

# Growing our own future

A manifesto for defining the role of  
integrated care systems in workforce,  
people and skills

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## What is the Integrated Care Systems Network?

A critical part of delivering the ambitions of the NHS Long Term plan will be empowering local systems and giving them the autonomy they need. At the NHS Confederation, we are supporting emerging systems and helping local areas on the journey to becoming integrated care systems by April 2021. We believe the ambitions of the plan can only be met through greater collaboration, partnerships and system working.

We are undertaking a number of activities to support local systems. Alongside tailored support for ICS/STP independent chairs, programme directors, clinical leads, mental health leads, workforce leads, non-executive directors and lay members, we have now established a national network for ICS and STP leaders – this is called the Health and Care Leaders Forum. This was set up in response to feedback from ICS/STP leaders across the NHS and local government who told us they wanted an independent safe space to exchange ideas, share experiences and challenges, and develop solutions.

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## About the NHS Confederation

The NHS Confederation is the membership body that brings together and speaks on behalf of the whole NHS. We represent over 500 members across health and social care, including hospitals, community and mental health providers, ambulance trusts, independent sector organisations providing NHS care, and clinical commissioning groups.

We have three roles:

- to be an influential system leader
- to represent our members with politicians, national bodies, the unions and in Europe
- and to support our members to continually improve care for patients and the public.

All of our work is underpinned and driven by our vision of an empowered, healthy population supported by world-class health and care services; and our values of voice, openness, integrity, challenge, empowerment.

To find out more, visit [www.nhsconfed.org](http://www.nhsconfed.org)

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# Foreword

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**Dr Amanda  
Doyle OBE**

*Chief Clinical Officer,  
Blackpool CCG, Fylde  
& Wyre CCG and West  
Lancashire CCG  
Integrated Care System  
Lead for Lancashire  
and South Cumbria*

Of all the moving parts that leaders in health and care are required to understand, it is the workforce that is the most interconnected. Our ability to both strategically plan for tomorrow and to operationally deliver for today is dependent on the millions of people that make up the NHS and social care services in England. The responsibility I feel as an integrated care system (ICS) leader in this area is significant, even though I sometimes lack the tools to bring about the level of change necessary.

This manifesto outlines what the new operating model for workforce development in health and care, promised in the Interim NHS People Plan, should focus on. It draws on the direction of travel for health and social care policy, the specific aims of the Interim NHS People Plan and the growing demands from local leaders for greater flexibility, support and accountability in this critical area.

The central recommendation in this manifesto is that ICSs become the default level at which accountability for system-wide skills and workforce decision making is based. We understand this will be a significant step given the traditional and centralised approach of the sector, but we hope the manifesto makes clear why this is needed.

Within the NHS in particular, these debates can sometimes be too internally focused. What struck me from the roundtable discussions we held to inform this manifesto was how the skills landscape outside our sector was evolving and the need, and expectation, for the health and care sector to play its part. This model for a more devolved system will, I believe, begin to position the NHS and social care as 'intelligent' customers in the local labour market – leading, influencing and developing our future and current workforce at a place-based level.

We are not asking to constrain the ability of individual organisations to undertake activities that seek to attract, retain and reward their staff. Nor are we calling for an end to national oversight of such a significant and valued workforce. What we are doing is developing an approach that we believe best positions our sector to deliver the NHS Long Term Plan, while addressing the complexities, and nuances, of the increasingly diverse local labour markets.

# Key points

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- There is a clear desire for integrated care systems (ICSs) to become the default level for future workforce decision making in health and care. This would enable increased autonomy over the development of local system architecture, responsibility for managing strategic external relationships and critically, control of dedicated funding streams.
- Sustainability and transformation partnership (STP) and ICS leaders have repeatedly argued that their success is dependent on much greater capacity to influence the development and deployment of the local health and care workforce and an improved ability to affect local labour markets.
- For an ICS to realise its potential, it should have increased accountability across three key areas of workforce development: strategy and planning, supply and retention, and system deployment.
- This manifesto outlines the workforce powers, freedoms and responsibilities ICSs and STPs are increasingly asking for and the local commitments and relationships necessary to deliver this change.
- To complement this more involved strategic role, ICSs should pilot and prioritise local approaches to supply and retention, such as 'Grow Your Own', and develop and deploy new measures to better understand and use their existing health and care workforce.

- While the role of the national arm's-length bodies will remain important, there is a need for greater clarity about the roles and functions of the various national workforce organisations and how they encourage longer-term, more strategic local planning.
- This manifesto also focuses on the role of the NHS in the wider local labour market. As the largest employer in any given area, the NHS and local authorities could exercise significant power and influence on local skills development and employment. However, there remains the question of how best to use it.

# Introduction

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Workforce is widely regarded as the biggest single challenge facing the health and care sector. For many leaders in the service, there is an acceptance that a one-size-fits-all approach to workforce development is no longer a viable solution for the NHS and for social care. There is also recognition that they themselves should be taking a more active role locally to shape how they provide their services.

The NHS Confederation is working with its members and partners to consider how a strengthened role for local system leaders can help develop, plan and deliver a health and care workforce that is both fit for the future and enables greater local system transformation. This manifesto forms part of that work.

Through roundtables with leaders from within our sector and from our external partners, we heard about both the scale of ambition in this area and what leaders believed could be achieved locally. By undertaking a [public consultation](#) on the issue, we received wider support for a much-strengthened role for the integrated care system (ICS) in workforce, people and skills. In developing this manifesto, we wanted to balance the principles of subsidiarity, pragmatism and influence, giving the NHS and social care leaders the best chance of securing lasting change.

In bringing these strands together, we are setting out a manifesto for the new ICS workforce operating model, focusing on the people and skills-related powers, freedoms and responsibilities that ICSs require in future to realise their potential. It also sets out the national support necessary to successfully deliver this change. Development of a new operating model was promised in the interim NHS People Plan published in June 2019.

To support the development of this manifesto, we will soon be publishing guidance setting out the ICS journey to becoming a more 'intelligent customer' in local labour markets. Together, we hope this approach enables the health and care sector to better influence where it is needed, lead where it is expected and support where it is required.

*“Our ambition is to make West Yorkshire and Harrogate a healthy place to live and a great place to work. Our partnership understands that we can benefit the health and care system through recruiting and retaining people locally and attracting the best talent to the area. In turn, we know this will improve health outcomes for people across the area. We already have fantastic examples of where this is happening – ensuring people can access employment and we can access their skills.*

*“Our partnership has developed the governance to manage workforce development in a way that backs local leadership of the agenda. We now need to work collectively, including with regional and national bodies, to ensure the right capacity and resources are available to deliver. This includes the ambitions of our workforce strategy for all people working across the health and care sectors, including the role of volunteers, unpaid carers and people with mental illness, learning disabilities and autism.*

*“The NHS People Plan gives us an opportunity to build on the recommendations in this manifesto and to ensure we can develop the workforce we need.”*

**Rob Webster, Chief Executive, South West Yorkshire Partnership  
NHS Foundation Trust**

**Lead Chief Executive, West Yorkshire and Harrogate Health and  
Care Partnership**

**Chair, NHS People Plan Operating Model Reference Group**



# Our recommendations at a glance

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This manifesto sets out a new approach for the workforce operating model across health and care. We believe strongly that the recommendations are necessary to realise the potential of integrated care systems and have the support of local leaders.

