Good Governance Institute

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People in Place

Meeting capacity and cultural challenges in the NHS

A report from the Good Governance Institute

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Allocate Software

The team at Allocate Software is delighted to have been able to work with GGI on this report. We believe place focused delivery of healthcare, public health and care provides a positive opportunity to do more to support, develop and improve the experience of the people that work within and across organisations, as much as it does to the place-based populations they serve.

Allocate Software is a leading international provider of Human Capital Management solutions, supporting the operational and administrative needs of health, care, government and defence sectors.

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Executive Summary

People in Place is a call to action on the fundamental skills and people issues which will determine the future of health and care in the UK.

The pandemic has thrown a sharp light on an increasingly complex and challenging people agenda at local and national level. This agenda is often characterised as a series of problems to be addressed, including capacity gaps in critical skills, staff health and well-being, embedded issues of cultural inequality and lack of diversity, and long-standing problems with fair pay and reward. More positively, there is growing evidence of more collaborative solutions to new ways of working, a live appetite for change nurtured by the pandemic, examples of more flexible career pathways and new ways of deploying skills across traditional boundaries.

There is consensus that this agenda requires collective thinking and action by the NHS and its partners both immediately and longer-term. But how can this be done most effectively at the pace and scale now needed?

People in Place takes a positive and practical view of the future. It offers solutions based on interviews, workshops and evidence-gathering from leaders and thinkers in the field. It argues that effective collective leadership at system and place, supported by creative modern governance, now holds the key to the people agenda. This report also offers a range of practical tools and resources to help make this happen, based on experience of what works. It sets out a clear set of realistic opportunities and possibilities for progress.

We explore how the guiding principles of good governance and subsidiarity can provide the right framework and enable a strong foundation for sustainable change. Whatever the pressures to tackle immediate people issues, we argue the real focus for ethical leaders who take their stewardship responsibilities seriously must be on a long-term framework, founded on clear principles and involving a wide range of partners. We focus especially on the unique role and potential for people committees, operating in systems above employers and below national level.

With the detail becoming clearer, we believe that the NHS reforms in England offer a genuine opportunity to refocus energy on driving forward the people agenda at local levels. The scope is there to tackle people issues in a way that serves local communities and employers well and helps meet the health and care needs of local populations better. In the rest of the UK, where integration and collaboration are more established, we recommend a similar approach, ensuring local leadership is truly enabled, through good governance, adoption of sound practical tools and effective resources, to create solutions to long-standing people challenges.

> *"There is already space to do things very differently on workforce issues at local system level, as long as local leaders genuinely make things happen with partners outside the NHS."*
>
> **Independent governance expert**

This report is designed to help local leaders in the NHS and its partners, as well as policy-makers.

It provides analytical tools and resources including:

- *a subsidiarity matrix for people issues in health and care*
- *a design resource for use in shaping governance of the people agenda at system level*
- *a mindset prompt*
- *a risk appetite prompt*
- *a core agenda for a collective people committee at system level.*

These tools have been developed to provide challenge and support for those serious about making change happen.

> *Well thought through governance principles provide a solid foundation from which local teams can ignite or maintain their shared purpose and practice the autonomy needed to innovate place-based people strategies."*
>
> **NHS supplier**

We suggest that system-level governance arrangements, including people committees, need to be varied, inclusive of all key players and pass tests of good governance. We recommend a tight focus by each committee on a small number of strategic issues which can most effectively be addressed only at system level. In our view this agenda includes:

- mobilisation of skills and capacity building based on new ways of working
- better shared data and intelligence and information on skills to meet local population needs
- new methods of registering and deploying skills where they are needed
- creating positive conditions for rigorous innovation and learning.

Alongside tools and resources for use now, we also make the following recommendations:

Our overall conclusion is that the future people agenda requires collective action beyond traditional organisational and professional boundaries and that this in turn demands the precision of good governance and of subsidiarity. This is a time when positive change on embedded people issues should be seen as a realistic, shared objective which is within grasp. The attitude and mindset of leaders will be as important as structures and formal accountabilities in making this happen.

People in Place is designed to provide stimulus and focus on mission-critical issues for health and care, to help define a sound governance framework and to offer practical tools and resources for local leaders on whom change depends.

The time for action is now.

- **Recommendation 1:** national guidance is needed to support the people in place agenda and should be issued in line with this report in England and Northern Ireland, and in each of the devolved administrations. At the very least this should bring to life the importance of the principles of good governance and subsidiarity and help embed them into thinking and practice.

- **Recommendation 2:** immediate investment in capacity building and governance support for people committees. We believe people committees need to be made effective and authoritative in their ways of working and focus, with a level of genuinely independent non-executive input. This will help avoid conflicts of interest. Dedicated senior time and expertise is also needed to support the work and impact of each committee, for example around modelling and data analysis as well as leadership on specific areas of work.

- **Recommendation 3:** we recognise that there is more research and collective thinking to be done. We suggest further lines of enquiry and key questions for these next steps.

- **Recommendation 4:** there a need for further development of a multi-professional community of interest to encourage knowledge sharing, to build momentum and to support implementation for the people agenda. The People in Place Resource Centre which was developed to support the report provides a good vehicle for doing this and could provide exactly the right impartial and independent space needed to do this.

Part One

Purpose and Scope

Part One: Purpose and Scope

This new report, 'People in Place', is about the future of health and care skills and talent. It examines the thinking, leadership and governance which will best enable real progress to be made on the 'people' agenda at local level, as an integral part of reforms in the NHS.

It is structured in four parts:

Part One (Purpose and Scope) explores the principles of governance and subsidiarity

Part Two (Options and Opportunities) analyses the people agenda and its future governance at local level

Part Three (Resources and Outcomes) gathers together resources and tools designed to help leaders make decisions about governance

Part Four (Recommendations) sets out four areas for further national and local action.

The first two parts of the report provide a framework and analysis largely based on England, and the second two parts provide practical support which we believe are relevant to all UK countries. These are colour coded to help navigation to the most relevant sections for each reader.

The report has been shaped and informed by:

- *Interviews with senior leaders at the forefront of people issues in the NHS*
- *Learning from the work of GGI, Allocate and others in relation to emerging ICSs, including a series of webinars*
- *Desk-top analysis of legislative proposals, policy documents and governance documents*
- *Wider experience in active development of good governance, collaborative and subsidiary models for emerging and established institutions and systems*
- *Primary research on people committee terms of reference, agendas and impact*
- *Two workshops involving researchers, executive directors and non-executive directors from across the health sector.*

The two main workshops were held virtually on 22 April and 4 May built around key lines of enquiry set out below.

A list of those who helped shape the report is at Appendix 2. Unattributed quotes drawn from the events, from interviews, and also from private conversations are included throughout the report.

> *Unless we are really rigorous about subsidiarity there is such a risk of wasting time and effort between us all."*
>
> **NHS national programme manager**

1.1 Lines of Enquiry

To provide a consistent focus for the work we also adopted lines of enquiry developed in partnership with Allocate Software including:

- *Is there clarity on the people agenda at system and at place levels?*
- *What are the emerging approaches to governance of the people agenda at system level in the NHS?*
- *What will help develop robust and effective governance of the people agenda at system level in the NHS?*
- *Is there a distinctive contribution that people committees can and/or should be making both now and from the implementation date for system governance in April 2022?*

> *I am still not sure whether the practicalities of the people agenda have been thought through by the NHS in terms of how partnerships and responsibilities will fit together. Place really matters."*
>
> **Local authority CEO**

1.2 The People agenda

Our definition of the 'people agenda' is broad. It includes organisational culture, capacity planning, professional development and learning, recruitment and deployment of skills and talent, well-being and welfare. This is explored further in Box 1.

We avoid the term "workforce" as this is an outdated term which suggests people's skills are owned by employers. It also reinforces lines of accountability which for example does not include independent practitioners, carers and contracted staff. The future capacity to deliver health and care needs is likely to be more diffuse, independent and less associated with employers in future.

Box 1: The People Agenda

The people agenda is the shorthand term used in the report to cover the wide range of people-related issues and initiatives articulated in plans and agendas at national, system and employer levels. It is not meant to be a tight definition or to synthesise a diverse set of issues into neat workstreams or groupings.

But we want to be clear that this people agenda is a multi-disciplinary, multi-organisational agenda which is both shared with other large non-NHS organisations whilst also being distinct to health and social care.

Our work has shown that similar issues are described in different language with little continuity between health and care organisations and meanings of terms are unclear or inconsistent. This is perhaps not surprising given the scale of the health and care environment.

We felt it made sense to reflect this lack of precision and consistency as one of the issues that needs to be addressed but also that it could provide a distraction from more important issues of governance. For this report, the term "people agenda" includes the following issues drawn from a review of plans and agendas.

People strategies and outcomes
People risk: identification and mitigation
Statutory requirements: policies and procedures; regulatory compliance
Pay and reward
Equality, diversity and inclusion and cultural norms
Recruitment and retention
Education, skills and capacity building
Workforce and capacity planning
Health and wellbeing
Future of work and new ways of working
Leadership and mindset
Talent management and succession planning
Values and culture
Engagement and voice
Professional standards
Learning and innovation
Communications: staff and stakeholder engagement
Impact assessment, data, internal and public reporting

The people agenda has become increasingly important in the changing world of systems and place, as the UK emerges from the pandemic, and in the wake of a number of national and international movements which have shone a light on the extent of inequalities within this country. It represents the most important set of strategic risks facing the NHS and its multiple partners and collaborators.

Managing the people agenda in UK health and social care across has been challenging for many years. The barriers to resolving these issues are complex and include:

- *Insufficient alignment between democratic and health sector accountabilities*
- *Insufficient long-term coordination*
- *Resourcing challenges*
- *Staff shortages*
- *Inefficient use of local skills*
- *Unclear accountabilities*

This report therefore explores how leaders committed to good governance can address these risks above employer level, and maximise the opportunities for radical change at local level. It is intended to provide a working framework for thinking and to stimulate discussion at both local and national levels. It is also designed to be of practical use for local leaders in the NHS and its partners, as well as policy-makers, as they address critical-path issues in implementing change in the coming months.

We explore how this complex agenda is currently being tackled at system and place levels, and discuss how new NHS statutory arrangements in England and Wales can be shaped to unlock long-standing people issues at the scale and pace needed.

Our conclusion is that this requires good governance at system level, built around an approach to governance which emphasises the principle of subsidiarity to facilitate collective action beyond traditional organisational and professional boundaries. This demands a contribution and mindset from leaders which is different from the past and focuses on a small number of high-impact outcomes.

We suggest that system-level governance arrangements, including people committees, need to be varied and inclusive of all key players if the potential to achieve new and innovative solutions is going to translate into something of real substance, not more of the same.

Throughout the report we have included quotes from those involved in the workshops and interviews which have provided the core of the analysis. These are anonymised at their request, but we have included the role descriptions for each contributor. We are grateful for their invaluable contribution of time, candour and openness as the project has developed.

