eWIN GOOD PRACTICE CASE STUDY

NHS North West

GM PCTS

SHARED HR SERVICE

SUMMARY

The Greater Manchester (GM) PCT shared HR service was built with the main aim of keeping the PCTs' HR functions resilient throughout major NHS reforms. However it also aims to provide structured support to the implementation and development of NHS Greater Manchester, to enable the longer term sustainability of the HR shared service, following the abolition of PCTs, whilst driving down costs.

By 1st April 2011, all PCTs were required to split their Provider and Commissioning Arms, under the Transforming Community Services (TCS) agenda. This would lead to large numbers of HR staff transferring out of PCTs and into the Provider services, resulting in inevitable weaknesses. It was therefore imperative that Greater Manchester's PCTs were ready for these changes, and that they put in place a collaborative, shared service before this occurred, to avert major problems,

As a result, this shared HR service went live on 1st April 2011, the same date as the TCS transfers, and since then it has achieved the following outcomes.

KEY OUTCOMES

This new shared service is still relatively young, so the long-term benefits and cost reductions have not yet been formally evaluated. However, Michelle Kaye has set up a HR scorecard, which can be used in monthly Board Reports and also Cluster Board Reports. This scorecard includes a full range of HR indicators linked to targets within the Boorman Review and will allow further evaluation of project outcomes in future.

Positive outcomes already evident at this early stage, include:-

- Each organisation's HR function has remained resilient throughout recent reforms, which has helped support the resilience of each organisation as a whole.
- Establishment of strong operational functions such as a centralised business support, joint learning and development and clerical support services.
- Demonstrated significant progress towards the desired service model and the estimated managerial cost savings of 40%, which this model is predicted to achieve through; reviewing the workforce composition of the collaborative service, establishing plans agreed through the Cluster EMT to bring about significant reductions in management costs, consolidating roles where there are duplications, developing proposals to centralise support functions such as Learning & Development administration, and transactional business support services such as workforce information, employee records and recruitment.
- A flexible service has been developed, which allows for further expansion to other organisations in future.
- Due to significant culture changes, barriers between Trusts have been broken down and a spirit of mutual support and collaboration has been fostered.
- Communication channels have also opened up across departments, and there has been collaboration with other services. This has helped HR teams to gain a better understanding of the business aims, which in turn has led to higher quality, customer-focused HR services.
- The move highlighted inconsistencies within the system. For example, it became clear that only Salford had an executive level HRD, the others were functioning with Associate Directors or none at all. By highlighting the inconsistent approach to positioning and leading HR across the Cluster it demonstrated a commitment to "Equity and Excellence" by ensuring that all subscribing organisations would be levelled up to the best model and that the entire function would be led by a Cluster lead HRD at board level.

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BACKGROUND

5 PCTs were involved in the first wave of shared services (Phase 1):

- NHS Bury
- NHS Heywood Middleton and Rochdale (HMR)
- NHS Manchester
- NHS Oldham
- NHS Salford

3 Other PCTs came on board in the second wave (Phase 2):-

- NHS Stockport
- NHS Trafford
- NHS Tameside & Glossop

2 PCTs are not part of the shared service:

- NHS Ashton, Leigh & Wigan (ALW)
- NHS Bolton

There are a total of ten PCTs within the Greater Manchester area, which have formed a PCT Cluster. Of these, eight have came together to form the shared HR service, which serves a workforce of just under 2600 staff across the eight organisations. As a result of TCS transfers Bury, Oldham and HMR were left with very few staff as of April 2011; having only 7, 2 and 0 respectively. However, collectively with Salford and Manchester there are now 70 staff employed within the shared HR teams. This provides more than enough cover across the shared service, so the plan is to reduce this level of staffing further over the next several months, to deliver cost savings.

The initial resourcing plan will take the current headcount down to around 60 through consultation, consolidation of roles and where necessary review of the status of fixed term contract holders, agency staff and secondees. A policy on voluntary redundancy and retirement is currently under consultation and it may attract applicants from the HR service. The intention is that during the second year of business the shared service keeps pace with changes in the health care economy and reduces its headcount further towards a target of around 35. The final numbers are dependent on developments around commissioning support.

There are also two Trusts which are not part of the GM PCT Shared Service, namely; Ashton, Leigh & Wigan (ALW) and NHS Bolton PCT. ALW instead engaged in an SLA arrangement with a provider organisation. NHS Bolton has transferred all of its HR&OD resource into their local provider Trust and is buying back the full range of services under an SLA. However, both Trusts still form part of the cluster and engage with the Shared HR Service in order to enable information sharing and collaborative working across the whole of Greater Manchester.

PURPOSE

Key Aims of Shared Service Project were to:

- Provide a structured approach to the migration from the existing interim Human Resources and Organisational Development Services to a fit for purpose substantive Shared Service arrangement, proposed to commence with effect from **1st September 2011.**
- engage with all interested stakeholders in existing and new organisations to clearly define their requirements of a level of commitment to a shared service and then dedicate the necessary resources and energy to its establishment
- Identify contingency plans to transfer the provision of services to this shared function from the second wave PCTs and ensure that the business continuity requirements of all organisations were adequately provided for during any transitional period.
- Provide structured support to the implementation and development of NHS Greater Manchester and to enable the longer term sustainability of the HR shared service following the abolition of PCTs. The old model would have had to have been reviewed anyway, as it was unsustainable in the long-term, so TCS just accelerated the process.
- Ensure each organisation met its legal, statutory and moral obligations as an employer.
- Improve workforce metrics across each Trust e.g. reduce sickness absence to 3%, across the entire Greater Manchester PCT workforce.
- Develop a consistent approach not only to the provision of workforce information but also as to how this information can add value to the management of the workforce.