We recommend:

- **the ICS becomes the default level for decision making in skills and workforce development** across England, with this reflected in the NHS People Plan operating model
- **a series of powers be devolved to the ICS level** in the areas of strategy and planning, supply and retention and system deployment, to enable the ICS to truly determine its future workforce
- **ICSs are given long-term, dedicated funding settlements** with which to develop the skills, capacity and priorities necessary to influence their local labour market.

For national leaders, we recommend:

- **providing much greater transparency on the workforce funding** that flows throughout the system
- **far greater alignment in national workforce policy terms between health and social care**, with a future narrative that truly supports local partnership working
- **developing a central repository of expertise** to enable ICSs to share, develop and implement local solutions

- **national coordination and oversight of ICS workforce plans** to ensure alignment with nationally determined deliverables, the evolution of national standards and, importantly, to better support future policy development
- **national bodies, such as the royal colleges and trade unions, work to determine a suitable model for engaging ICS** leaders and to support their membership to understand how to influence an ICS locally.

For ICS leaders, we recommend:

- **supporting local NHS organisations to develop strategies as ‘anchor institutions’** which develop employment policies with the explicit intention of supporting local recruitment and addressing population health and community needs
- **a duty to consult and secure commitment from local members** when seeking additional requirements for ICS responsibility, including mutual accountability of delivery and clear governance over the use of funding
- **close collaboration across ICS boundaries where there is a common need**, sharing ideas, resources, data and learning – this will involve regional collaborations with like systems in terms of locality and ICS maturity, but also geographic partnerships across, for example rural, coastal and metropolitan areas.

# What systems need to succeed

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STP and ICS leaders have repeatedly told the NHS Confederation and other national bodies that their success is dependent on much greater capacity to influence the development and deployment of the local health and care workforce, and an improved ability to affect local labour markets.

We believe that for an ICS to realise its potential, it should have increased accountability across three key areas of workforce development.

## Strategy and planning

- More workforce-related powers and funding to be devolved to the ICS level.
- Increased local responsibility for the design of the system architecture necessary to best enable development of an individual ICS, including refreshed system focus on how best to influence the local labour market.
- ICS approaches to population health that better understand the needs of local communities and shape subsequent decision making.

*“We want to avoid the fragmentation of workforce functions and leadership and recognise that the current model of management, governance and leadership need to change to support tackling the workforce challenges we face. By devolving these responsibilities to systems, we believe that it will create the best environment to deliver on this workforce agenda.”*

**STP Lead and Local Workforce Action Board Chair**

## Supply and retention

- The opportunity to create and co-develop with education and training partners better health and care career opportunities for local people to understand and enter the workforce (through Grow Your Own) and for subsequent onward progression.
- To continuously evolve new and different system roles that cross traditional sector and clinical boundaries.
- Developing place-based strategies for talent management and retention that bring in other relevant local sectors.

## System deployment

- The opportunity to build in to typical employment the clear expectations of working flexibly across traditional clinical boundaries.
- Schemes to assist with real-time system deployment decision making.
- Local oversight and support for the advanced training of existing roles.

The manifesto builds on these guiding points with a series of proposed responsibilities that we believe the new operating model for workforce should prioritise as part of future ICS development.

*“To date we have had to beg, steal and borrow the resources to plan and develop our workforce. This cannot continue.”*

**ICS Local Workforce Action Board Chair and ICS Director of Workforce**

*“The imperative for partners to work across the system to plan for and govern workforce matters is self evident as the scale and complexity of issues now exceed the capacity of any individual organisation to work alone. Systems will also be better placed to agree relative priorities and work with a sector wide perspective towards strategic partnerships and alliances.”*

**ICS Leader**

# A manifesto for change

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The following sections explore the process, strategy and detail involved in developing this manifesto for workforce, people and skills. It covers:

- Developing the manifesto: our approach
- Building the national case for local change
- Developing the operating model for workforce
- Resetting relationships: the role of ICSs in workforce, people and skills
- What ICS leaders need to develop the health and care workforce
- Our asks of national bodies
- Delivering the manifesto: next steps

# Developing the manifesto: our approach

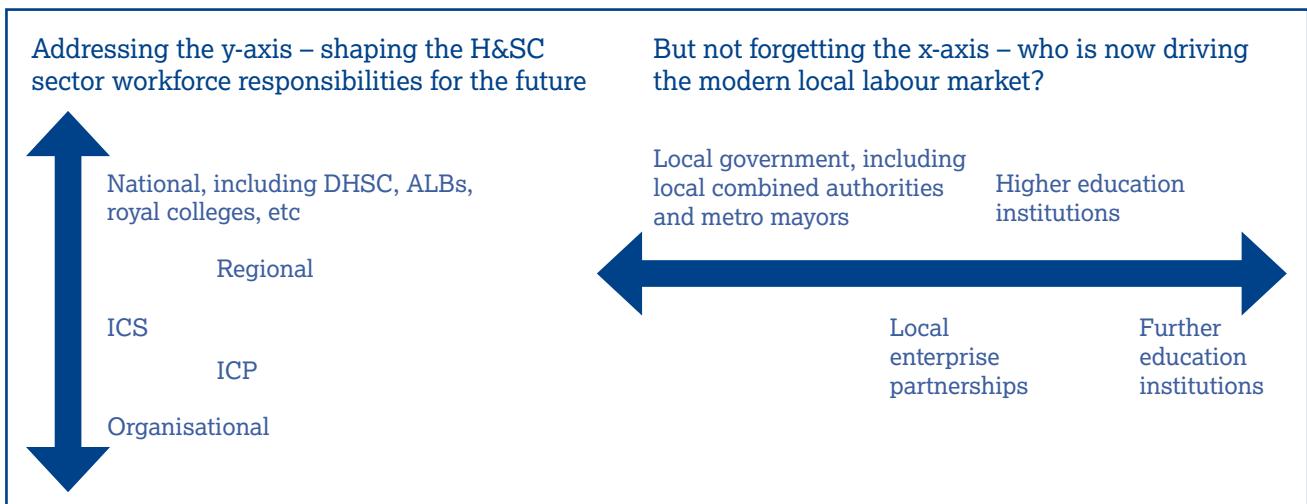
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It is important that any ICS manifesto for workforce, people and skills be shaped and modelled by local health and care leaders, championed by national organisations, such as the NHS Confederation, and strengthened by our sector's external partners.