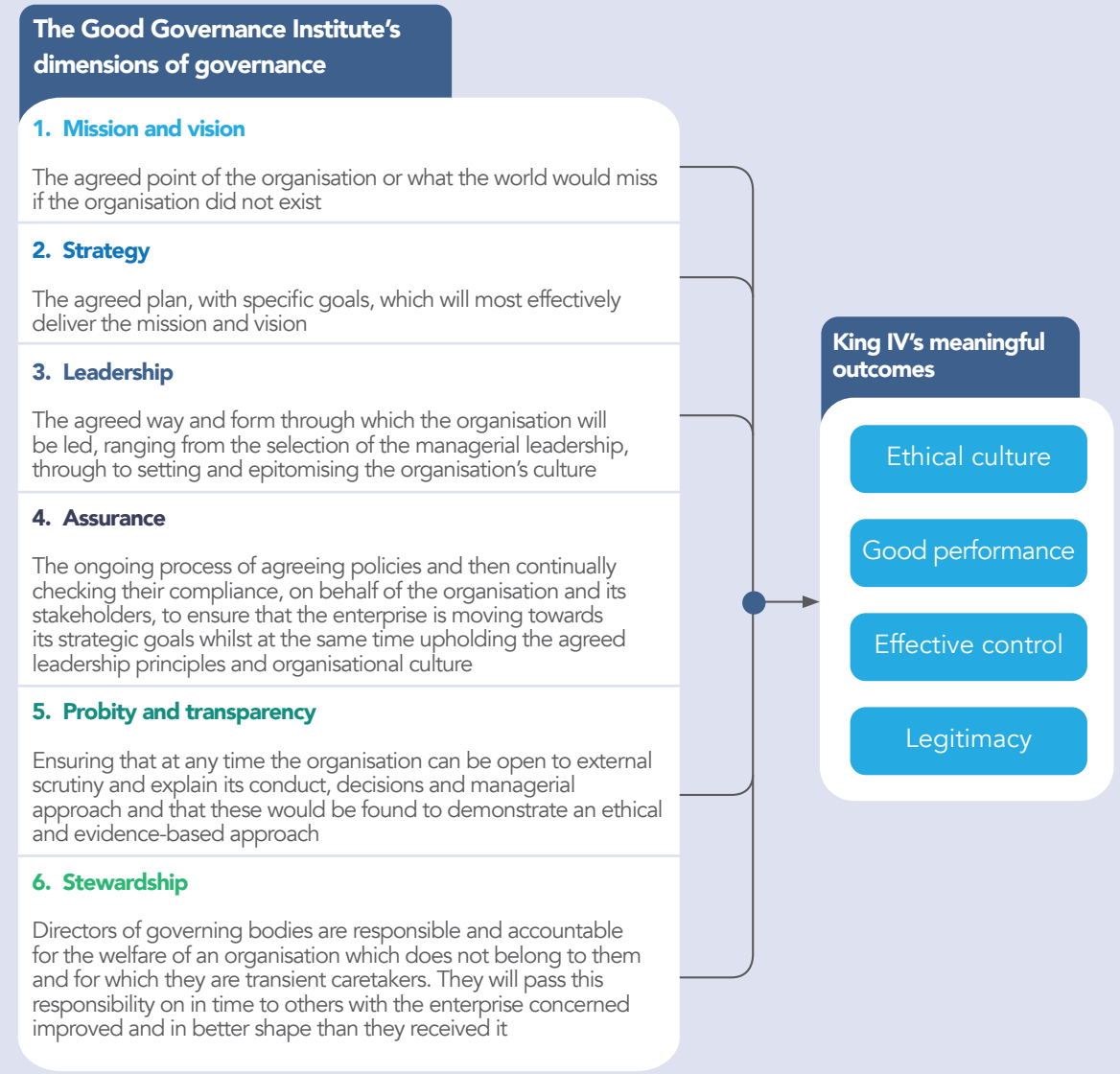
1.3 Our approach

The People in Place programme of work has been shaped by clear definitions of the characteristics of good governance and of subsidiarity. These provide a conceptual and practical framework for our work.

Good governance matters. It brings precision and clarity and a focus on long-term outcomes. This is particularly helpful in relation to the people agenda where stewardship of an essential national resource - the people who provide health and care - has developed as the collective responsibility of multiple players at national and local level.

Good governance is essential as these responsibilities and relationships change to provide a series of shared principles which focus on contribution, risk, accountability and values.

Box 2: Principles of good governance



Subsidiarity is also an important concept when considering the space between national and local and between policy intent and employer responsibility. This is particularly relevant to the people agenda, which is complex and influenced by many different players locally and nationally, with overlapping responsibilities.

This inevitably leads to many dependencies and assumptions which have developed over the years.

Applying the principles of subsidiarity alongside those of good governance provide the foundation for a strong, objective framework which will bring precision and clarity to a system which has evolved rather than be designed.

> *When we talk about ICSs, half the time we are not looking at the whole healthcare system. We are actually talking about the NHS part."*
>
> **Policy commentator**

Box 3: Subsidiarity – a short summary

Subsidiarity is the concept that decisions and accountability are best delivered with the greatest impact at the lowest possible level, in a system or organisation where authority can be vested.

With its roots in Catholic social governance theory, it has become a governing principle in a range of corporate and political institutions.

The concept has had noted success in a range of sectors over many years from the corporate world to the recent rapid vaccine rollout in certain US states.[1]

Box 3: Subsidiarity – a short summary

For the principle to be effective, certain essential characteristics have been identified:

Clear vision

A clear shared vision that lower levels can take actions that clearly contribute to an organised goal and bring unity within diversity

Trust

Genuine trust and commitment from all levels to all the principles of subsidiarity and a respective appreciation of the functions exercised at various levels

Culture

All levels of the organisation are not only respected but are also required to assume responsibility and accountability for whatever they are able to do on their own initiative

Application of subsidiarity should be based on the context and circumstances of a particular capacity, decision or place

All levels should be given autonomy to work towards shared objectives

Higher groups need the flexibility to move capacity down levels if those below could perform certain functions

Initiative

Employees and less senior groups must assume their responsibility and accountability for doing whatever they can on their own initiative, by developing an entrepreneurial spirit

Support

Higher levels should take responsibility for providing the resources and training necessary for lower levels to discharge their functions

All levels require the opportunity for learning and growth when mistakes are made, rather than reverting to centralisation

Power

Lower groups should have real power to shape how they work towards objectives

Senior groups should not prevent or absorb any responsibilities that can be discharged by a lower level

Circumstances

Subsidiarity needs to be applied in each case through consideration of all relevant circumstances or a particular place or decision, meaning the way it is applied in practice may differ widely from one situation to another

Data transfers

Subsidiarity should be supported by effective transfers of information from one level to the next, allowing senior levels to assist where necessary and to create open communication across various levels to cultivate trust and strong relationships

We explore the interconnection between good governance and subsidiarity throughout the report and bring them together in a single framework in section 2.4.

If you would like to read more about our wider programme of work, the specific methodology used for this review, as well as additional supporting resources, please visit our People in Place Resource Centre here.

> *In such a complex environment I do not think that it's all just a matter of culture, we also need to be creating and sharing a common aim and approach."*
>
> **NHS Chief Executive**

Part Two

Options and Opportunities

2.1 The current environment – potential and limitations in a changing world

We recognise that governance at system and place levels is emerging, dynamic and complex.

We use NHS reform in England and the impact of the pandemic to provide a dynamic and live context in which to position the people agenda.

We recognise that Northern Ireland and the two devolved governments in Scotland and Wales have different policy, leadership and organisational contexts, not least where integration of health and care and partnership have been actively pursued as the foundation for the way the national health and care infrastructure is structured and operates.

A detailed examination of the English context of NHS restructuring can be found in Appendix 1 at the back of this report.

Our focus is on a shared people agenda, some of which is devolved and specific, and some of which is integrated at UK level. It is not the remit of this report to map out a comprehensive UK-wide policy context on people issues. That would need a lengthy report of its own.

But we have always been careful in our work to assess the application of the underlying principles and issues and their relevance beyond England. We believe people agenda issues are fundamentally shared across the UK, whatever the specific operating and structural context of each country.

The use of England as the context is therefore not intended to exclude the other UK countries and we believe the conclusions of the report, and the tools it contains, apply just as equally in each country.

> *Everyone is repeating the same work and this is creating significant demand on our time"*
>
> **NHS Director of People and Culture**

The pandemic has crystalised long-standing issues around capacity, mental health, agility of deployment of skills and the importance of expertise from beyond the NHS including in carers, in communities, and in private providers. Strategic commitments to achieve improved population health outcomes and make a decisive shift to foregrounding prevention are demanding clarity on the shape and character of the future health and care workforce. They are rightly challenging the use of the term workforce as a limiting and unhelpfully internal term which excludes significant areas of skill and of critical people contributions to collective outcomes.

Many of the complex issues which make up the health and care people agenda have been around for years, addressed within a centralised statutory and regulatory environment, which has placed emphasis on the accountability of individual employers and on national direction and leadership from a suite of national organisations. The space between the two in place and system has been less developed since the Lansley reforms.

At the same time, issues such as retention and culture have only increased in prominence in recent years.[2] Arguably the workforce has not been seen as a high enough policy priority, with accountability scattered across many layers of governance.[3] Consistently, the NHS has not invested in the leadership capacity and skills to manage its workforce.[4] Indeed, resource constraints and workforce shortages present one of the primary barriers to delivering the NHS' Long Term Plan.[5] Given this, people issues could feasibly be described as the principal strategic risk in relation to health and care.

The spill-over effects of this are significant, and have been exacerbated by the pandemic. The NHS, as much as, politicians has been challenged around its ability to make the right decisions to support not just the retained health and care workforce but also those working at the periphery, on which the idea of a national service depends. During this period, staff in the NHS have been asked to work in particularly challenging and, at times, potentially unsafe environments and this has taken its toll. The scale of difficulties now faced means organisations will have to take serious, bold decisions if they are to secure the health and wellbeing and the sustainability of the healthcare workforce. As such it is essential to find long-term structural solutions centred around accountability and positive outcomes, to manage the NHS' most important asset.

The new focus on systems and place has the potential to address some of these issues, and also to remove confusion, overlap and inconsistency where it exists if handled properly. Already, people are increasingly able to work across professional and organisational boundaries so staff will increasingly be taking on more place-based careers meaning workforce challenges will become system issues. The performance of single organisations will have significant implications for the system, particularly influencing reputation, perceptions of trust and therefore the ability to attract and retain staff. This also has benefits for patients with complex health and social problems who require a mix of providers that can collectively address their needs.[6]

The critical issue is purpose. There are choices being made and to be made about people leadership and accountability at system and place. Clarity is needed about what must be discussed and agreed at a system level and what can be delegated in subsidiarity terms. This includes consideration of issues such as workforce planning, recruitment and data.

This delegation must be coherent with the rationale made plain for the various institutions involved. Capacity to set these up and the time and expertise to govern people issues is essential. A shift in mindset is required to overcome authority, attitudinal and professional barriers and make substantial change.

> *We are seeing some excellent pockets of change to new ways of working and innovative pathways linked to capacity building. These need scaling up beyond projects and will require much greater sharing of learning than we are seeing at the moment."*
>
> **Senior independent researcher**

It is also true that collaborative solutions to long-standing problems are already visible or emerging around people and service issues. Amongst the most visible where there is further potential are:[7]

- *new models of general practice, including multidisciplinary teams of health care professionals*
- *innovative initiatives such as the NHS' 'digital staff passport' to support staff working across organisations and to address skills and capacity gaps*
- *joint professional development and joint recruitment events in charity, third sector, private sector, NHS and local authority to harness and audit the health care skills in the area*
- *core skills development across a population with joint professional development sessions based on shared standards, for example around individuals with mental health qualifications*
- *new technology schemes for scheduling and deployment of skills, supporting flexible working and individualised planning of time and development*
- *growing non-contracted community and neighbourhood capacity*
- *team-based responses to care in cancer*

There is a balance to be struck here in terms of the future as it is important to balance optimism and opportunity with a full appreciation of limitations and concerns.

Box 4: Opportunties and limitations

Opportunities and potential

Develop a long-term approach to local people challenges

- Focus on long standing strategic people issues below national level
- Create space to plan, look longer-term and move beyond the immediate

Strategic deployment of people and resources

- Find the right scale to place people at the heart of addressing population health and inequality
- Release and reconfigure resources at scale
- Mobilise leadership talent within and beyond NHS
- Recognise skills beyond the NHS workforce – adopt currency of skills

Generate consistency across organisations

- Breakthrough traditional organisational and professional boundaries
- Promote consistency across organisational and professional boundaries

Set and deliver measurable improved outcomes

- Generate measurable impact on social and economic priorities with partners

Create a site for local partnerships

- Consolidate collaboration and collective intent on people
- Establish partnerships that would otherwise not be possible for individual employers
- Build a foundation for collaborative partnerships beyond health
- Enable the inclusion of private sector, third sector and entrepreneurs

Bring decision making closer to staff and the public

- Ensure place matches public interest in localism and accountability
- Create structures that more accurately reflect how staff and the public connect to services

Limitations and concerns

Persistence of competitive mindsets

- Governance at system level will not enable a step change without a change in mindset

Focus on short-term demands

- The potential for transformation of work and workforce will be swamped by an immediate agenda and short-term focus
- Agenda agreements being only on short-term

Concentration of power

- Power will remain with the employers
- Resources will be centrally directed rather than locally prioritised
- Ambition will be undermined by centralised control
- National intervention will lead to insensitivity to local dynamics

Immediate accountabilities stifling innovation

- Emphasis will be on NHS accountabilities, rather than the potential for innovation at place
- Defaulting to HR and statutory and employment agendas

Lack of agreement on aims and risk appetite

- Inconsistent risk appetite among partners results in unambitious targets
- Inconsistent risk appetite results in defaulting to the least ambitious

Time and resource constraints

- Under resourcing leads to the privileging of quality and finance over people agenda
- A lack of time and energy to drive the people agenda at system and place level

Unbalanced partnerships

- Uneven contributions and resourcing between employers will cause tensions
- Conflicts of interest will not be recognised or addressed between place and employer interests
- Dominance by large acute employers

Limitations and concerns

Ineffective use of subsidiarity

- Insufficient practical governance support will be secured to support effective working
- Place and system will be confused to the detriment of both
- Inability to recast current structures to new purposes
- Form will not match function
- Duplication and repetition of work between tiers will continue
- Same leadership as at institutional level, leading to a focus only on personal agendas

Inertia

- Lack of independence and challenge to current thinking

At system and place levels people are much less sure about what can and can't be done, what their role is and there isn't much guidance to steer them on this"

Public sector governance expert

2.2 The people agenda - the dynamics of change

The people agenda needs more clarity. There is a danger that referencing a 'people agenda' might give the impression that there is a single homogenous agenda derived from a set of clear and consistent national and local policies being operationalised by NHS bodies, by systems, in place and by employers.

