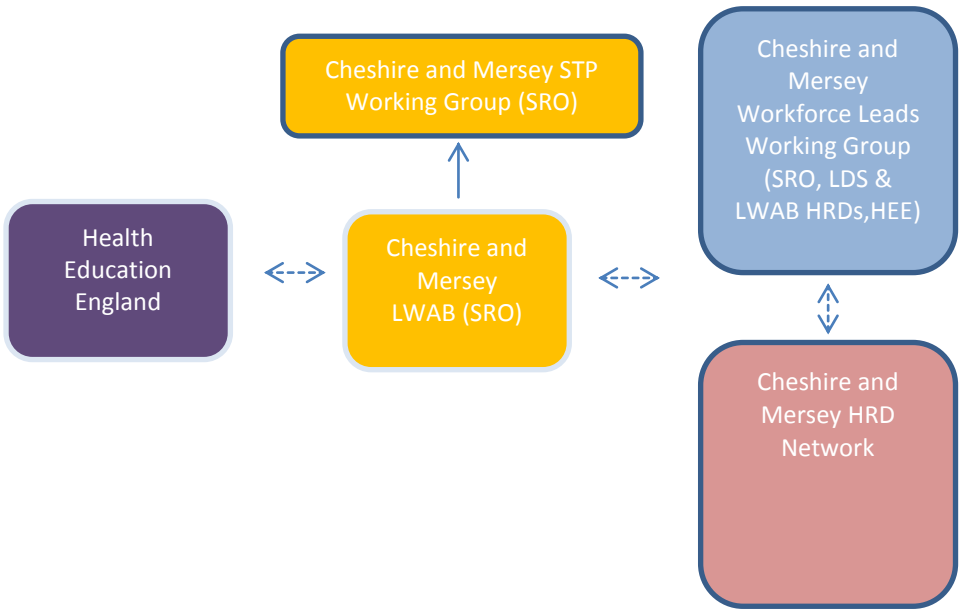
Within the workforce workstream there will be need to be considerations relating to where and how CM providers provide services outside the STP populations, and where providers outside of the CM STP geography provide services to CM population, in addition to considerations around the boundaries of CM with neighbouring STPs in relation to patient and workforce flows.

HEE in its support and assurance role around workforce both co-chair and support the LWAB in all aspects of its governance and work. Recognising the systemic and multifaceted nature of workforce engagement and accountability across the system, HEE senior officers take a system leadership and facilitation role in support of the SRO in bringing together and working between (primarily) the leaders in the system, the other ALBs and the STP leads/ programme office in developing the narrative, intelligence, and plans to deliver the workforce enabling workstream of the STP. This is being done through engagement with the key HRDs and the wider HRD network, the other ALBs across the North and locally (who, for CM meet monthly) and NW Leadership Academy, NHS Employers, and leads within the STP workstreams.

HEE through the delivery of obligations in its Mandate and statutory duties, also provide a range of resources into the system; direct to the STP/LWAB in terms of workforce data, narrative and analysis for the baseline and future scenario planning from a range of sources; intelligence on projected workforce supply for HEE commissioned non-medical programmes and within postgraduate medical and dental education; and a range of resources supporting workforce and education transformation including support for new and developing roles; as well as intelligence on quality in and of learning environments through multiprofessional quality education provision (for medical and dental trainees), management and assurance.

The LWAB has a further link into HEE through the co-chairing arrangements, and to the national Workforce Advisory Board consisting of all the ALBs, chaired by the CE of HEE.

The LWAB, meeting bimonthly will require improved collaborative arrangements to enable work to progress between meetings, and working (sub)group to ensure any decisions or actions that need to take place can happen in a timely manner for the STP process in support of the SRO. A working group consisting of the three LDS HRD representatives, the two LWAB HRDs and the SRO supporting by HEE senior officers is in development to undertake this role. The overall STP workforce governance arrangements are set out in the diagram below:



2. 'As Is' Position

This section includes key highlights from a range of sources of workforce data and narrative from existing workforce intelligence across and within the STP footprint. (*NB – draft in development resource document and accompanying data document provided in support of this section, references to data sources to be included in final workforce section as required*) (*NB 'as is' areas of priority work/ planning are included within the later sections below*)

- There are 57,900 staff (FTE) employed within CM secondary healthcare providers. This is against a FTE establishment of 63,097 indicating an average 7.7% vacancy rate.
- Medical and dental vacancies within CM secondary healthcare providers are reported as 20% for North Mersey and 22.5% for both Unified Cheshire and the Alliance LDSs. Key vacancies include Dental, Psychiatry and run through specialties such as Histopathology and Paediatrics. (**confirm training/ non training*)
- In non-medical clinical professions, some of the highest vacancies in CM are in Clinical Psychology (20%), Multi-therapies (16%) Learning Disability Nursing (13%) and Pharmacy Technicians.
- 76% of secondary healthcare organisations in CM have used or are planning on using international recruitment as part of their recruitment strategy.
- Staff sickness rates are reported as 4.6% average across CM secondary healthcare providers, with specific examples of significantly higher rates in individual organisations.

- The profile of the workforce in CM secondary healthcare providers shows an ageing workforce with c35% of the current workforce being aged over 50. For some providers special officer and mental health officer status compounds workforce planning and supply issues with earlier retirement dates anticipated than in other sections of the workforce/ wider services.