We were clear that this would be a complex and challenging conversation for many in the sector. This manifesto has sought to understand how the health and care sector should organise itself internally in terms of what level should do what, but, just as importantly, how the sector relates to the wider economy and changing labour markets. To inform our thinking, we explored the following:

**System leadership level:** Exploring how greater responsibility for health and care workforce planning could be delegated and devolved to STP and ICS footprint level. Through a roundtable, we explored the key workforce challenges facing the system and the powers, freedoms and flexibilities system leaders feel would enable them to adequately plan the wider development of roles, models and systems needed to shape and provide services locally. The NHS Confederation publicly consulted on this in the spring of 2019. See [\*Defining the role of integrated care systems in workforce development: A consultation\*](#).

**The wider place:** A second roundtable was held, seeking to build on the draft separation of workforce powers by understanding the changing nature of skills policy and labour markets, and discussing the external relationships necessary to influence and deliver this increased local accountability for the health and care workforce. We heard directly from strategic and training partners on their experiences of working with our sector and the level at which optimal decision making would help secure the future local workforce the sector needs.



This work helped to shape our recommendations, including the workforce powers and responsibilities ICSs require in future to realise their potential, and the national support and local commitments necessary to successfully deliver this change.

To evolve our thinking and recommendations more broadly, we wanted, through the second phase, to identify not only where decision making in health and care sector should reside but the point at which the sector could best influence the labour market to determine its future workforce. This work helped to shape our recommendations in our forthcoming guidance on the ICS journey to becoming a more intelligent customer in local labour markets.

Collectively, we wanted to support local leaders to identify the responsibilities they should aspire to have and the practical steps necessary to best deliver this.

*“We agree that an ICS’s role in workforce development, transformation and planning should be strengthened. Devolved responsibility needs to be matched with devolved resources and capability building at this level.”*

**ICS Lead and Local Workforce Action Board Chair**

# Building the national case for local change

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*“Too often in the NHS, the term workforce is viewed through an operational lens, meaning our focus is on short-term management and process. The challenge for the sector is to recognise that developing people with the ambition, skills and values necessary to transform their communities is a clear leadership priority and is best delivered at system level.”*

**Dr Amanda Doyle OBE, Chief Clinical Officer, Blackpool CCG, Fylde and Wyre CCG and West Lancashire CCG and Integrated Care System Lead for Lancashire and South Cumbria**

## A stronger local voice

ICSs are critical to delivering the [NHS Long Term Plan](#), published in January 2019. By April 2021, ICSs will cover the whole of England, growing out of the current network of STPs.

As the plan states: “An ICS brings together local organisations to redesign care and improve population health, creating shared leadership and action. They are a pragmatic and practical way of delivering the ‘triple integration’ of primary and specialist care, physical and mental health services, and health with social care, consistent with what doctors report is needed.”

The plan set out future expectations and requirements for the governance, accountability, funding and leadership of an ICS. In health and social care policy terms, there is simply no plan B.

The direction of travel for local system working has the broad support of the service itself, though national policy is not always seen as fully supportive and enabling. [Letting local systems lead](#), published by the NHS Confederation in November 2018, highlighted that while over 60 per cent of leaders either strongly agreed or tended to agree that STPs/ICSs represented the right



approach for partnership working, progress had often been achieved *despite* national policy. The paper also suggested that the national infrastructure to support service change included too many hurdles. The NHS Confederation strongly believes in the need for effective local leadership and for local systems to strengthen ownership in their communities of the NHS Long Term Plan's vision.

## The current workforce crisis in health and social care

### Nursing



44,000

### Administrative and clerical



20,000

### Allied health professional



10,000

The NHS employs around 1.24 million full-time equivalent (FTE) staff across its range of services, making it the largest employer in the UK. Its current vacancy rates are significant, with approximately 90,000 FTE vacancies in hospital and community services alone. Of these vacancies 44,000 are nursing, 20,000 are administrative and clerical, and 10,000 allied health professionals.

Primary care services employ 130,000 staff, with the NHS currently having 2,500 FTE fewer GPs than it needs and a projected gap of 7,000 FTE GPs within five years, if current trends are maintained.

Mental health sees particularly high vacancy rates, with 9.5 per cent (just under 20,000 roles) vacant. For consultant psychiatrists in England, vacancies reached 9.9 per cent in 2019, with 12.1 per cent of child and adolescent consultant posts vacant. [Stepping Forward](#), Health Education England's mental health workforce plan published in 2017, aimed to recruit 19,000 additional staff to the mental health workforce by 2020/21, during the first year of the plan. Only an additional 915 were realised.

Although a much more fragmented market, there are 1.13 million FTE currently employed in adult social care in England, working across an estimated 18,500 organisations. Vacancies total 122,000 (7.8 per cent) at any given time, with around one in ten social worker roles and one in 11 care worker roles vacant. There is also a registered nurse vacancy rate of 12 per cent in adult social care, implying around 5,000 nursing vacancies in this sector. Around a quarter of the workforce are employed on zero-hours contracts, while the staff turnover rate of directly employed staff working in the adult social care sector was 30.8 per cent in 2018/19.

## Further reading

The Health Foundation, The King's Fund, Nuffield Trust (2019), [Closing the gap](#).  
The Health Foundation, The King's Fund, Nuffield Trust (2018), [The health care workforce in England](#).

Skills for Care (2019), [The state of adult social care sector and workforce in England](#).

Health Education England, [The mental health workforce plan](#).

# Developing the operating model for workforce

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Workforce is one of, if not the, most important enablers underpinning an ICS. Around 80 per cent of respondents in *Letting local systems lead* highlighted staff recruitment and retention as their most significant system pressure. While we expect the maturity of an ICS to be matched with increasing powers in the future across a range of policy areas, there is a strong case for workforce to be the first such priority issue with which to devolve specific responsibilities.

The NHS Confederation is not alone in seeking to raise both the ambition and ability of ICSs in this area. The Interim NHS People Plan committed to developing a new operating model for workforce and to “continue to work collaboratively and to be clear what needs to be done locally, regionally and nationally, with more people planning activities undertaken by local ICSs”.

We are fully supportive of this approach and believe this manifesto to be an important part of the conversation.

It should be noted that while this manifesto strongly relates to the development of a new operating model, its principles extend beyond simply this point, with a clear focus on the NHS People Plan priorities for making the NHS the best place to work, improving the leadership culture, tackling the nursing challenge, and delivering 21st century care.

## A new operating model for workforce: what the Interim NHS People Plan says

The arm's-length bodies (ALBs) have developed the following principles to underpin decisions about which workforce activities should normally be carried out at which level:

- **Activities will be carried out nationally where:**
  - it is necessary to meet statutory responsibilities
  - it is more efficient and effective because of economies of scale
  - planning is needed over a longer time frame, such as over 15 years
  - there are clear benefits from a national role in standardisation or coordination/implementation
  - national teams have specific and scarce skills/knowledge that it is not possible or desirable to duplicate sub-nationally.
- **Activities will be carried out regionally where:**
  - there is a need for a coordination and/or assurance role in delivering national priorities such as international recruitment
  - planning is needed over a medium-term time frame, eg over five years there is demand for improvement support on a large scale
  - there is a need to help foster capacity and capability in local health systems
  - decisions need to be made across a regional labour market.
- **Activities will be led by ICSs where:**
  - regional footprints are too large to affect change
  - strong local partnerships are required
  - planning is needed over a short- to medium-term time frame, such as in-year or over three years
  - decisions need to be made across a local labour market.
- **Activities will be led by local employing organisations** where they relate very directly to the employment or wellbeing of an organisation's people.