There is an element of truth in this, reflected in the aspirations of the various strategies on people, but there is significant scope for differences in agenda and approach at each level and between levels. This will be shaped by distinctive operating environments, localised strategic and organisational priorities and by personal appetites and contributions of individuals.

Use of the term people strategy deliberately marks a move away from use of the non-inclusive term 'workforce strategy' with its narrowing to contractual skills and their ownership by the employer.

Drawing on our work it is possible to see what a core people agenda for the NHS needs to be, to align with immediate and future needs. Narratives and ambition for people issues are increasingly connected to large strategic objectives including:

- *population health,*
- *social inequalities and injustice,*
- *economic and civic renewal and sustainability,*
- *digital transformation and agility,*
- *skills and capacity development and mobilisation within communities.*

It is, however, more difficult to see a shared or consistent people agenda being taken forward below national level and there is little evidence of agile governance, clarity of role and accountability on which this would be built.

Instead, we found recognition by leaders of duplication of effort and intent, and similarity and overlap between agendas and actions at different levels.

Importantly, elements of this agenda are inherently more discretionary than others. We try to show this now by making a distinction between statutory people issues (compliance, regulatory, accountability to beyond the NHS) and strategic people issues (levels of discretion within policy bounds; ability to reflect local priorities and dynamics). Responsibility for the former is largely placed on employers.

This means that what might seem like a shared agenda is approached differently not only at employer level but also at system level, and even between national agencies.

This diversity of approach is not necessarily a problem, but it becomes more important to take into account when looking at models of governance at system level where statutory and discretionary accountabilities may not align easily.

Box 5: Core accountabilities

Statutory	Strategic
Duty of Care	Culture and defining values
Impacts on health inequalities	Skills
Eliminate discrimination and harassment	Communications
Disability Discrimination Act	Stakeholder engagement
Workforce Race Equality Standard	Capacity building
Gender pay gap reporting	New roles and ways of working
Health and Safety Standard	Standards of behaviour and conduct
Freedom to speak	Reputation management
Guardians of Safe Working Hours	Succession planning – leadership and professional

> *At the moment it is frustrating that we are not involved enough at systems level. It feels like we are being excluded and thinking is still too closed and inward-looking."*
>
> **Professional body regional officer**

Statutory and compliance requirements and non-statutory, strategic and discretionary issues are not sharply distinct, but rather closely interwoven. For example, all employers and national bodies have statutory responsibilities in respect of the duty of care, health and safety and equality, diversity and inclusion with clear accountabilities and consequences for directors. But there is significant scope for the specific requirements to form part of a broader cultural agenda in which there are high levels of discretion to go beyond any statutory minima.

There are many different influences on the people agenda. It is not an HR agenda nor even an OD agenda. This is a genuinely strategic agenda requiring a heterogenous approach embracing all health and care professions and skills, all executive and NEDs at system level, as well as national leaders and local partners.

The people agenda is also fashioned by local employers with significant scope for acting as self-contained and powerful agents of change and obstruction, whatever the narratives might be around moving to positive collaboration.

Although the NHS is described as the biggest employer in Europe, it is in fact a network of separate employers accountable individually in different ways in devolved settings and in some cases as autonomous bodies. Many are anchor organisations of scale in their local place, with high social and economic impact beyond health and care. In terms of both the statutory and discretionary, individual employers are still the accountable default for the NHS, albeit in the context of directional and centralised policy-making which affects people agendas directly (for example in relation to the NHS Code and professional codes of practice) and indirectly (for example in relation to recruitment and retention).

2.3 People in Place - agendas for change at local level

The terms place and system are often used interchangeably or without proper clarity with regard to their difference. There are risks in doing so where governance is concerned. We suggest, therefore, that there is a useful distinction in role between place and system in terms of the governance of the people agenda.

Indeed, it is our view that embracing *place-based* governance offers a genuinely transformational opportunity to go beyond normal organisational boundaries. It allows us to look differently at long-standing intersectional issues at a local level between multiple agencies, partners, communities and individuals and include those not necessarily tied to the NHS or accountable for oversight of tax-supported activities and employment. This represents a major change of focus. Many people agenda approaches currently in action adopt a 'workstream' model, which allows for an approach which is both inclusive and flexible, enabling a radical agenda of change to be developed, albeit without traditional authority models. This makes sense for place.

However, we would suggest that s*ystem governance* needs to be more carefully defined, focused on outcomes assurance and, in the case of the people agenda, leveraging NHS strategic skills for place-based change. The use of public money requires both the rigour and agility offered by good governance in relation to structure, process and outcomes connected to national accountability frameworks. In particular, system governance should place greater emphasis on risk, on effective use of public money and on the connection between different assurance roles performed in the name of the system.

From our work, it is clear that the current agenda above local NHS employers and below national level is a mixture of the ambitious and the pragmatic, the proactive and the reactive, the statutory and the discretionary.

Box 6: The breadth of "above employer" people issues

Our review of agendas of people committees showed the range of system and place issues being discussed at employer level.

Workforce strategy e.g., supply, strategic oversight
Job redesign - clinical and non-clinical
International recruitment
HRD & employer support
Workforce transformation
Inclusive leadership
Regional talent management and OD
People experience e.g., health and wellbeing and values-based culture
National benchmarking
Employee engagement
Sharing good practice/learning
Bringing together corporate teams for integrated development agenda
Medical and clinical education
Equality diversity and inclusion
Resource prioritisation
Wellbeing
Engagement and communication
Identification of community/population trends

2.4 People in Place - a suitable case for subsidiarity

One of the elements we set out to test was whether the principles of subsidiarity can help prioritisation, reduce duplication and most importantly create a focus alongside good governance to provide a framework for system and place-based change.

Our review suggests that the principles of subsidiarity are being actively considered either explicitly or implicitly in different ICS settings as they develop, but that there is no consistency as to how they are applied.

This variance is important as subsidiarity is crucial to place. It helps tailor decision making and services to the particular needs of a population. Place-based working, by definition, is a structure that seeks to account for and to the population, history, population and institutions in a particular locality.[8]

Recently in healthcare, a range of documents and recommendations from the NHS England and the Department of Health and Social Care have suggested that systems should be adopting the principle of subsidiarity to guide their division of services.[9] Indeed, the NHSE Draft System Collaboration and Financial Management Agreement 2021/22 gives explicit mention to the establishment of the subsidiarity principle. Additionally, a number of organisations have suggested this should be a cornerstone of system-working.[10]

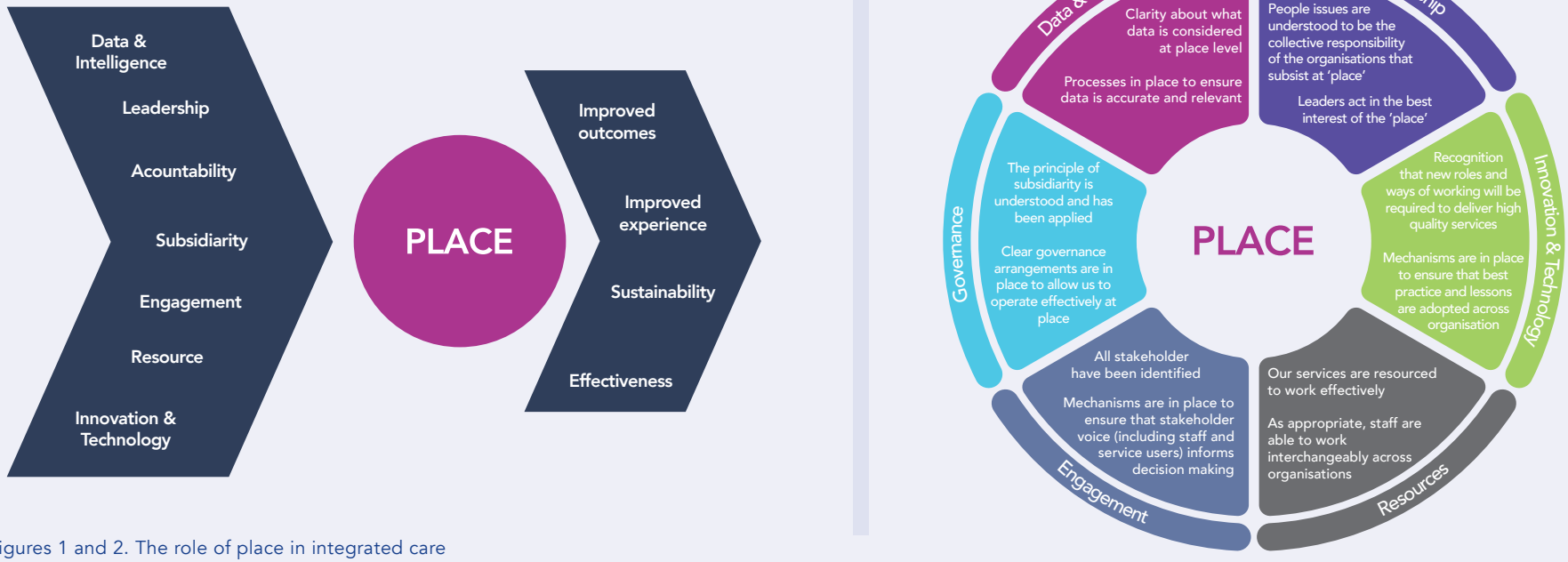
Yet it is not always clear what it means in practice. Subsidiarity can be understood as the principle that a central authority should only perform tasks that cannot be performed at a more local level. Subsidiarity is also about agreeing where responsibilities should reside and creating a multi-levelled system of clear responsibilities. Equally, to be successful, it should not mean implemented with the most important decisions made centrally and the least important more locally.

Fully realising subsidiarity involves reversing many previous assumptions around top-down NHS working. Crucially, subsidiarity is not only the delegation of responsibilities to lower levels, but a wider concept that promotes the freedom and autonomy of lower levels to organise and make their own decisions. As such, there needs to be multiple decision making centres that retain autonomy.[11] They must also be supported to find their own solutions to problems and develop uniquely local ways of serving the organisation's objective, in this case enhancing health and wellbeing.

Box 7: Subsidiarity or empowerment[12]

Empowerment	Principle of Subsidiarity
Empowerment is a means for obtaining better results or competitive advantages.	This principle prescribes the creation of structures, according to groups circumstances and needs.
Managers assign part of their power to employees.	Recognition that lower levels should have the power to organise their own work and to make decisions.
Frequently used as a pragmatic tool or as a technique.	This is a principle of reflection which needs careful and wise consideration of circumstances before it is applied.
Empowerment permits workers to make decisions. Some authors give suggestions for how to succeed in empowerment.	The principle of subsidiarity requires that workers organise themselves and make decisions stimulated by management. This could include training and technical and personal support.

Box 8: The meaning and value of subsidiarity in action



Figures 1 and 2. The role of place in integrated care

Advantages

Enhances access to local and informal institutional knowledge
Enables feedback to higher levels on the impact of rules and instructions
Allows aims and instructions to be implemented to adapt to each local problem, rather than a generalise approach
Enables easier creation of metrics that can be affordably monitored
Delivers diverse solutions to common problems and therefore avoids wide-scale system failure by providing autonomy to individual units
Provides local groups with maximum scope to solve problems they face in the way that suits them best
Clarifies accountability and responsibility over which decisions should be made at certain levels
Reduces duplication as decisions only need to be made once
Promotes legitimacy among the local population through the proximity and involvement with decision making

2.5 People Committees - lessons and learning

Over the last decade the people agenda has become more defined and received greater attention at board level in the NHS. Traditionally finance and quality have tended to dominate board time, driving information to support assurance. It is not unreasonable to say that many boards have tended to be reactive and retrospective and not well served in terms of good intelligence and data around the people agenda. This is perhaps not surprising given the regulatory impetus provided by the CQC.