- Staff turnover remains significant and there is evidence to suggest significant movements of staff between secondary healthcare organisations and anecdotal reporting of examples of direct/ indirect incentives which may attract local staff from other providers which is an area of focus for system wide working

- The majority of secondary healthcare organisations (65%) of providers have active plans reviewing skill mix needs and progressing the consideration of new roles such as Physician Associates, Nursing Associates. There has been some uptake of HEE led workforce transformation initiatives and is potential for CM organisations individually and system wide to further maximise the benefits on offer from these initiatives.

- The primary care workforce is an area requiring further focus, investment and development, particularly given the likely impact of the STP on primary and wider out of hospital services. There is an aging GP workforce with 20% of the workforce aged over 55, whilst another 14% aged between 50-54. In certain parts of the patch, recruitment to GP training posts has been challenging, albeit recent incentive schemes associated with such posts appear to be increasing popularity of those areas. CM has the second lowest number of direct patient support staff (FTE) compared to other regions in England, with a 19% difference compared with Greater Manchester and 46% less than Cumbria/North East. Building capacity in this group represents a significant workforce opportunity.

- There is a significant CM social care workforce (68,000), but more collaborative efforts to develop integrated working, investing in supporting the abilities and resilience of this workforce will be key to the STP delivery.

3. STP Impact

Whilst the four critical decision areas, CCTs and LDSs develop plans to which a workforce enabling 'response' can be developed, it is recognized that workforce is not only an enabler to plans within those areas but a key driver. By ensuring a workforce 'voice' in each of the critical decision areas, CCTs and LDSs, there can be both early identification from key leaders of the challenges that may impact the workforce, and an ability to input specific direct and indirect workforce knowledge to those areas to ensure plans are achievable, and meet the quadruple aims of the 5YFV, within and across the STP. Workforce leads/links in each area will be developed and supported to operate in both 'push' and 'pull' roles in that way.

Workforce accounts for around 70% of total health and care spend, and whilst areas of new future/ additional workforce supply are critical, it is the case that for the most part, the health

and care workforce at the end of the 5YFV period will be the workforce employed in the system now.

CM system wide workforce workstream programme management and support arrangements will be put in place to support the workforce leads, and wider LWAB, to maximize both planning and assurance of progress of actions and performance, towards the achievement of the overall STP plans (see 4. below).

The existing NW workforce streamlining programme workstreams will be accelerated in CM (linked to back office consolidation) and (other) key priority areas of strategic and operational HR linked directly or indirectly to workforce spend, will be identified to reduce variation and maximize efficiency and opportunities within and across the STP (see 4. below).

4. Priority Plans

The workforce leads/ links and LWAB will consider existing and initial plans from within and across the STP critical decision, CCT and LDS areas as they develop in order to inform priority areas for action. The following areas have already been identified in relation to this workstream:

a. CM workforce workstream programme support arrangements to link with the STP Portfolio Programme Management arrangements and maximize wider system resources. The ability to ensure timely and relevant workforce input to STP workstream areas, and response to plans from those areas, will require specific programme management, oversight and support. As both the responsibility for workforce, and resources associated with this workstream are distributed, programme management and support arrangements will enable effective collaboration and updating, in addition to face to face meetings. Key leaders within this workstream recognize the importance of ensuring sustainable programme management using consistent methodology, formats within the overall workstream and identification of appropriate resource from within the system will be addressed as a priority as plans are firmed up and agreed.

b. Strategic and Operational HR Priorities. This is anticipated to cover an extensive programme of work developing existing activity and new areas of work at both LDS and wider STP level. The established NW streamlining programme of work driving efficiencies in organizations' recruitment and induction of staff, and mobility of staff between organisations using a training passport model will be accelerated in terms of scale and pace of delivery in CM. Other key priority areas of strategic and operational HR linked directly or indirectly to workforce spend will be identified to reduce variation and maximize efficiency and opportunities within and across the STP including a full review of the areas of focus identified in the Carter report. These will include harmonization/ consistency of policies (e.g. pay protection), system wide contracts, use of temporary staff, agency rates and spend, reduction of sickness absence, improving staff experience, early system wide planning for known turnover (e.g. retirement of key staff).

c. Workforce Intelligence Provision and Analysis. HEE provide a range of intelligence, analysis and support, alongside other organisations (e.g. NHS I's workforce metrics in its data collection for its Single Performance Framework, organisations' own internal workforce metrics to Boards). Ensuring the relevant baselines for the STP and areas within it are accurate, up to date, and complete, and there is universal utility of consistent sources requires improvement in collaboration and sharing across the STP and support/ assurance organisations. In addition, costed workforce modelling of 'do nothing' and 'do something' scenarios along with analysis of how (workforce) costs will be released between current baseline and moving to new arrangements will be required, and the increased take up of modelling tools like the Workforce Repository and Planning Tool (WRaPT -developed in the NW to map workforce to service models) will be required to aid this task. Leadership and supporting systems to maximize collective resource within organisations will be required, making this another priority area.

In addition, CM HRDs have identified the STP back office critical decision area as a priority in terms of contribution and input, linking in the NW Streamlining Programme (see above). There are planned changes in services where the workforce workstream will be critical, (merger of Royal Liverpool, Aintree and Liverpool Womens and proposals around Liverpool Community Health all in North Mersey). If CM organisations fully exploit the opportunities associated with the new Apprenticeship Levy there is significant potential to align apprenticeship pathways and developments consistent with new service requirements and organisational working, and this will form a priority area of work.

The LWAB and SRO have identified initial priorities as the urgent and emergency care system; improvements in health and care system navigation and coordination to enable care at home; and carer coordination and support in relation to the wider workforce. Once more detailed plans are available from other STP workstreams then a fuller review of the workforce aspects of those can take place to ensure the LWAB and respective leads can prioritise accordingly.