Some activities, such as developing people strategies, talent management and workforce planning, will need to be carried out at all or most levels.

Source: Interim NHS People Plan, June 2019

## The changing nature of ‘place’

This manifesto is focused on the role of the ICS, highlighted in the NHS Long Term Plan as the critical level for decision making. The landscape that sits below and above the ICS is still emerging, with a range of new tiers being established, including the regions, primary care networks (PCNs), and integrated care partnerships (ICPs). The size, scope and footprint of these groupings is still being decided and will likely vary across England.

Rather than attempt to set out what we believe should be undertaken at these levels, the NHS Confederation has called for the ICS to be the default setting for decision making, with future divergence from this level (whether at a more or less localised tier) agreed where there is a just argument. We are clear that all tiers of the health and care sector will have a role to play in developing a modern workforce and that subsidiarity, pragmatism and flexibility will be important principles in developing the agility needed to best influence and deliver.

## It’s all about relationships

Relationships are at the heart of the future of health and care policy, and workforce is no different. Within the sector, the development of ICSs will be largely dependent on how local organisations (and not simply commissioners and providers) work together in new ways, but also on the role of the national bodies, including arm’s-length bodies, professional regulators and representative bodies such as royal colleges, Healthwatch and the trade unions.

Implementing this manifesto will require all levels of the health and care sector to reflect on their role and contribution to the workforce, including many potentially difficult and challenging conversations. The NHS Confederation will continue to work with partners to understand better the nature of the future relationships necessary to deliver change successfully.

## Devolution and/or delegation?

Devolution and delegation are two differing concepts of decentralisation. The former marks an ability to develop and determine one’s own decisions; the latter more simply reflects national decision making taken at a more localised level.

We strongly believe that ICSs ultimately require the ability to shape their own future according to local need and that devolution of workforce development is an important principle. In practice however, we accept this may represent a more blended approach, particularly in the early phase of implementing the

new operating model and where system capacity and capability is still in its developmental stages.

## The need for wider influencing

One of the core reasons why we believe the ICS to be the most appropriate level relates to external circumstance, namely the changing nature of our local labour markets. Our forthcoming guidance sets out more detail about this and focuses on how an ICS can best influence local skills policy, partnerships and practice. This is particularly vital in supporting ICSs to better understand their communities and local economy and to use existing resources, including funding, to address challenges. The NHS Confederation is supporting ICSs on the ground to extend their influence, bringing lasting local benefits.

## Assessing system maturity

While we have certain clarity in terms of the destination, the present health and care landscape is often described as following old rules while the new rules are being written. In particular, significant recent focus has been placed on assessing the maturity of an ICS, both in a general context in terms of its progression from an STP and more specifically in relation to workforce. Our external local partners, however, do not see a distinction between these twin approaches. Local economies and labour markets will not wait for a local health and care system to be formally designated as 'mature'.

Influencing a local labour market is as much a leadership challenge as an operational one. While some form of staggered devolution linked to maturity is to be expected, we would strongly support a collaborative, transparent and streamlined transition process to determine this. This process should also make clear that where ALBs judge an ICS as not being in a position to gain relevant powers, they assume central responsibility for supporting the local system leaders to influence labour market development.

## What can ICSs achieve?

The NHS Confederation's consultation included a range of case studies relating to strategy and planning, supply and retention, and system deployment. It is clear from the responses that sharing new and innovative approaches that local systems are developing is an important part of empowering system leadership and gaining greater understanding of what can be achieved locally.

We have included a number of these case studies within this manifesto, along with more examples that responses to the consultation brought to light.

## What leaders told us: responses to the consultation

The consultation on the [draft manifesto for workforce development](#) was published in March 2019, following a roundtable attended by ICS and organisational leaders from the sector. The roundtable heard how ICS leaders were becoming increasingly clear about how national leadership can enable them to realise their potential and proposed a draft manifesto that would position ICSs as the default level at which accountability for system-wide workforce decision making was based.

Responses were largely supportive, with an understanding that the present situation called for a radically different approach to workforce and that this was a key success criteria for ICSs. What is clear is that leaders are up for the challenge, but this increased local accountability had to be matched with much greater transparency, funding, and resource. The recommendations in this manifesto for both what accountabilities should lie at what level and the support necessary to best use them, reflect the nature and scope of the responses to the consultation.

**A collection of anonymised quotes taken from the consultation responses are featured throughout the manifesto.**

# Resetting relationships: the role of ICSs in workforce, people and skills

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An ICS should become the default level at which accountability for system-wide workforce decision making is based. This will involve the passing of powers, responsibility, funding and governance down from the national level, but also an increased understanding from individual anchor institutions of the essential requirement for further system collaboration locally.

ICS leaders need to be clear that with increased accountability comes responsibility, requiring widespread system commitments to partnership working and enhanced local leadership that are co-designed with national and local leaders. This will involve the need to have a whole health and care sector approach, to be more influential, to share best practice and to work across boundaries to ensure the right decisions are being made at the right level.

## The workforce powers an ICS should gain control over

**1** **Strategy and planning:** an ICS should be the default level for strategy and planning. We know how important this is and leaders are ready for the challenge.

Strategy and planning in workforce, as with many other priority areas, is a critical enabler of an ICS. While local education and training boards were established in 2013 with a strategic area-based focus, successive national and structural reforms have negated this function and weakened the local ability to plan, just as labour markets have become more competitive and locally responsive.

A strengthened role for the ICS in strategy and planning would form an important part of re-balancing the future needs of the system with the ability to deliver change on the ground.

### **We are calling for ICSs to have responsibility for:**

- control of local, long-term, funding streams to support system-wide workforce planning, innovation, coverage and collaboration – these funding streams will bring together national funds from the arm’s-length bodies, with additional local funding (from within and outside the sector) where agreed and appropriate
- development and management of the local workforce system architecture (including responsibility for the design, remit, membership and direction of the local workforce action boards, or similar)
- assessment of system-wide demand and associated workforce need, with numerical targets and metrics aggregated upwards to support national planning, rather than vice versa
- management of strategic workforce relationships with local external partners, including universities, colleges, mayors, combined authorities, local government, local enterprise partnerships, voluntary and community social enterprises, independent sector, patient groups, and trade unions
- establishment of core ICS workforce priorities, co-created in partnership with local stakeholders and reflective of population health priorities
- development, use and publication of local labour market information (LMI) data tools, in partnership with other local sector representative bodies and underpinned by population health management tools
- lead responsibility for the ICS-wide delivery of key national NHS and social care workforce strategies, such as the Workforce Race Equality Standard
- development of transparent ICS-wide strategies focused on making the area the ‘best place to work’ and linked to wider issues, rather than being reliant on individual organisational approaches
- oversight of outcomes-based workforce commissioning, with funding guided through an ICS to ensure regional consistency across various PCN/ICP-level planning
- development and support for the ICS-wide HR and organisational development workforce, with focus on skills and behaviours required for leaders to influence external partners



- development, testing and roll out across an ICS of innovative and new approaches to workforce delivery and training.