The introduction of People Committees at various levels is one mechanism that Boards have used to help manage and address such challenges. People committees come in different guises.

Box 9: Types of people committee

- People committee
- People and culture committee
- Workforce committee
- Workforce and OD committee
- People and remuneration committee
- People and digital committee
- Strategic people committee
- People and performance committee
- People participation committee
- People and organisational governance committee

> *We have made a lot of progress in the last year on delivering skills creatively through place-based consortia, but this is without having cracked the problem of longer-term workforce planning."*
>
> **CCG Chair**

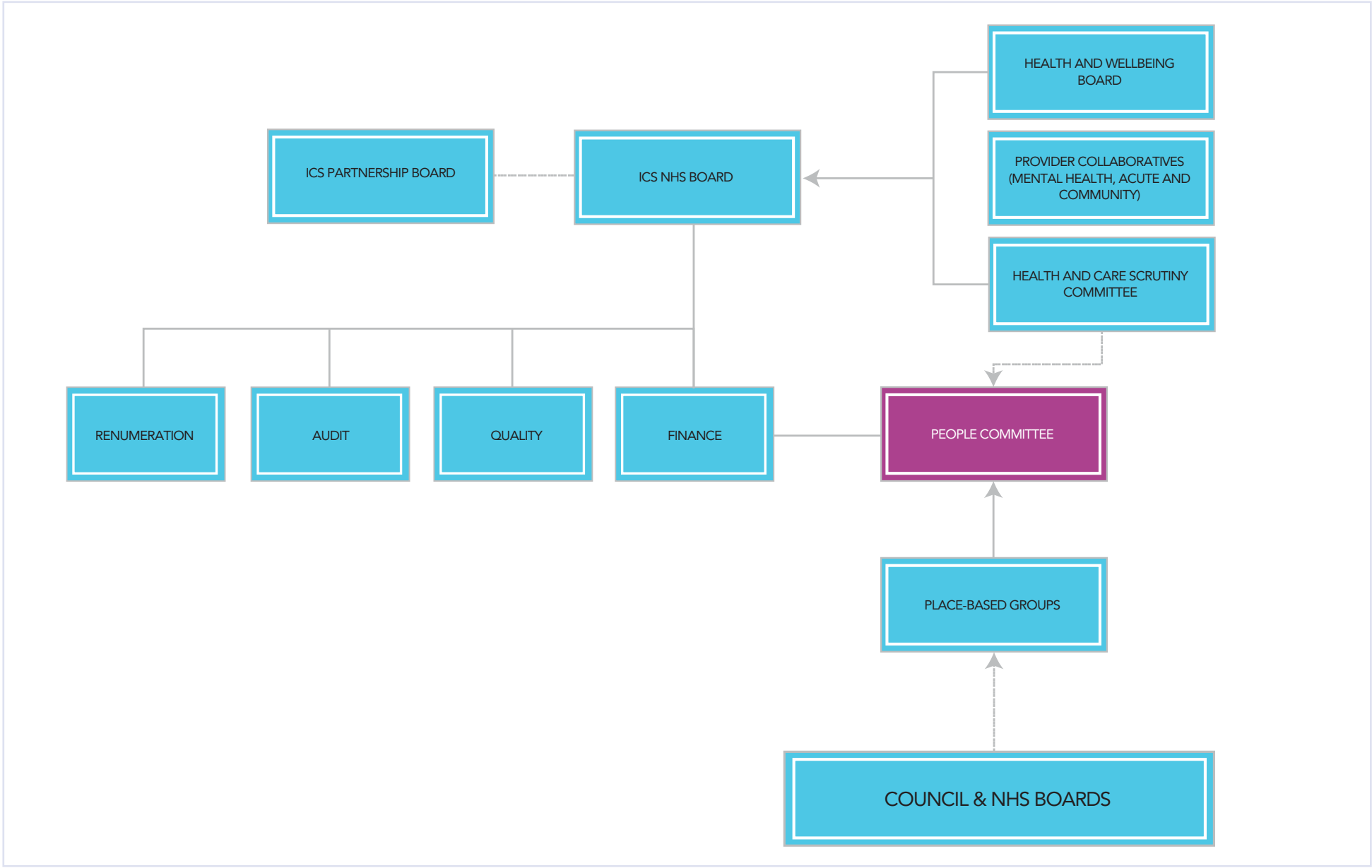


Figure 3. The Role of the People Committee in the new NHS structure

Generally, people committees are less developed in their ways of working and impact than quality and finance committees. There is also less clarity and precision about their terms of reference and focus, as evidenced by the wide variety of titles for similar committees. This is being replicated at system level.

There are clearly conflicts of interest built into any supra-employer accountability.

Our research is informed by a benchmarking exercise using 60 NHS people committee terms of reference, agendas and cycles of business. 40 of these were NHS trusts, which included acute, ambulance, childrens', community and mental services trusts, 6 CCGs and a range of regional, system and other public, third sector and private healthcare organisations.

This showed a wide variance, with some people committees clearly being well-established and performing a strategic and assurance role on behalf of the board and embracing and engaging with the complexity. Others, however, seem to be struggling to find a route through complexity and focus almost exclusively on current compliance and generalised strategic intent.

> *When you're convening leaders from different organisations you need to have specific issues or barriers that you are actively trying to overcome and goals you are trying to achieve. That way everyone can buy into the process and know what they are getting out of it"*
>
> **Local authority CEO**

Overall, we believe the following is a fair assessment:

- *There is no consistency in purpose, title or membership issues.*
- *Issues constituting the people agenda vary depending on organisation and sector and include areas such as pay, EDI, organisational development, tracking progress against people strategy, monitoring people risks, succession planning, talent management, appointments, performance management, staff consultations, work practices and health and safety monitoring.*
- *The core function of most people committees is a focus on evaluating the organisation's People Strategy, ensuring it was meeting the stated strategic objectives and making strategic recommendations on policy and practice for these to be met. The broader issues considered by people committees seem varied and inconsistent.*
- *There is significant and worrying confusion about the role of the people committee as an assurance committee reporting to the board as opposed to it fulfilling an executive role. This is reflected in the chairs, which we found varies between a non-executive, a board-member executive and the director of human resources, and terms of reference which make the committee an executive committee which should not be reporting to the board.*
- *Often, people committees report their recommendations to the board at the following board meeting as well as any particular people functions and reporting specific to the organisation.*

- *Membership is drawn from a varied group.*
- *Most people committees we examined meet quarterly, but this varied from bi-annually to monthly. Additionally, a small number of committees use departmental 'People Champions' through a constituency model who would engage with people issues in their team, hear their views on the various issues the people committee is responsible for, and feed this back at meetings. This models some established practices at quality assurance committees.*
- *Often people committees remain too focused on operations and lack the space to think strategically. Many individuals we spoke to highlighted issues around evidence. Frequently, people committees lack compelling evidence, particularly around EDI. Reports and data presented are not consistently benchmarked against local or national comparisons or contextualised enough for leadership to get a comprehensive understanding of key issues. This should be buttressed by using a variety of evidence, ranging from individual staff stories to larger surveys.*
- *This was also reflected in the ways that evidence is gathered. Often modes of engagement with staff, or representation of staff groups on people committees, were inconsistent and not systematic. Instead, organisations should look to embed representation of unions, staff representatives and networks on their committees, rather than giving them ad hoc invitations.*
- *Too little time is devoted to system issues, influence and expectations. Levels of briefing and insight on important strategic repositioning of regulators and NHS national organisations, such as Health Education England Leadership Academy. and skills and economic regeneration partnership bodies, are not given enough emphasis or time and potential inputs to committees by partners undervalued.*
- *Benchmarking is often used inconsistently and often in response to specific issues. Metrics relating to social and economic impact of NHS bodies as anchor organisations remains largely at the rhetorical level.*
- *EDI has significantly grown in importance in the last eighteen months but embedding EDI in governance more widely continues to be elusive for many trusts.*

Awareness of these issues and trends in respect of people committees matters. It could directly shape the potential value, ways of working and expected impact of people committees at system level.

After all, people committees at systems level are likely to be dominated largely by members drawn from the leadership of component NHS organisations on their own people committees at employer level. There is a risk that this might become a limiting factor in terms of mindset and ambition at system level.

The following visualisations present the frequency of topics, role composition and evidence from the people committees we examined.

Issues considered by people committees at institutional level:

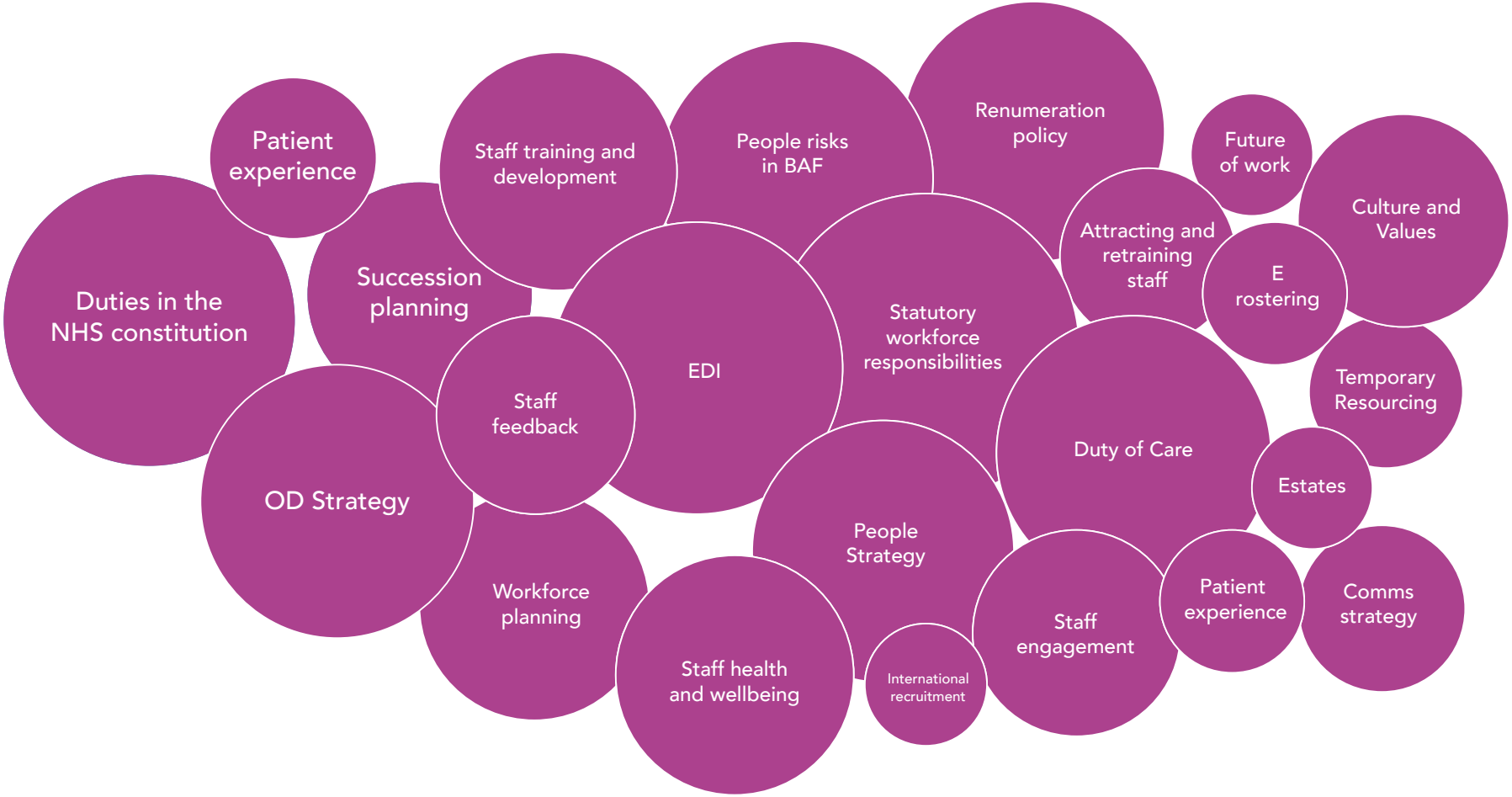


Figure 4. Frequency of issues considered by people committees

Typical membership of institutional people committees

Composition again differed across sectors but frequently the Committee was chaired by a board member, Chief Executive or Director of Human Resources. The Board Secretary and selected Executive and Non-Executive Directors comprised the committee members.