**2** **Supply and retention:** ICSs need to take more control over the future workforce, not be passive bystanders

Many of the existing and immediate workforce challenges across health and care relate to supply and retention. In terms of supply, there is a need to develop strategies which address sector need but also support a far greater diversity in how local communities are engaged in potential careers. Many NHS organisations are engaging in innovative retention practices which should be encouraged and, where appropriate, spread across the ICS footprint with wider partnerships within and outside the sector.

**We are calling for the ICS to have responsibility for:**

- development of ICS-wide health and care approaches to Grow Your Own, including specific focus on Widening Participation and the associated public engagement necessary to provide greater clarity and understanding of career options
- development of different health and care roles across an ICS
- control of future talent management development programmes, both within health and care (including graduate and clinical) and in collaboration with other sectors locally (as part of wider place-based leadership)
- the co-development of system-wide curricula for certain roles where appropriate, in association with local education providers and national bodies – this would include the ability to develop tailored, local pipelines of supply that supports people from a much greater range of backgrounds to successfully work in the sector
- devising area-based workforce recruitment and retention strategies, using good practice from elsewhere and testing local initiatives
- design and/or implementation of system-wide strategies to direct people into the sector from local partners, such as the Armed Forces or HM Prison Service
- design and/or implementation of system-wide strategies to maximise local impact of tools, such as the Apprenticeship Levy
- the ability to plan and enforce mandatory training for healthcare professionals in local priority clinical themes

- responsibility for succession planning (especially for specialist roles), including strategies for shadowing and policies that support health professionals to develop into specialists.

**3 System deployment:** ICSs need a flexible workforce, with oversight at system level

The ability of an ICS to look across a given system in real-time is a particularly important operational attribute. To fully use this ability requires organisations at local level and the arm’s-length bodies to be consistent in their understanding of the ICS as the optimal place for decision making.

Similarly, a more empowered system role around deployment would require the ICS to develop mature relationships with organisations such as trade unions and the professional bodies.

**We are calling for the ICS to have responsibility for:**

- management of the ongoing, ICS-wide deployment of the health and care workforce, including through rolling out innovative schemes such as passporting
- advanced training of existing roles
- design and/or implementation of strategies for role development which reflect demonstrable improvements to service delivery and outcomes, rather than simply plugging gaps
- establishment of in-built expectations of flexible working across clinical and non-clinical boundaries throughout the system
- design and/or implementation of continuous service commitments, to support the ability of staff to move within public services across an ICS region and to retain their benefits.

## Commitment from leaders

With accountability comes responsibility. If given the requested resources and ability to lead on workforce development, ICS leaders should commit to the following:

- better understanding of their role in the local economy, including through promoting their local NHS and social care organisations as ‘anchor institutions’ that develop employment policies with the explicit intention of supporting local recruitment and addressing population health and community needs

- a duty to consult and secure commitment from members to additional requirements for ICS responsibility, whether sought from national or local organisations – this would cover mutual accountability of delivery and clear governance over the use of funding
- working together across ICS boundaries where there is a common need, sharing ideas, resources, data and learning – this will involve regional collaborations with like systems in terms of locality and ICS maturity, but also geographic partnerships across for example rural, coastal and metropolitan areas.

*“There should be mechanisms, oversight and accountability to ensure that the workforce plans of ICSs align to national workforce plans and policy. While it is sensible that ICSs should have more control over aspects of recruitment locally, a centralised, coordinated approach to workforce planning at national level remains essential.”*

**Royal College**

### Case study: The Dorset ‘Development Hub’

The Dorset ‘Development Hub’ is an innovative partnership to create a space for improvement across the Dorset ICS, developed in partnership with the Ministry of Defence (MoD). The Hub is in a vacant building at the West Moors logistics base, set up for an initial 12 months, in line with the aspirations of the NHS Long Term Plan and the MoD’s site optimisation strategy. The Hub opened its doors in April 2019 and has helped pioneer new ways of working between multi-disciplinary teams of clinicians, NHS professionals, and colleagues from a range of partners who are using West Moors for hot desking, learning events and meeting in collaborative working environment.

A new, joint Dorset ICS workforce team is now based at the Hub, working together to address workforce challenges with clinicians, and delivering joined-up recruitment campaigns, workforce retention and expansion plans. This includes new ways of working with wider agencies outside of Dorset’s health and social care partners, including schools, colleges, universities, and business, and co-locating with public sector teams beyond our ICS partners.

In the future, the model which led to the creation of the Hub also offers opportunities to use houses and accommodation for key workers, their families and overseas recruitment communities.

Find out more at [Our Dorset Hub](#).

## Case study: STP approach to mandatory and statutory training

Across North Central London (NCL), the STP has taken a collaborative approach to mandatory and statutory training (MaST). Through optimising the use of the electronic staff record (ESR) system, they have streamlined and incorporated better housekeeping and processes, establishing consistent MaST standards, aligning systems and automating as many functions as possible to reduce variation and gain greater consistency across all NCL trusts.

NCL are currently piloting a six-month project with Whittington Healthcare Trust and Haringey and Islington Training Hubs, to consider an effective way of delivering MaST across the system provided by community and general practice colleagues. This is an opportunity to prepare the groundwork for future sharing of staff, new care models and standardising the level of training enjoyed by staff in both community and general practice settings on some core subjects. The pilot launched on 5 August 2019

and is supported by ESR through using unused capacity using their live system.

This has supported a streamlined approach to managing bookings across sectors increasing takeup in training places.

The North London Partners programme, led by Haringey and Islington community education provider network, will support NCL general practice staff to access the classroom training they require as part of the Whittington Health's MaST in a standardised way, locally and free. The training will enable multi-professional learning, building understanding of other colleagues' roles and create a system-wide set of credentials. This is an excellent example of collaborative working across sectors which impacts over 70 practices raising consistency, increasing skills and knowledge and providing value for money.

Follow North Central London STP on Twitter @nclstp

# What ICS leaders need to develop the health and care workforce

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Devolving default workforce development to ICSs raises the question of the role of health and care partners at the national, regional, local and institutional level. We are clear that they have a critical part to play in addressing the workforce needs of the sector. However, we need clarity across these tiers on how best to truly realise the future workforce.

This manifesto is focused on the critical role of an ICS in workforce development and through that the support necessary to deliver this through both a national and organisational lens. We do not set out here guidelines for other new groupings, such as PCNs or ICPs. Nevertheless, these tiers will have an important role to play and their focus and priorities in this area should be developed with this manifesto in mind.

## The role of national leadership

The role of the centre of the NHS in workforce is critical, but complex. The ability to speak nationally with one coherent voice is a significant strength of the health service, bringing resources, interest and status. This should remain a central feature of workforce development, with policy aims and messaging that are much more closely aligned with social care to reflect the necessary parity of local systems.

There is a need to be clearer about the balance in the relationships and responsibilities we are fostering. Central to this lies the need for greater clarity about the roles, transparency and funding of the various national workforce organisations, improved central coordination and an explicit focus on encouraging longer-term, more strategic local planning.

ICS leaders need clarity over what we can do and the support to best achieve it.

The Interim NHS People Plan states that national NHS leaders “are committed to developing a new operating model for workforce – one that ensures activities are happening at the optimal level, whether this is in individual organisations, local health systems, regionally or nationally, and where roles and responsibilities are clear. This will need to be dynamic to respond to changing capacity, capability and needs at these different levels, as they evolve.”

The work the NHS Confederation has been leading to develop an ICS manifesto for workforce development has been done in parallel to – and independent from – the development of the NHS People Plan. Nevertheless, it is hugely positive to see this level of read across and the intention of the national arm’s-length bodies to empower local systems.

### **Our proposals for the national health and care leadership include:**

- clarity about what an ICS can and cannot do
- the need for transparency about the workforce funding in the NHS, how it navigates the system and who has power over its use
- how to encourage the professional bodies and regulators to show greater collaboration, engagement and leadership in how they work with local system leaders.

ICS leaders are increasingly clear about how national leadership can enable them to realise their potential. National partners include both the Department of Health and Social Care and arm’s-length bodies, but also the range of royal colleges, trade unions, member organisations such as the NHS Confederation, and national charities.

### Case study: The South Yorkshire and Bassetlaw (SY&B) ICS workforce hub

The South Yorkshire and Bassetlaw (SY&B) ICS workforce hub is supported by Health Education England and has three initial workforce priorities: developing the SY&B Region Centre of Excellence (unregistered workforce); creating a Faculty of Advanced Clinical Practice for the region; and expanding the primary care workforce. A system-level workforce plan is being developed to progress this work programme across the ICS's five integrated care partnerships, seven providers and five CCGs. More generally at the ICS level, the hub is leading work around a streamlining programme to identifying efficiencies

and increasing productivity; the development of new apprenticeship roles; assessing the risk and impact of Brexit; developing a workforce plan for allied health professionals; commissioning education provision; widening participation; establishing a major plan for schools engagement; and implementing the recommendation of the ICS's recent acute services review.

Find out more at [Faculty for Advanced Clinical Practice, South Yorkshire & Bassetlaw Primary Care Workforce & Training Hub](#) and [South Yorkshire Region Excellence Centre](#).

### Case study: Bristol, North Somerset and South Gloucestershire STP Apprenticeship Group

Bristol, North Somerset and South Gloucestershire STP ('Healthier Together') Workforce Programme has established an Apprenticeship Group, which has been working collaboratively for nearly two years and includes four NHS providers, three community providers, the CCG, three councils, learning disabilities charities, two hospices and all GP practices. The group has jointly procured a number of apprenticeships, including advanced clinical practitioner and

nursing associate, and collects data to benchmark locally and support quality assurance and share expertise and resources. This reduces duplication, improves efficiency, ensures common approaches, and drives up quality of provision. The group has also agreed a levy sharing agreement, which has enabled a number of non-levy paying GP practices to utilise the unused levy of NHS trusts.

Find out more at [Healthier Together](#).

# Our asks of national bodies

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## Strategy and planning

- Far greater alignment in national workforce policy terms between health and social care, with a narrative that reflects how interrelated the workforce is and truly supports local partnership working.
- Being clear and transparent about how existing NHS workforce funding, including that for training and development, passes through the system from national to ICS level.
- Support in the co-design and development of ICS partnership models, ensuring primary care, the independent sector and social care form a critical part of decision making. This co-design would also include the stated ICS commitments.
- Building a central repository of expertise which can be accessed by ICSs to share, support and develop local solutions. This could include, for example, advice on forming local collaborations and knowledge of external funding sources.
- Supporting and funding national rapid evaluations of local good practice that can be spread elsewhere.
- National coordination and oversight of ICS workforce plans, in particular to ensure alignment with nationally determined deliverables (such as national reviews and recommendations), the evolution of national standards and to better support future policy development.
- Mechanisms to develop and support the direct relationship between ICS leaders and national bodies.
- Much greater coordination and alignment between the different professional contractual arrangements.



- Recommendations on the type of data to be collected and used, particularly where this supports future national health and care policy direction.
- Implementation support for common projects and programmes, such as enabling staff movement through passporting and return to practice.
- Coordinated support from organisations, including the royal colleges and trade unions, for members to adapt to the changing policy environment and to provide guidance to members on how ICSs work and to influence at system level.
- Addressing national health and care challenges and priorities as and when they occur in partnership with ICSs. This could include, for example, clear national shortages in certain roles.
- Clinical training commissioning to be led and delivered by the appropriate body, directly linked to ICS workforce strategies.

### Case study: Widening participation across the Humber and North Yorkshire to support local medical supply

Encouraging greater NHS supply in many parts of England is a long-standing issue, even where local medical schools exist. Some universities are working with the local health system to jointly address this through their widening participation schemes.

Hull York Med School is a partnership between the Universities of Hull and York, regional NHS trust providers and community healthcare providers. It now operates a MB BS Medicine with a Gateway Year as a six-year programme. This programme aims to support those who may not meet the entry requirements of the School's five-year MB BS Medicine programme but are keen to pursue a career in medicine. Applicants must be either a care leaver or fulfil

other contextual data criteria such as reside in an area of low participation in higher education, have parents who do not have any higher education qualifications or have applied for and received the UCAT bursary. The programme prioritises applicants from the local Hull York Medical School area as there is evidence to suggest that students who train locally, remain in the area. The Gateway Year focuses on facilitating the transition from school or college to university, bringing scientific knowledge up to the required standard, and enhancing study skills while teaching students about professionalism and the NHS.

Find out more at [Hull York Medical School](#).

- The testing of possible new national workforce remits at regional or ICS level in the first instance.
- Clarity over any potential legal implications of new local workforce collaborations.
- The development of new national programmes for educational and employment rotations, retention strategies and data sharing (including the necessary expectations).

## Supply and retention

- Promoting flexibility in the way professional and NHS regulators work across clinical boundaries and through their continuous engagement with ICSs. There is a clear need to develop a consistent and mutually empowering engagement process between ICS leaders and, for example, the royal colleges.
- Developing a common approach to national workforce standardisation and authorisation for new clinical roles, responding openly to bottom up creativity in addressing clinical workforce development. This could be a form of blended design, with essential clinical standards allowing rapid adaptation to changing local needs.
- Specialising in promotional activities and campaigns to attract people to certain health and care careers, for example when shortages appear or there is a clear future focus needed. Such a PR focus should also be able to be applied locally as appropriate with national expertise used to support local work.
- Ensuring equity of the workforce, and particularly the specialist roles, across England from a national oversight perspective.
- Consistent standards and guidelines for clinical training and recruitment, to be adopted in local decision-making processes.