Figure 5. Membership of people committees

Evidence examined by people committees

The evidence examined by each people committee depended on its specific duties as stated in the Terms of Reference and sector. Examples of this include staff consultation reports, proposed appointments, people risk registers, Board Assurance Framework, health and safety reports relevant to people from the Health and Safety Committee and HR-related Key Performance Indicators.

Figure 6. Evidence examined by people committees

What are the lessons to be learnt of most relevance to people committees at system level?

Box 10: Lessons from people committees

Genuine authority and leadership

- the people agenda must be seen as being genuinely led by the CEO with cross-professional leadership
- people committees need to be endowed with the authority and influence, in their terms of reference, to challenge and shape people strategies at all levels not just "at the top"
- workforce issues need to be given equal importance as finance in the minds of the board. This should be reflected in reporting processes and lines of accountability to the board and to other committees

Clarity on purpose, priorities and outcomes

- clarity of purpose and impact measures are vital to maintain strategic and assurance focus. This helps avoid any tendency for the operational to dominate
- clarity is needed on what constitutes issues for whole board consideration and those delegated with proper authority to the people committee, especially in areas such as values, culture, organisational development and pay, to avoid duplication and prevent any feeling of exclusion by non-committee board members
- attention to formal terms of reference at the outset is vital. This should include the committees' priorities, desired outcomes and, most importantly, metrics of success as part of a comprehensive dashboard of workforce metrics
- public reporting and board reporting against clear outcomes of people progress is a sign of confidence and opennes

Clear and planned cycles of business

- focus needs to be on both statutory and non-statutory agenda items with careful planning of capacity and time and a membership which reflects this
- the interconnection between people, quality and finance committee agendas is complex and duplicating. This can be helped by clear cycles of business

Clear roles and responsibilities

- the roles of individual committee members in advocacy, voice and influencing with system partners and with national stakeholders should be agreed and subject to regular assessment

Effective engagement of partners and stakeholders

- attention to partnerships and alliances, including the formal arrangements which support them such as Memoranda of Understanding should form part of the remit
- clarity on co-production with stakeholders (staff and service users/public) of policies and processes increases their likelihood of ownership and success
- the role of unions and professional organisations should be unequivocal and resolved. Effective partnership agreements which bring staff voice into formal governance are a sign of maturity of governance in respect of people agendas

Rigorous use and production of evidence

- useful strategic data needs to be driven by clarity and determination of board members (executive and NED) on what is needed, in the face of statutory demands for analytics and support time
- rigour on quality of people data, and the validation and triangulation of intelligence sources, should be a core responsibility of the committee and form part of the audit committee's cycle of business and responsibility

Identification and mitigation of risks

- people risks need to be identified as such and converted into clear mitigations and solution-based

Embracing learning, innovation and ethics

- learning, innovation and ethics should be core business for people committees requiring clarity in respect of the board and other committees

2.6 Summary of analysis

Our analysis of the key issues relating to people at place can be summarised in the following statements and observations:

People and culture committees (or their equivalent) at system level have the potential to provide a vital and energetic role in delivering population health outcomes, social and economic change and in fulfilling stewardship responsibilities for local assets (not just in the form of people).

People committees will be crucial in the execution of the wider people and place agenda. If implemented effectively, they can help ensure that integration works not just for institutions but for the staff who run them and the people they serve.

People committees should be central to ensuring that systems successfully negotiate the NHS's upcoming challenges by providing a designated space for scrutiny and assurance around people strategy to ensure the right steps are taken for a sustainable health and social care workforce.
There is a high level of enthusiasm for creating a dynamic approach to a progressive and transformational people and place agenda. However, this is currently dependent on individual enthusiasm and is therefore fragile and discretionary. Governance around place and system need to have a sharper focus on accountabilities, contributions and responsibilities for assurance, reflected in formal governance with consequences.

Rigorous application of the principle of subsidiarity is helpful in minimising areas of potential duplication and confusion between what can uniquely be done at national, system, place and employer levels. This strongly suggests that each level needs to have visibility not just on what the other tiers are uniquely doing, but also what they should not be doing. Irrespective of the final formal organisational and governance arrangements

System and place are different and need clear definition and distinguishing. People organisations at system level need to learn lessons from the institutional committees but also be distinctive.
The current models of assurance at system and place levels are prone to conflicts of interest. These need to be addressed with precision in supporting schemes of delegation and policies and processes. People committees have the potential to resolve complex issues which are tangled up in personal relationships at employer level.

Job redesign needs to cross professional and organisational boundaries and this can be effectively driven beyond employer competition at system and place levels.

Connection and visibility are needed between different assurance processes for quality, finance and people. This is about more than avoiding duplication. If progress towards population health is to be achieved, people and culture committees need to be given equal prominence to quality and finance in the development of ICS assurance models. The interconnection between all three committees and audit committees also needs modelling and thinking through with cycles of business which are planned together. This in turn requires a level of dedicated governance support, equivalent to a trust board or company secretary.

There is no consistency in current arrangements in terms of reference, focus, membership, size. This is not surprising given the incremental and local approach taken to date and represents both a strength and a problem.

Skills supply is arguably the biggest risk facing health and care and delivery of population health ambitions. However, risk appetite around people and place is hugely underdeveloped and, in many cases, absent from the business of place and systems working. It should and could provide the basis for joint working and collaboration but needs to be more openly stated and worked through in formal business rather than being assumed. It is also likely to be different from institutional or national risk appetites.

Unions and professional organisations have an important role to play at all levels. Staff and union voices seem too distant and insufficiently included in systems development and governance. People in place is a multidisciplinary, multi sector agenda requiring agile and strong governance. Heterogeneity of committee membership and inclusivity in design and implementation is of vital importance. More work is needed on governance of people and place, if the unique opportunity to leverage real change is to be taken.

Our analysis has concluded that many of the key decisions and approaches to people issues at system and place level will need to be made by local leaders from different backgrounds. We also believe there is not yet sufficient practical guidance and support available to support those taking responsibility for the stewardship of people in place in the space between national bodies and employers.

Part Three

Resources and Outcomes

This section sets out resources and tools which are intended to be helpful to local leaders and policy makers in strengthening local governance of the people agenda as systems governance is developed and implemented during 2021-22.

These resources include:

- *a subsidiarity matrix for people issues in health and care*
- *a design resource for use in shaping governance of the people agenda at system level*
- *a mindset prompt*
- *a risk appetite prompt*
- *a core agenda for a collective people committee at system level*

3.1 Subsidiarity matrix

The following subsidiarity matrix has been developed through work for this report. It provides a clear means of differentiating the contributions and focus for each of the four main elements of employer (institution), system, place and national authority.

The distinction between system and place are important as the contribution and the governance of each is likely to be different.

It would be possible to add Regional as a fifth dimension to reflect a further gathering point for authority, but we believe that focusing on the four dimensions provides a more rigorous and helpful framework, reflecting the NHS guidance language and intent.

We suggest that for each issue or dimension the specific focus, contributions and outcomes can be mapped as part of an integrated whole, allowing the governance arrangements to reflect interconnections and expectation from one to another.

> *Moving people and resources around the system will still be a real problem unless there is much more trust and agile governance."*
>
> **Mental Health Trust Director of Finance**

Box 11: A Subsidiarity matrix for people issues in health and care

Issue	Institutional level	System level	Place level	National
People strategies and outcomes				
People risk: identification and mitigation				
Statutory requirements: policies and procedures; regulatory compliance				
Pay and reward				
Equality, diversity and inclusion and cultural norms				
Recruitment and retention				
Education, skills and capacity building				
Workforce and capacity planning				
Health and wellbeing				
Future of work and new ways of working				
Leadership and mindset				
Talent management and succession planning				
Values and culture				
Engagement and voice				
Professional standards				
Learning and innovation				
Communications: staff and stakeholder engagement				
Impact assessment, data, internal and public reporting				

This means the matrix could be used to identify the specific and unique contribution at each level, making the connections, interdependencies, expectations and outcomes clear and capturing them. This approach was strongly supported by those engaged in this project.

Over time, this analysis could be used as the basis for a maturity matrix approach around governance at each level and their development, connectivity and the overall coherence and integrity of governance of the whole people agenda. The intention here is to include a matrix which also deliberately separates out the contribution on place and system which have different functions (as explored earlier in this section).

At a system level there are emerging approaches to the governance of system issues, including the people agenda. These are being developed in the absence of clear central direction on agenda and governance. The recent guidance on ICS design has not fully clarified roles and responsibilities and it remains uncertain which aspects of the guidance will be legal requirements moving forward. In the absence of specific requirements for governance arrangements in relation to the people agenda, many systems and their interface with national agencies are largely hidden or not captured explicitly.

Where these do exist, systems governance tends to be presented thematically, supported by workstreams with supporting information on what will support progress and governance and accountability backed up by high-level dashboards. In most cases these take their lead in terms of themes from the national people plan and blend place and system accountabilities and responsibilities.

The North West People Programme[13] is a good example of current thinking; working to four strategic themes, channelled into five workstreams, supported by three enablers, an analysis of strategic risks and a series of network leads. The summary is below.

> *Locally I feel the practicalities of the most important staffing issues have not yet been thought through by the NHS in partnership with us and with a proper focus on social and economic impact. There is a real worry about there just being lip-service about place in the national guidance."*
>
> **Local authority CEO**

Themes	Workstreams	Enablers
Looking after our people	Workforce supply	Workforce modelling and intelligence
New ways of working and delivering care	Workforce transformation	Equality diversity and inclusion
Belonging in the NHS	HRD and employer support	Social care
Growing for the future	Inclusive leadership talent and OD	
	People experience and health and well-being	

Figure 7. NW People Programme approach to subsidiarity

The supporting explanatory papers on governance set out a clear connection between the workstreams and strategic collective intent:

"Our overall aims are that our activities improve population health, reduce health inequalities, ensure the delivery of safe, effective, inclusive compassionate care to our local communities and existing patients and service users through the growth, development and support of our amazing health and care workforce."[14]

The NW People Programme also has a governance structure including named individuals and organisations which include groups, boards and forums.

This is a particularly helpful example as it has been based on adopting a subsidiarity approach as a guiding principle.

Most other systems are putting in place or have in place governance arrangements which mirror employer committee structures based around quality, finance, audit and remuneration, as well as people committees.

Looking more broadly across the NHS in England, there appears to be little consistency as to where the lines of responsibility are drawn between the four tiers and marked differences in focus and outcomes and impact measures. Some look to take a more facilitative place-based approach involving local and national partners in reporting and/or accountability arrangements, including local authorities and the third sector. These typically have a greater focus on one issue over another, such as skills and supply, and social and economic measures, or on a specific programme of work around creating new models of care or work.

In all cases we have seen, accountability for the people agenda is internal to the NHS, built around NHS accountable board members and executives from within that system. People committees at system level which are functioning, attempt to cover the whole people agenda rather than targeting one or two clear objectives, with shorter time-lines and clarity on governance, public reporting and outcomes/deliverables. There is significant confusion between place-based governance and system governance, about cycles of business, connectivity and accountability and about the data and information flows.

This analysis is not intended to convey criticism of any specific local arrangements or more generally. It is perhaps inevitable that in the absence of any specific guidance that there will be diversity of approach. It raises a concern, however, about how a national implementation approach will engage with this diversity in its guidance and requirements, and whether local arrangements already in place will need to be significantly adjusted as central direction becomes clearer.

We wanted to explore whether it was possible to identify a constructive way of reconciling local diversity and variance with the obvious requirement for clarity and consistency on governance and accountability.

We now examine the potential for people committees to provide this anchoring and energy at a time when it is needed. Getting the design right for the governance of the people agenda at system/place level should matter to both policy makers and local leaders. From our work we suggest this requires:

- *a clear set of design principles based on the principles of good governance and subsidiarity*
- *a leadership mindset which is specific to place*
- *an agenda which is ambitious, focused and pragmatic.*

3.2 People committee at system level - a design resource

This sets out a check list of success criteria for consideration in getting system people committees established on a sound footing and fulfilling it's responsibility as a distinct entity. It includes prompts both for those designing the committee and for members of the committee. They build on the learning from the previous section and on evidence from GGI on what works in good committee design.