## The role of organisations in the health and care workforce

The breadth of individual organisations that make up the health and care sector are the main employers of our staff, both directly and indirectly. It is these organisations which both deliver frontline services to their communities and which are seen by these communities as the face of the public sector.

While decision making across a range of areas now needs to be elevated above organisational level, this must be matched by local accountability, incentives and engagement. After all, it is at this organisational level that we often see the innovations shaped which can support greater system development. In particular, the role of individual health and care organisations as ‘anchor institutions’ reflects the critical role they have in inspiring, developing and using the workforce, and in the economic and social success of the local place more broadly. An ICS should support its constituent parts to realise this potential.

The scale and complexity of workforce issues we face now exceeds the capacity of individual organisations to work alone.

While the strengthened role of an ICS requires empowering and supporting from above, its maturity and progress will also be underpinned by the approach taken by the local organisations and its constituent parts. This manifesto does not seek to restrict or limit the role of these organisations, rather it focuses on the mutually supportive approach necessary to deliver change on the ground. In particular, we believe that by supporting organisations to understand and develop an approach that incorporates the ‘anchor institution’ concept, both the system and its organisations will benefit from a workforce perspective.

### Case study: Greater Manchester Continuous Service Commitment

As part of work developing a Greater Manchester employment offer, over 30 public sector employees across Greater Manchester signed up to their Continuous Service Commitment. This means that from April 2018, staff can keep their service-related benefits (annual leave entitlement, sick pay and maternity schemes), when they move between a host of public sector organisations who have adopted the commitment. Continuous or ‘unbroken’ service has long been recognised when moving between local councils or between different NHS organisations, but this is the first time it has been recognised across different public sector employers. This aligns with the approach

highlighted in the NHS Long Term Plan to enable staff to move between employers more easily and support career development. To date, the commitment has been applied to more than 20 staff moving between these organisations. The landmark commitment has been achieved as a result of partnership working between Greater Manchester’s public sector employers and their trade union partners. It is an example of how they are using the opportunities of devolution to find better ways to recruit and retain high quality staff in transforming public services.

For more information, [read the FAQ for applicants and employees.](#)

# Anchor institutions and the power of employment

The UK Commission for Employment and Skills defines an anchor institution as one that, alongside its main function, plays a significant and recognised role in a locality by making a strategic contribution to the local economy.

Anchor institutions share a number key characteristics:

**Spatial immobility:** these organisations have strong ties to the geographic area in which they are based through invested capital, mission and relationship to customers and employees.

**Size:** anchor institutions tend to be large employers and have significant purchasing power. Both these factors influence the level of impact these institutions can have on the local economy.

## Case study: Developing advanced paediatric and neonatal clinical practitioner roles (APCPs and ANCPs) through Improving Me, the Cheshire and Merseyside Women's and Children's Service Partnership

A perfect storm of workforce challenges was viewed as a potential threat to the safety, quality and experience of health care services for infants, children and young people across the North West. To address this the Cheshire and Merseyside Vanguard (Improving Me) supported the development of a new model of paediatric and neonatal advanced practice training that used the agility and clinical relevance of a social enterprise to bridge the theory/practice gap (higher education institution/NHS) and provide the workforce needed for children's services redesign (while maintaining patient safety during the transition).

They have created an online learning platform that combines web-based and face-to-face delivery of paediatric and neonatal advanced practice modules that are embedded into an established MSc advanced clinical practice programme. Seventy-nine APCPs and ANCPs, across three cohorts, have been (or are on track to be) delivered to frontline NHS acute and community services across the region.


Visit [Improving Me, Cheshire and Merseyside Women's and Children's Services NHS Partnership](#).

**Non-profit:** these institutions tend to operate not-for-profit; it is much simpler for private businesses to move, meaning there is no guarantee they will continue serving the local community in the long term. However, there are examples of for-profit organisations playing the role of an anchor.

The Health Foundation published a report in August 2019 on the **NHS as an anchor institution**. The role of the NHS, and local government, as large local employers is a clear example of the impact we have locally, bringing both opportunities and responsibilities.


The report makes clear that “anchor workforce strategies involve thinking not only about how the NHS can grow local workforce supply and widen access to employment for local communities, but also how it can be a better employer and place to build a career for more people. It acts as an anchor not only in the number of jobs it creates, but in how it can support the health and wellbeing of its staff through good employment conditions and the working environment”.

NHS organisations are rooted in their communities. Through its size and scale, the NHS can positively contribute to local areas in many ways beyond providing health care. The NHS can make a difference to local people by:



- Purchasing more locally and for social benefit**  
In England alone, the NHS spends £27bn every year on goods and services.
- Using buildings and spaces to support communities**  
The NHS occupies 8,253 sites across England on 6,500 hectares of land.
- Working more closely with local partners**  
The NHS can learn from others, spread good ideas and model civic responsibility.
- Widening access to quality work**  
The NHS is the UK's biggest employer, with 1.6 million staff.
- Reducing its environmental impact**  
The NHS is responsible for 40% of the public sector's carbon footprint.

As an anchor institution, the NHS influences the health and wellbeing of communities simply by being there. But by choosing to invest in and work with others locally and responsibly, the NHS can have an even greater impact on the wider factors that make us healthy.

 The Health Foundation

References available at [www.health.org.uk/anchor-institutions](http://www.health.org.uk/anchor-institutions)  
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Source: *Building healthier communities: the role of the NHS as an anchor institution*, August 2019. For more information, visit [The Health Foundation website](http://The Health Foundation website).

# Securing the change

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To secure this progress, the NHS Confederation is calling for an immediate focus on:

- **Financing:** increased local accountability must be matched with the devolution of funding that is currently used to cover education and training pathways in the health and care sector. This resourcing will have a dual focus: helping to establish dedicated ICS workforce teams to supply the necessary strategic and operational capacity and capability local systems require, and control of the multi-year system-wide commissioning budget for education and training. It would be fair to place a requirement on ICS boards to clarify their governance for using this funding.

## Case study: National Centre for Rural Health and Care

The National Centre for Rural Health and Care was established in 2018 as a community interest company. It is supported by public, private and voluntary and community sector partners and has approaching 50 trusts and CCGs in membership across England. Workforce is one of the centre's priority areas, recognising the particular challenges around recruitment and retention for more dispersed areas.

A recent National Centre report led by Professor Anne Green at the University of Birmingham identified the challenges facing rural STP/ICS areas and identified several common opportunities for securing a future workforce and maximising local impact.

These include realising the status and attractiveness of the NHS as a large employer in rural areas, developing 'centres of excellence' in particular specialities or ways of working in rural areas that are attractive to workers, highlighting the varied job roles and opportunities for career development available and that rural areas are attractive locations for clinical staff with generalist skills, and providing opportunities for people who need or want a 'second chance' – perhaps because the educational system has failed them, or because they want to change direction – and for whom their 'life experiences' should be seen as an asset.

Find out more about the [National Centre](#).

- **Leadership and skills development:** the skill set needed to plan, prioritise and influence workforce development at system level is not a traditional part of NHS leadership models. This urgently needs to change, with support from national bodies critical to this. We are particularly calling for a renewed focus on organisational development and change management skills, including multiagency working, mentorship and facilitation. Data analytics and management and commissioning skills should also be prioritised.
- **Support:** systems are at different places on their journey to ICS status and maturity. There is clearly a need for support from regional and national organisations (including arm's-length bodies, professional regulators and membership organisations, such as the NHS Confederation). This support must recognise the flexibility that systems need to embed a structure and system that works for their place. How the supporting organisations work together with one voice over time to help ICS models emerge will be critical to their success.

### Case study: Reinventing careers advice in schools in South West London Health and Care Partnership

Careers advice is a critical part of helping students make informed decisions about their future, both when selecting subjects for their first job or in terms of wider career choices. To support local students in making their decisions, South West London Health and Care Partnership has developed the Jobs that Care programme in collaboration with Health Education England, specifically focusing on careers in health and social care.

Jobs that Care launched in January 2019 and uses a suite of blended learning solutions. This includes Jobs that Care Play, which takes the audience through three realistic scenes based in a GP surgery, a community setting and a hospital.

In phase one, Jobs that Care Play was targeted at Year 8 groups in 20 schools in South West London, reaching around 5,000 students in total. Reinforcing the play is the Jobs that Care Game, which is a bespoke game designed to develop general knowledge around health and care, learn about different roles and how they fit with medical issues. Building on the learning is a Jobs that Care Digital solution consisting of an app and website.

Jobs that Care will over time become available to all schools and a resource for local health and social care providers to use as part of their own school programmes.

Find out more at [Jobs that Care](#).

## Case study: Health Education England place-based pilots

Health Education England (HEE) is piloting the development of a place-based approach to the use of tariff (funding for practice placements initially focused on non-medical placement activity). This involves multiple stakeholders across different types of 'place' (including whole ICSs) coming together to work with HEE to jointly find ways to maximise educational capacity in new and existing placement providers across a place, using innovative place-oriented approaches to learning, for example across care pathways within a place giving students experience from prevention through to acute care; and testing different approaches to utilisation of tariff to support placement activity. The pilot programme is supported by the Department of Health and Social Care including formal evaluation of pilot sites with different characteristics,

issues and opportunities, aims and ambitions to ensure there is the broadest consideration of what would make the biggest impact on enabling places to best meet their needs and aspirations through maximising educational capacity, so further consideration can be given to addressing these at the appropriate level to ultimately benefit all places (eg changes to national policy). HEE's initiative, which is in development, will provide ICSs with education funding accounts. Making more transparent the education funding that flows into systems will help enable all systems to take a place-based approach to exploring how they maximise that funding across and within the system, learning from the experience to date of the existing pilot areas.

Find out more by contacting [educationfunding@hee.nhs.uk](mailto:educationfunding@hee.nhs.uk)



# Delivering the manifesto: next steps

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The NHS Long Term Plan was clear in its direction and vision for integrated care systems. They are, and will remain, the central health and care policy in England. It is in this context that we have published the manifesto defining the role of ICSs in workforce, people and skills.

Devolution is in effect an incremental process requiring continuous evolution as ideas, courage and partnerships mature. The timing of this manifesto is therefore important. Confidence in the sector's ability to identify, plan and deliver nationally the health and care workforce needed for the future is falling rapidly, just as local leaders are collaborating on skills in new ways and with a range of different sectors and partners. This is where the devolution of health workforce powers meets the wider devolution of skills policy.

Delivering this manifesto would, we believe, position the health and care sector in the best possible place to deliver against its significant workforce challenges and to establish the strategic vision necessary to plan for the future. However, just as an ICS cannot realise its full potential without addressing local workforce challenges, the arm's-length bodies cannot devolve workforce responsibility and maintain a concrete wall around other ICS priority areas. Rather than see this (as some colleagues do) as the national NHS setting local systems up to fail, we may just have glimpsed the start of real system leadership across the range of critical policy areas.

We call on the government and the arm's-length bodies to deliver this manifesto in partnership with local leaders and we offer our continued support in making it a reality.

## Further information

To discuss this in more detail please contact our head of health economic partnerships: [michael.wood@nhsconfed.org](mailto:michael.wood@nhsconfed.org)

### Health economic partnerships

The NHS Confederation is the only national body directly helping the health sector to engage with the devolution and local growth agenda – building partnerships with local economic leaders which drive lasting improvements in public services for our local communities. The Health Economic Partnerships work programme focuses on the many policy areas which connect health and wealth locally; including skills, innovation, population health, estates, and finance. We combine national leadership with tailored local services. Find out more at [www.nhsconfed.org/localgrowth](http://www.nhsconfed.org/localgrowth)

# Who to contact – your regional lead

Our regional leads are on hand to support ICSs and STPs across the different regions in England. They provide access to learning and good practice, support relationships and leadership development, and create opportunities to influence national policy and thinking. They also provide a stronger and more direct link between members and the NHS Confederation, acting as a conduit to transmit messages and concerns to national bodies.



**Fiona Claridge**

*London and East*

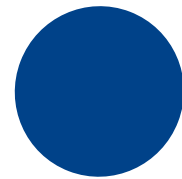
*fiona.claridge@nhsconfed.org*



**Kerry McQuade**

*North East and Yorkshire*

*kerry.mcquade@nhsconfed.org*



**Rory Deighton**

*North West*

*rory.deighton@nhsconfed.org*



**Denise Vittorino**

*West Midlands*

*denise.vittorino@nhsconfed.org*



**Sarah Walter**

*South East*

*sarah.walter@nhsconfed.org*



**Gemma Whysall**

*East Midlands and East*

*gemma.whysall@nhsconfed.org*



**Helen Wolstenholme**

*South East*

*helen.wolstenholme@nhsconfed.org*





## How to stay in touch

We offer a wide range of email newsletters, including:

- Regional Integrated Care Bulletin
- Media summaries
- Member update
- Local growth bulletin
- NHS European office update
- Mental Health Network update
- Independent Healthcare Providers Network update
- NHS Clinical Commissioners update
- Local growth bulletin
- NHS Brexit bulletin
- NHS Confederation chief executive's blog

Visit us at <https://www.nhsconfed.org/ICSNetwork>

Contact your regional lead – see **page 43 for details**

Blog with us on NHS Voices – visit [www.nhsconfed.org/blog](http://www.nhsconfed.org/blog)

Showcase a case study of innovative work – visit [www.nhsconfed.org/resources](http://www.nhsconfed.org/resources)



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Floor 15, Portland House, Bressenden Place, London SW1E 5BH

Tel 020 7799 6666

Email [enquiries@nhsconfed.org](mailto:enquiries@nhsconfed.org)

[www.nhsconfed.org](http://www.nhsconfed.org)

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