Box 12: People committee at system level - a design resource

	Prompts	Comments
Title	- Does the name of the committee reflect it's system purpose?	• It may be useful to avoid workforce as this is too limiting to employers • We suggest a default of "People and Culture"
Purpose	- Is the purpose agreed with the board as an assurance committee and clearly stated as such? - Is there a formal set of terms of reference which translate this purpose into responsibilities and focus?	• Important in relation to people committees to ensure they do not act as executive committees/management groups or fulfil executive functions
Outcomes	- Are short-term and long-term outcomes and measures signed off? - Is there a strategy for people which has been developed with wider involvement? - Are expectations of contribution from others outside the NHS clearly articulated and agreed?	• The legitimacy of an above employer strategy on people needs special attention. It needs to be more than an amalgamation of the strategies of component bodies and have a focus, clarity and character of its own
Authority	- Are our authority and accountability clear and how do we know this? - What exactly do we have stewardship responsibility for?	• It could be useful to look forward to decisions that will be made and how they are validated and reported in some detail to stress-test issues of authority
Accountability	- Is the specific responsibility for resources clear?	• If system-based governance is to leverage change, clarity on "ownership" of people resources and their movement across the system and with partners is important to get right at the outset
Scope of decision making	- Are decision making powers clearly delegated from the board and secured from employer boards?	• It is important to distinguish between influencing and discussion
Leadership and roles	- What does leadership at system level mean in a way that is different from employer or national leadership roles? - What skills are needed in the committee? - How is independence and relative autonomy for action going to be achieved?	• This should not be about the authority of component bodies. For example, the chair and members should not simply be taken from employers or the governing body of the ICS. Capacity and energy need to be identified for the specific purpose and outcomes identified uniquely for the people committee at system level

	Prompts	Comments
		• One question to consider is whether independent NED oversight is needed. If so, how is that going to be achieved?
Mindset	- Is there a distinctive system mindset based on what the committee uniquely will do?	• This needs to be distinct from employer mindset (see section 3.4) • How will this be supported and developed further?
Membership	- Do we have a membership which is specific to the purpose of the committee and gives it sufficient independence and agency?	• Heterogeneity is critical – professional leaders need to guard against strategic people issues defaulting to being HR issues rather than collective professional and skills-based
Business flow	- Is it clear how the agenda is agreed and by whom? - Is the agenda and cycle of business precise and realistic?	• We suggest a short agenda focused on a small number of specific issues uniquely owned by the people committee (see section 3.5)
Formal relationships	- What are the relationships with audit, finance and quality? - Are there MoUs in place around deliverables and dependencies?	• Ensuring that there is balance between agendas is important to engender the right level of focus"
Risk appetite	- Is there a shared risk appetite which has been developed collectively and captured?	• We suggest external/independent facilitation around strategic and practical examples will help
Engagement	- What are the responsibilities for communication?	• If the remit includes messaging on behalf of the system this requires particular attention early on
Reporting	- What are the reporting arrangements internally to the NHS, with partners and to the public?	• Public integrated reporting is recommended
Governance support	- Are adequate resources in terms of capacity, time and skill in place?	• Dedicated time from governance support equivalent to a board secretary is needed to make the cycle of business land. The same question should be asked of other committees on which the people committees depend
Conflict resolution	- How are conflicts of interest defined and declared? - Are processes for handling disputes in place and formally agreed, including escalation?	• This is potentially a complex issue to get right given multiple roles of committee members. Important to set out handling and accounting for conflicts at the outset

3.3 People leadership at system level - a mindset prompt

Our analysis suggests that the system people committee will need to adopt a distinctive mindset if it is to operate in the right space and with the right collective focus.

It is important that members feel committed to the specific purpose and role of the system committee and do not import any unhelpful expectations from other roles and committees they are members of.

It will obviously be down to each committee to decide what approach to take to establish, capture and support a positive mindset which creates the intended impact for the committee.

We suggest time is spent early in the life of the committee by members working together on the markers of culture in the committee. Drawing on the work for this report, we suggest discussion should cover not just what the committee will do but also equally importantly what it will not do.

Given many of the committee members will be well-known to each other, considering mindset in this way will help grow collective intent and focus on active participation in fulfilling the committee's purpose.

It is important members do not just show up, but are actively present as members sharing accountability, not just participants and contributors with perspectives and interests.

> *"We have made good progress as local senior leaders in growing a collective mindset based on commitment to collaboration. But to be honest it is going to be the detail which addresses our capacity and workforce issues together, as NHS employers still dominate."*
>
> **Third sector director**

Box 13: Mindset prompt

What not to do (we will not...)	What to do (we shall...)
Frame people in narrow terms reflecting historical definitions and professional divisions	Include all skills needed to deliver population health outcomes
Just re-describe problems	Frame what we do in terms of action
Repeat or parrot the national agenda	Interpret for local relevance and influence
Restrict contributions to meetings	Be active and advocatory on people committee purpose and business
Mirror a debilitating everything or nothing mentality	Choose a sharp agenda with clear impact and outcomes on a small set of strategic issues
Replicate what others are doing	Be clear on unique contribution and have measures for all outcomes
Act as project leaders or workstream leads	Act as an assurance committee with a defined governance accountability
Be passive on available data and information	Demand the information we need for committee purposes

What not to do (we will not...)	What to do (we shall...)
Defer to the biggest employer	Act collegiately and have agreed ways of challenging each other
Be closed	Invite participation from national agencies as active ingredients in local solutions
Stick to narrow accountabilities and positional authority	Make both ambition and action collective responsibility for the committee
Confuse place and system	Be precise on the specific accountability and assurance role of the committee
Use governance for control and compliance	Use governance to enable
Focus on "people" in isolation from related issues of quality, finance and governance	Make connections and be open to connections between quality, finance and people
Be dominated by HR agendas and language	Ensure heterogeneity and diversity including cross-professional leadership
Default to consensus	Adopt a challenge mindset with processes for openly addressing conflicts and disputes
Be seduced by examples from elsewhere	Think at a scale that works locally
Make this about employers and HR	Seek clinical and staff buy-in in everything we do

3.4 Risk appetite prompt

Leaders will need to be bold if they are to make strides in addressing workforce issues. Making a big impact will necessitate some risk taking. Crucially leaders should not be blindly exposing themselves to risk. Instead these should be carefully considered, calculated risks, in full knowledge of the potential benefits and negatives that may arise from them.

To systematically understand the amount and type of risk the organisation is prepared to take, it should consider its risk appetite. This enables leaders to balance the potential benefits of innovation and the threats that any changes inevitably bring. As such it should be at the centre of any organisation's risk management strategy.

This process of risk management is dynamic; risk probability and impact as well as risk appetite can change through circumstances and experience. The perception of the public to risk and confidence in the organisation's ability to identify and mitigate risk successfully can shift quickly in the light of publicity and risk failures often outside the direct control of the organisation. As such, risk awareness and communication play an important part in protecting the reputation of the organisation from such instances of outrage.

For more information see Appendix 1 the GGI Health and Social Care Partnership risk appetite prompt.

3.5 People in Place - a core agenda

An effective system people committee will need to carve out a specific role in a crowded environment where most of the strategic agendas are held in or influenced by multiple bodies and individuals. Settling on an achievable agenda and a cycle of business will therefore be critical to the success of the committee.

We suggest a system people committee should focus only on those issues where it can be an agent of measurable progress or where it has specific assurance responsibilities which it can reasonably fulfil. Each system will of course want to set their own approach, reflecting local priorities, capabilities and aspirations. The subsidiarity matrix for people issues (section 3.1) should help.

Here we illustrate how lean an agenda could be to achieve real impact and add value. We use the term people and culture committee to reflect its purpose.

> *"It's so important that when we relocate responsibility, we also relocate authority"*
>
> **ICS Chair**

Box 14: Illustrative agenda - People and Culture Committee

Core agenda - main focus and outcomes

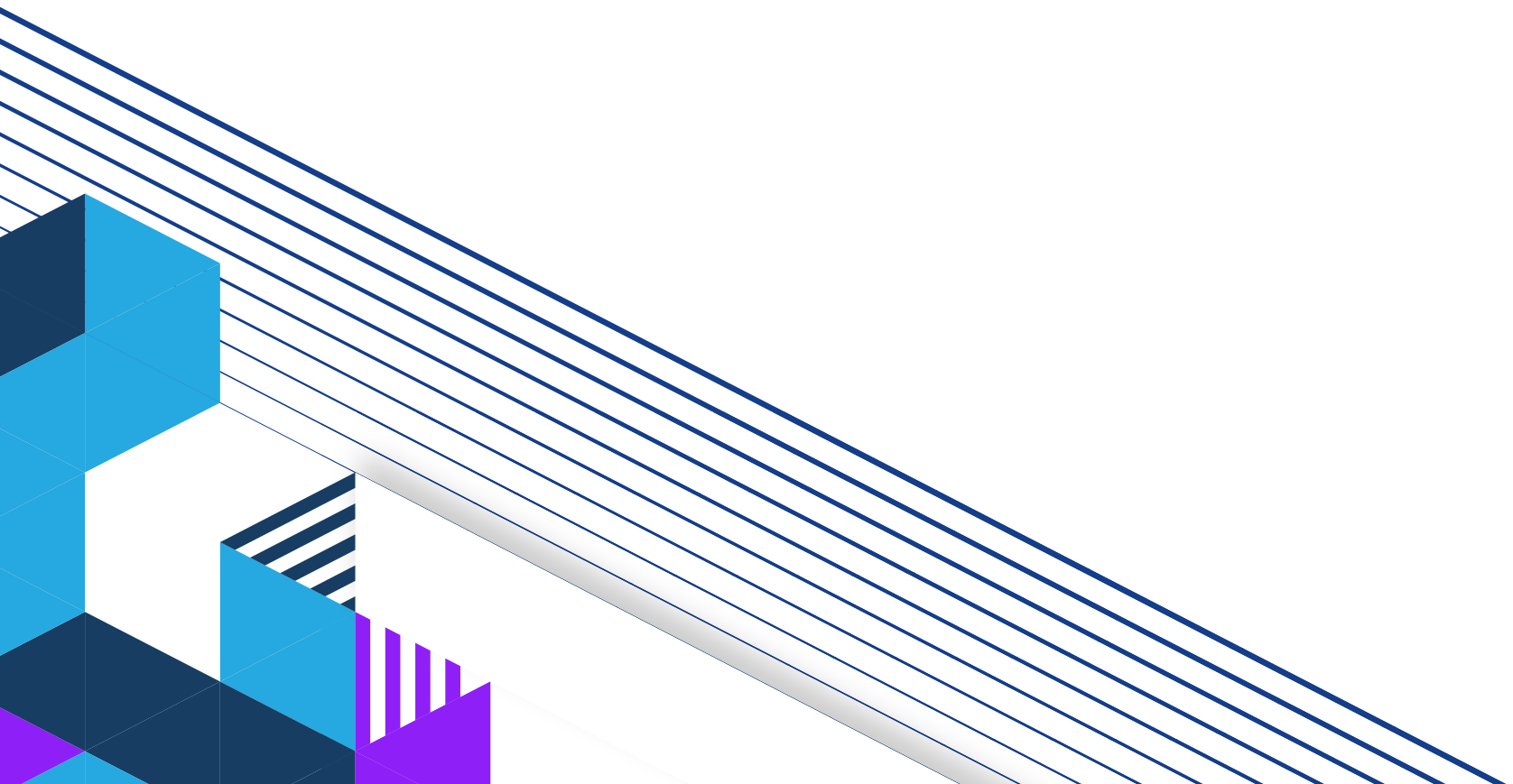
Agenda item	Focus	Activities	Potential Outcomes
People strategy and risk	Creation of an integrated approach to people issues between the NHS and its partners Focus on system and place risks and mitigations	Narrative development Risk assessment	Clarity of a shared and focused agenda Shared risk appetite between employers and partner organisations on health and care people agenda
Skills and capacity building	Mobilisation and rebalancing assets and skills towards prevention and population health Taking responsibility for ensuring place and neighbourhood levels have the skills and capacity to autonomously discharge their responsibilities	Commissioning analysis of future skills needs for place beyond the NHS Deployment methodologies between employers Terms of employment and agreements with suppliers of skills Oversight of new ways of working which cross organisational and professional boundaries	Positive move from "workforce crisis" narrative to greater mobilising of skill System-based skills planning and capacity building Scheduling and deployment of skills across boundaries A single capacity building/OD approach

Agenda item	Focus	Activities	Potential Outcomes
Cultural cohesion - equality diversity and inclusion	Establishing consistent standards and expectations on EDI within the NHS system and with the public	Assessing consistency and impact of individual employers minimising duplication and reinvention; promoting good practice	An integrated cultural statement at system level Ownership of unions and professional organisations of system thinking and working
People data and information	Developing fit for purpose people information to support system working and strategic objectives	Core data set for systems Ensure data transfers support subsidiarity principles	Single data sets for the people agenda and greater consistency and use of information
Learning and innovation	Supporting conditions for innovation Sharing of learning across organisational boundaries	Creating communities of interest and learning Coordinate local embedding of digital practices Commissioning assessment of new pathway skills Creating programmes to stimulate and reward innovation	New local models of working Coordinated capacity building
Messaging and communications	Providing a consistent connection to the local population		Promotion of NHS and partners as good employers and career destinations

We recognise that this will not be seen as comprehensive and may well not reflect progress being made in each system or perceived accountabilities. Our point is that simply making progress on these six specific issues with clear deadlines would be transformative in a complex environment and make a decisive contribution. It might be that focusing on one alone would be enough.

Just getting the data from provider organisations has been a nightmare as everyone thinks in different ways"

ICS Chair



Part Four

Recommendations for Action

People in Place was set up as a programme of work to explore a range of governance issues of immediate relevance to statutory and mindset changes in system and place during 2021-22.

These conclusions are meant to be of practical use to those designing or actively involved in system and place-based governance both now and in future.

Our report suggests there would be value in adopting some guiding principles for leaders and policy makers in designing the effective governance of the people agenda at system and place levels.

We suggest that local arrangements for both place and system governance on people are supported by guidance on the application of good governance rather than central instruction and imposition."

We suggest there needs to be a clear distinction made between a place-based workstream approach and a system-based governance approach.

We make four practical recommendations.

Recommendation 1: National guidance to support people in place is developed and issued in line with this report

It is worth reiterating the small set of guiding principles which underpin our conclusions about what will drive success of step change and added value on people agendas at system and place level.

This would include:

- *a short, good governance guide to support local arrangements*
- *the subsidiarity matrix included in the report*
- *a risk appetite prompt specific to systems governance*
- *the mindset checklist included in the report*
- *outline terms of reference for a people committee*
- *a set of success criteria*

We suggest this should not be left to local development alone. There would be value in these guiding principles and prompts being adopted consistently and we would hope they would be used to shape national guidance as well as being relevant to local leaders.

Our suggestion is that any guidance should be enabling rather than directive so that local variation is encouraged but consistency of principles and their interpretation is supported.

In addition, we strongly suggest that consideration should be given to extending the duty to collaborate specifically to cover the people agenda.

Box 15: Guidance prompts for people committees

- Treat the people agenda as equivalent importance to those of finance and quality in securing collaboration with impact and requiring equivalent attention and governance
- Apply the principles of good governance in both design and operation
- Adopt an explicit and rigorous approach to subsidiarity (Box 3)
- Invest in the people committee as an assurance committee with clear authority
- Identify a distinctive people agenda with impact measures of success (Box 12)
- Learn from the experience of people committees at trust level but do not replicate them
- Distinguish clearly between the governance of place and system
- Adopt a mindset based on what a people committee will NOT do as well as what it will do
- Resolve a formal shared partnership model with unions and professional organisations
- Participate in networks and share ideas and resources systematically

A lot of previous attempts and tackling these big problems have been done in silos. We need to a new approach that brings these efforts together"

Local authority CEO

Recommendation 2: Investment should be made to support system People Committees

Our work suggests that there is the need for more dedicated technical and governance support to ensure the work of the people committees is not compromised by other demands. This is important as in most cases the main members of the committees and those responsible for supporting their business are drawn from component NHS organisations. This has implications for independence and focus.

We would strongly suggest that given their importance people committees at system level should have a balance of clear independence in their governors, to avoid conflicts of interest and self-interest distorting business, focus and progress. There is currently a real danger of this happening if the committee is essentially made up of, and supported by, members of NHS component bodies on whom the committee's work should be having impact. One of the lessons from the integration joint boards in Scotland is the need from the outset to ensure that these risks and identified and actively mitigated.

This analysis suggests that careful attention must be paid as to whether the non-executive members are able to act with independence and fulfil their roles and responsibilities in the setting of the committee. This should meet an objective standard. An independent assessment of the effectiveness of these arrangements would in our view be a minimum.

It also suggests that any people committee at system level should have dedicated governance support to ensure it meets the core requirements of good governance in respect of cycle of business, flow of information and attention to matters of risk. This equally applies to other systems committees

One area where more work is needed is around the degree to which an independent chair might be needed to provide the right degree of separation between the NHS employer bodies and the people committee.

Recommendation 3: Further work is undertaken in a coordinated way on a set of lines of enquiry/enabling questions

There are several issues or lines of enquiry which have emerged from this report which are in Box 17. Others will undoubtedly occur, and surface as national guidance and local practice continues to move forward during 2021.

There is also a clear overlap with equivalent questions in respect of systems governance more widely and quality and finance in particular. GGI will continue to frame and share these through its communication channels and networks including the ICS, mental health and NED webinars and events and the Festival of Governance and National Commission on the future of governance in the public sector.

Recommendation 4: A Community of Interest is created to support the effective development of people in place.

People in Place continues beyond production of this report. We have placed on-line an archive of material used to inform the report in an independent Resource Centre. We are keen that this develops as a space where the governance of place and systems are worked through during 2021-22 as a community of interest, with or without our involvement.

Box 16: Emergent lines of enquiry to be explored

- How can governance at system and place best complement one another?
- Is there a role for independent non-executive oversight in the governance of people (and other assurance committees) at place level?
- What are the most effective ways of identifying and handling system-level conflicts of interest?
- How should risk appetite be developed and supported at system level?
- What role could and should staff and union/professional organisations play in the development and delivery of the people's agenda at system level?
- What are the conditions for subsidiarity to be successful when delegating to system, place or neighbourhood level?

Box 17: People in Place Resource Centre

Purpose

The intention would be not to duplicate work being undertaken elsewhere but would allow:

- live engagement by a mixed community of leaders and stakeholders as the statutory and operating climate becomes clearer
- advocacy for a proactive approach to promoting the potential of a people in place agenda
- sharing of experience and insight and progress
- development and refinement of supporting models, tools, intelligence

To be effective we suggest a core steering group for overseeing the content and focus. It's work would be open, engaged with and communicated widely.

Membership could be drawn from:

- A balance between executive and non-executive (not necessarily "representative")
- Professional leaders for medical, nursing, other skills from NHS and partners
- CEO/AOs
- Finance directors from NHS
- HR and OD expertise - workforce planners
- HEE
- National policy leads
- Unions and professional organisations
- Third sector professional leadership
- Private sector
- Higher and further education

Meeting frequency:

- At least every two months

GGI and Allocate would be willing to host.

Conclusion

The focus on people in place is not just timely. It is an essential area for immediate action.

This seems to be a genuine moment when a decisive step forward could be made on the health and care people agenda. If it is not taken then the consequences in terms of mitigating mission-critical strategic risks could be severe.

We believe that a focus on people committees as a critical agent for change at system level provides one of the governance foundations for improved health and care outcomes and positive social and economic impact on populations. Our report is intended to help progress along that path in a practical way.

We would like to thank Allocate Software, and especially Liz Jones and Hayley Boulton, for their enthusiastic support in making this report happen, and also those who gave their time generously in interviews, in workshops and in roundtables who are listed in Appendix 2.

> *We will achieve more if we blur our own autonomy. It is an absolute no-brainer that pooling our resources will lead to new and innovative ways to serve local communities"*
>
> **ICS Chair**

August 2021

Good Governance Institute contacts:

- Mark Butler, Executive Director (Partner), Good Governance Institute
- Christopher Smith, Consultant, Good Governance Institute
- Sam Currie, Policy and Research Analyst, Good Governance Institute

Allocate Software contacts:

- Liz Jones, Marketing Director, Allocate Software
- Hayley Boulton, Head of Campaigns, Allocate Software

Appendix 1 Risk appetite board assurance prompt for health and social care partnerships

Good Governance Institute

Risk Appetite for Health & Social Care Partnerships
A maturity matrix to support better use of risk in partnership decision taking

Aberdeen City Health & Social Care Partnership
A caring partnership

DEVELOPED WITH ABERDEEN CITY H&SCP
V 1.1 OCT 2015

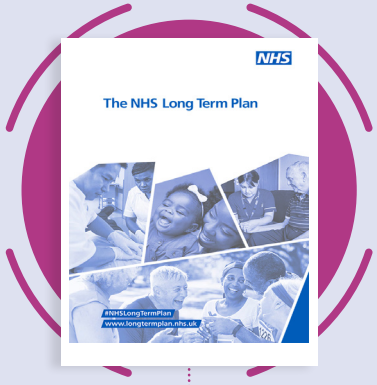
RISK LEVELS / KEY ELEMENTS	0 AVOID Avoidance of risk and uncertainty is a Key Organisational objective; No consensus by partners	1 MINIMAL (ALARP) (as little as reasonably possible) Partners have reference for ultra-safe delivery options that have a low degree of inherent risk and therefore potential for only limited reward	2 CAUTIOUS Partners have preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward	3 OPEN All parties willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 SEEK All parties eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)	5 MATURE Partnership confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
FINANCIAL /VFM	Avoidance of financial loss is a key objective. Only willing to accept the low cost option. VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept the possibility of some limited financial loss. VfM still the primary concern but willing to also consider other benefits or constraints. Resources generally restricted to existing commitments	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on potential opportunities.	Prepared to invest for the best possible return and accept the possibility of financial loss (with controls and assurances in place). Resources allocated without firm guarantee of return – 'investment capital' type approach	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself
COMPLIANCE / REGULATORY	Avoid anything which could be challenged, even unsuccessfully. Play safe	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation
INNOVATION/ QUALITY / OUTCOMES	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems / technology developments	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations	Tendency to stick to the status quo, innovations generally in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
REPUTATION	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management encouraged to distance themselves from any chance of exposure to attention	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Proactive management of organisation's reputation	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweigh the risks. New ideas pursued
APPETITE	NONE	LOW	MODERATE	HIGH	SIGNIFICANT	

Based on the Risk Appetite Matrix developed initially by HMT, 2005 and subsequently by GGI and Southwark BSU, 2011
ALL GGI matrices are published under license form the Benchmarking Institute.

WWW.GOOD-GOVERNANCE.ORG.UK

Figure 8. GGI Health and Social Care Partnership risk appetite prompt

Appendix 2 English Context at a glance



1. The NHS Long Term Plan

The NHS Long Term Plan (LTP), published in January 2019, established a vision for health and social care over the next 10 years, particularly emphasising the need for greater collaboration and integration between health and social care.

The document made a clear commitment to 'back our workforce,' which, it acknowledged, had been 'feeling the strain.' Some of the ways that it was envisaged this would be achieved included through:

- the development of a comprehensive new workforce implementation plan
- taking steps to increase the NHS workforce through 'thousands more clinical placements for undergraduate nurses, hundreds more medical school places, and more routes into the NHS such as apprenticeships'
- leadership and talent management
- plans to make the NHS a better place to work including through

2. The NHS People Plan

Just over a year after the publication of the LTP came the NHS People Plan. Published by NHSE/I and Health in July 2020, this important document set out what the people of the NHS could expect from colleagues and leaders for 2020 and into 2021.[15]
In particular, the People Plan acknowledged the impact of COVID-19 and established six key themes for the future:

Figure 9. NHS People Plan

Whilst welcomed in some parts as a step forward for the sector, the People Plan was also criticised upon its publication for not progressing many of the actions outlined in the LTP. Some of the key criticisms include that:

- The plan lacks the long-term investment and concrete commitments required to recruit the doctors, nurses and other staff needed to address workforce shortages and meet the government's manifesto commitments
- The additional work that is needed to treat the cause (and not the symptoms) of health and wellbeing issues e.g., normalisation of chronic excessive workloads, is not sufficiently explored
- There was no equivalent plan for social care

3. Integration and innovation: working together to improve health and social care for all

More recently, several key documents have been published which set out the Department of Health and Social Care's White Paper, *Integration and innovation: working together to improve health and social care for all*, sets out legislative proposals for a new 2021 Health and Care Bill and further crystalises future ICS arrangements.[16]

As the document is principally concerned with the establishment of the ICS, it does not cover workforce issues in any detail. That being said, there are several aspects that will be relevant to this research topic. Firstly, the paper proposes a new legal duty for all NHS providers, together with the new legal entity that is the ICS, to collaborate to address the needs of local populations. While the detail of the duty to collaborate' has not yet been provided, it is likely to have positive ramifications for partnership working. For example, it could viably lead to increasing staff sharing arrangements and more strategic workforce management.

The current proposal is for the ICS to be led through two different boards, an NHS body and a health and care partnership board, with different roles and responsibilities:

ICS NHS Board

- Responsible for the day to day running of the ICS and be comprised of NHS organisations
- Developing a plan to meet the health needs of the population within their defined geography
- Developing a capital plan for the NHS providers within their health geography
- Securing the provision of health services to meet the needs of the system population
- Delivery against local priorities set out in ICS strategy and local people plan

ICS Health and care partnership

- Brings together the NHS, social care, public health and other partners from the wider public space to developing a plan that addresses the wider health, public health, and social care needs of the system
- Developing a plan that addresses the wider health, public health, and social care needs of the system

Place

- Brings together a range of place-based leaders from the NHS, social care, third sector and other partner organisations with provider and commissioner leadership
- Delivery against place priorities in ICS plan, including primary and community care and population health

Provider Collaboratives

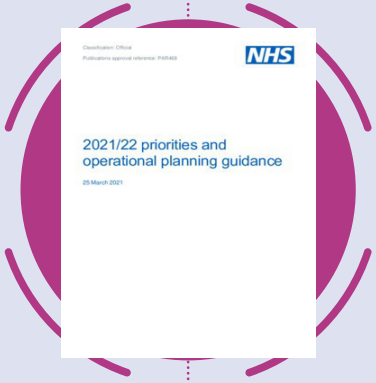
- Responsible for executing the ICS plans at a place and institutional level
- Most NHS trusts and NHS foundation trusts will need to belong to one or more provider collaboratives.
- Alongside participation in ICSs and provider collaboratives aims to build on, and further facilitate, collaborative working between NHS trusts, NHS foundation trusts and other providers in order to achieve the benefits of working at scale.

The introduction of this model would have implications for the implementation of people committees at system and place levels, with clarity needed around reporting and accountability as well as purpose and agendas.

System level	Example Collaboration	Focus	Forum	Objectives
System	All acute providers in an ICS	The system	ICS	Develop strategic commissioning to achieve population health outcomes
Sub-system, system or cross-system	All organisations who provide NHS care	A particular population	Provider collaborative	Achieve benefits of scale Drive quality improvements and service change and transformation
	All organisations providing • mental health • acute services	Service provision		
Sub-system	All NHS organisations providing health and care to a discrete population	A place	Place-based partnership	Provide joined-up care, prevention and wellbeing

Figure 10. Types of collaboration

It is hoped that operating at scale will improve workforce planning and use of resources, including clinical support and corporate services. Whilst this is positive, our recent research indicates that several pitfalls including a lack of clarity around purpose and limited stakeholder engagement can stymie progress in this space.[17] Boards will need to be clear about the aims of their provider collaboratives and also around core governance issues such as subsidiarity. This will also have obvious implications for the people agenda, particularly around how teams and individuals function.



4. NHS Planning Guidance

Swiftly after the publication of the Department's White Paper, came NHSE's 2021/22 Priorities and Planning Guidance, setting the NHS' priorities for the next year.[18]

The Guidance acknowledges many of the significant challenges that the NHS is now facing: a need to restore services, meet new care demands and reduce caused by the pandemic, whilst also supporting staff recovery and taking further steps to address inequalities in access, experience and outcomes.

That being said, delivering the Guidance will stretch staff, especially given the trials of the previous year. The Guidance is supporting the health and wellbeing of staff and tackling recruitment and retention. It acknowledges the extraordinary efforts of staff over the previous year and outlines the steps that will be needed to support staff further over the coming year. This includes:

- Looking after our people and helping them to recover
- Belonging in the NHS and addressing inequalities
- Embed new ways of working and delivering care
- Grow for the future

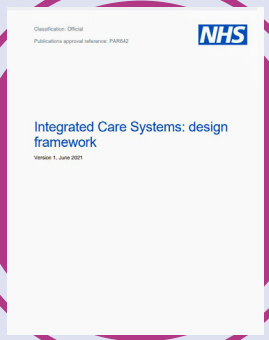
Delivering these priorities will require a joined-up approach. In particular, systems are asked to:

- Develop and deliver a local workforce supply plan with a focus on both recruitment and retention, demonstrating effective collaboration between employers to increase overall supply, widen labour participation in the health and care system, and support economic recovery
- Ensure system plans draw on national interventions to introduce medical support workers (MSWs), and make use of associated national funding, increase health care support workers (HCSWs) and international recruitment of nursing staff

- Support the recovery of the education and training pipeline by putting in place the right amount of clinical placement capacity to allow students to qualify and register as close to their initial expected date as possible
- Develop and implement robust postgraduate (medical and dental) training recovery plans that integrate local training needs into service delivery planning
- Ensure that workforce plans cover all sectors – mental health, community health, primary care and hospital services. The plans should support the major expansion and development of integrated teams in the community, with primary care networks (PCNs) serving as the foundation, assisted to make full use of their Additional Roles Reimbursement Scheme funding, including through the options of rotational or joint employment.

The oversight of the development of such plans and strategies should be a key function of any people committee at system and place level. They are not framed as statutory requirements but are situated as part of the governance outcomes at systems level without much guidance on structure or authority.

In terms of structure and planning this context is in effect an emerging governance landscape which is demanding a significant amount of energy and time in its development with an implementation day for reformed structures of April 2022.



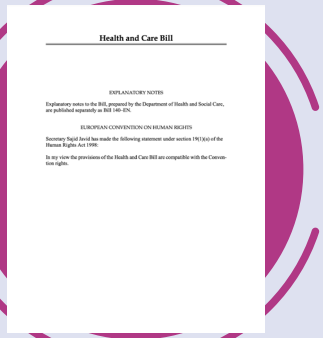
5. Integrated Care Systems: design framework

Finally, and most recently, the Integrated Care Systems: design framework, published in June 2021, updates NHSEI's thinking around ICSs and particularly focuses on the governance of these new bodies. Whilst there are still many unanswered questions, the Framework does emphasise that 'successful ICSs will develop a culture that attracts people to work in and for their community and supports them to achieve their full potential.'

The Framework makes plain that from the establishment in April 2022, ICSs will be expected to have specific responsibilities for delivering against the themes and actions set out in the NHS People Plan and the people priorities in operational planning guidance. This will be achieved through a 'one workforce' approach which brings together partners and staff in order to improve system effectiveness and quality of care.

The ICS NHS body will be expected to establish the appropriate people and workforce capability to discharge their responsibilities, underpinned by effective governance and strong local leadership. In particular, the NHS Body will be expected to:

- have clear leadership and accountability for the organisation's role in delivering agreed local and national people priorities, with a named SRO with the appropriate expertise (registered people professional (CIPD accredited) or with equivalent experience)
- demonstrate how it is driving equality, diversity and inclusion. It should foster a culture of civility and respect, and develop a workforce and leadership that are representative of the population they serve


Health and Care Bill

EXPLANATORY NOTES

Explanatory notes to the Bill, prepared by the Department of Health and Social Care, are published separately as Bill 140–EN.

EUROPEAN CONVENTION ON HUMAN RIGHTS

Secretary Sajid Javid has made the following statement under section 19(1)(a) of the Human Rights Act 1998:

In my view the provisions of the Health and Care Bill are compatible with the Convention rights.

6. Health and Care Bill

The newly published Health and Care Bill sets out the government's proposals to build a modern health and care system, with the ambition being to make the NHS 'less bureaucratic, more accountable, and more integrated in the wake of COVID-19.'[19]

The Bill contains six key clauses particularly pertaining to:

- Part 1 – Health service in England: integration, collaboration and other changes
- Part 2 – Health and adult social care: information
- Part 3 – Secretary of state's powers to transfer or delegate functions
- Part 4 – The Health Services Safety Investigations Body
- Parts 5 and 6 – Miscellaneous and general

In particular, the Bill looks makes real some of the proposals seen in earlier policy documents including the introduction of a two-part statutory ICS model comprising:

- an integrated care board (ICB), bringing together the organisations that plan and deliver NHS services within the geographic area covered by the ICS (the white paper called this part the ICS NHS Body)
- an integrated care partnership (ICP), bringing together a broad alliance of organisations related to improving health and care (the white paper called this part the Health and Care Partnership)[20]

ICBs will also have a duty to avoid patients and the public in commissioning decisions.

As with previous government papers, many of the proposals contained in the Bill are relatively permissive, with local systems able to determine much of the underlying governance themselves.

The Bill is, however, almost silent on the implications of all of this for staff. The addition of a clause setting out a duty for the Secretary of State to publish, at least once every five years, a report which sets out the workforce needs of the health service in England and how these will be met is welcome. However, and as others have pointed out, it arguably does not go far enough. NHS Providers, for example, have been vocal about the need for an additional duty "to ensure the development of regular, public, long-term workforce projections drawing on input from all relevant NHS arm's length bodies, NHS frontline organisations such as ICBs and trusts, and expert bodies such as think tanks".[21]

Others have warned about the impact of the increased powers for the Secretary of State set out within the Bill, as well as the challenges for staff and leadership teams in delivering the proposals at the same time as services are recovering from the impact of the COVID-19 pandemic.

Appendix 3 Appreciation

GGI and Allocate Software would especially like to thank the following for their support and participation in the People in Place project:

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Sultan Taylor
Duncan Tree
Rachel Royall
Peter Warrener
John Whitehouse

Endnotes

1.M.J.Chertoff. 'Start Small: Subsidiarity Principles Show that Local Approaches can Work in COVID-19 Vaccination Program'. Available at: https://www.law.georgetown.edu/salpal/our-work/covid-19/start-small-subsidiarity-principles-show-that-local-approaches-can-work-in-covid-19-vaccination-program/ [Accessed: 04/05/21]
2. Kings Fund. 'Closing the gap: key areas for action on the health and care workforce'. 2019. Available at: https://www.kingsfund.org.uk/publications/closing-gap-health-care-workforce [Accessed: 04/04/21]
3. Ibid..
4. A. Miles and J. E. Asbridge. 'The NHS Long Term Plan – Is it Person Centred'. European Journal for Person Centered Healthcare. 2019. 7:1 1-11.
5. Ibid..
6. L. Busetto, S. Calciolari, L.G. González Ortiz, K. Luijkx, B. Vrijhoef. 'Integrated Care and the Health Workforce'. In: V. Amelung, V. Stein, N. Goodwin, R. Balicer, E. Nolte, E. Suter (eds) Handbook of Integrated Care. 2017. Springer, Cham
7. Kings Fund. 'Closing the gap: key areas for action on the health and care workforce' 2019. Available at: https://www.kingsfund.org.uk/publications/closing-gap-health-care-workforce [Accessed: 04/04/21]
8. F. Barca, P. McCann, and A. Rodríguez-Pose. "The case for regional development intervention: place‐based versus place‐neutral approaches." Journal of regional science. 2012. 52:1. 134-152.
9. NHS. Integrating care: Next steps to building strong and effective integrated care systems across the UK. Available at: https://www.england.nhs.uk/wp-content/uploads/2021/01/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems.pdf [Accessed: 20/03/21]
10. Local Government Association. Six Steps to Achieve Integrated Care. Available at: https://www.local.gov.uk/six-principles-achieve-integrated-care [Accessed: 20/04/21]
11. G. Marshall. 'Subsidiarity, and community-based environmental governance beyond the local level'. 2012. International Journal of the Commons. 2:1, 75-97.
12. D. Mele. 'The Principles of Subsidiarity in Organisation: A Case Study'. 2004. Working Paper No.566.
13. NHSE/I. North West People Programme. 2020. Available at: https://www.nwacademy.nhs.uk/sites/default/files/inline-files/NW%20People%20Programme%20Summary_December%202020.pdf [Accessed: 14/04/21]
14. NHSE/I. North West People Programme. 2020. Available at: https://www.nwacademy.nhs.uk/sites/default/files/inline-files/NW%20People%20Programme%20Summary_December%202020.pdf [Accessed: 14/04/21]
15. NHS. 'We are the NHS: People Plan for 2020/21'. Available at: https://www.england.nhs.uk/wp-content/uploads/2020/07/We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf [Accessed: 06/04/21]
16. C. Ham. 'The challenges facing the NHS in England in 2021'. 2020. BMJ. 371:m4973.
17. F. McVey. 'Essential Guide to Provider Collaboratives'. Good Governance Institute. 2021.
18. NHS. 'NHS Interim People Plan'. Available at: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf [Accessed on 20/03/21]
19. Department of Health and Social Care. 'Press release: Health and Care Bill introduced to Parliament.' https://www.gov.uk/government/news/health-and-care-bill-introduced-to-parliament [Accessed on 07/07/21]
20. UK Parliament. Health and Care Bill. https://bills.parliament.uk/bills/3022 [Accessed on 10/07/21]
21. NHS Providers. The Health and Care Bill. 2021.


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