KEY STAGES OF SET UP

First Phase (Nov 2010 – April 2011)

- Since November 2010 informal exploratory work was carried out to look at the feasibility of a shared service across Greater Manchester. The option of a shared service was compared with that of buying in services and it was decided that sharing services was the most cost effective option.
- In February 2011 CEO sign-off was gained for collaborative working to ensure HR&OD business continuity for all five organisations that joined the service; NHS Bury; NHS Heywood, Middleton & Rochdale: NHS Manchester; NHS Oldham and NHS Salford
- A project implementation group was established, with work stream responsibilities.
- Staff within the existing services were communicated with, as to the temporary need to establish the shared arrangement, as soon as possible, and with maximum flexibility and collaboration.
- The interim arrangement went live with effect from 1st April 2011, with a draft operational structure in place, with all staff temporarily aligned to roles that matched their skills and experience, so that they could deliver effective services to all subscribing PCTs.
- A centralised business function was set up, as well as a common learning management system to help make services uniform and easier to manage across several Trusts.

- Once established, it was agreed to progress with a more substantial programme to formalise the arrangement for the "original five" and engage with the "remaining five" as to their level of commitment, in order to establish a robust service capable of facilitating the remaining organisational transformation processes, support the development of Clinical Commissioning Groups and develop an HR&OD component of the proposed Commissioning Support Service offer.

Second Phase (April - Sept 2011)

- Agreement was reached with three of the "remaining five" including NHS Stockport; NHS Tameside & Glossop and NHS Trafford.
- A visioning event was held in May for all the HR leads across each of the PCTs. The purpose of this was to gain engagement from key stakeholders and to gather them together in a single facilitative environment to help scope the project. The event was facilitated by Peter Reilly and the following key decisions were reached:-
  - Project management methodology
  - Project plan in regards to who would undertake which roles, with specific workstreams and a timeline
  - Potential risks and challenges
- By June the first Project Board meeting was held and an executive sponsor was agreed initially as John Boyington, Managing Director of NHS Bury. This Board is composed of HRDs from all ten PCTs and not just from the ones involved in the Shared Service. Under revised governance arrangements agreed in July 2011, the Project Board became directly accountable to the NHS Greater Manchester EMT.
- Project implementation via several workstreams was then initiated, with an action plan and time frame (the Project Initiation Documents around each of these workstreams are available as appendices to this case study)
- Throughout August agreements were formalised and a single locality management team was set up to make HR provision more representative and to align HR resources to services. This senior management team is composed of one HR Lead from each Trust with Andrea Anderson from NHS Bury appointed as Lead HR Director to represent the shared service within the GM cluster. She now meets regularly with each Locality and work stream HR lead and this allows potential problems to be quickly resolved.
- Going forward there may be up to three locality management teams or there may be only one, but this will be determined based upon decisions taken by the Cluster Board.
- Firm connections were also made with the staff partnership forum, which is composed of staff from each of the PCT's Joint Strategic Consultative Committees (JSCC), in order to keep staff side and union bodies engaged and informed of any changes in structure.

Sign-off

- The Project Board agreed a number of structural options in September to present to the NHS Greater Manchester EMT. The EMT decided that as the HR & OD function was crucial to delivering the change agenda, it would not immediately be required to deliver maximum cost efficiencies as these could be worked on later. What the EMT did require was a single service that was fit for purpose and had the capacity and capabilities to re-organise itself, support the transformation of the NHS locally and facilitate the development of the emerging organisations. This then required the Project Board to rethink some minor amendments to the structures, which are subject to a final financial analysis.
- The final suggested structure was included in a consultation paper which was presented to the NHS Greater Manchester Staff Partnership Forum on 4th October and approved by the Project Board on 5th October. Some minor amendments were then made so that this could be presented to all of the HR&OD staff, at a subsequent consultation launch meeting.

HOW IT WORKS

The project has the potential to achieve significant cost reductions on current HR&OD costs. These are being achieved through:-

- Reduction of duplication
- Using technology in support of adminsitrative and advisory services
- Reducing staff headcount e.g reducing Director level posts from eight to one. This has an estimated value of £610,000
- Consolidating administrative processes and reducing admin costs (including consolidation of non-pay budgets)
- Revising the skill mix of the HR & OD establishment
- Rationalisation of posts by ensuring that roles within the function are evaluated at the appropriate pay band for the level at which they are operating and resourcing elements of the function to create career progression and succession planning options

Centralised Business Service Function

This function manages workforce and t ransactional information for all of the member organisations, and ensures that they each attain a stable and appropriate HR service throughout this period of reform. Based at NHS Salford, which was the Trust with the highest remaining HR headcount, this business services function administers payroll, recruitment and employee records for the service. With a centralised function and a stronger focus on technology, this enables the delivery of higher quality more efficient services.

Joint Learning and Development Function

Again, based at NHS Salford, this function administrates learning and development (L&D) across the first wave of Trusts. With a Common Learning Management (AT Learning) System this ensures that each Trust enables its staff to partake in essential L&D. There is a single administrative delivery system, with a single mandatory training matrix agreed for each Trust, which is delivered via the e-learning National Learning Management System (NLMS). Setting up this function was a necessity as so many trainers had left the PCTS during the transfers/reforms.

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RESOURCES

The arrangement was established within each Trust's existing budget constraints and within the existing staffing establishment so there was no huge outlay of money required. However NHS NW did provide some funding to help with project delivery.

KEY CHALLENGES

Creating the service whilst running it

As Kevin Moynes summarised, ***"It is like building an airplane whilst trying to fly the plane"***. In other words, there was no opportunity to create the service before it was required to work effectively. Therefore, decisions had to be made very quickly and this put much more pressure on the project. Single examples of the intensive co-operation and flexibility shown by not only the project team, but also the mainstream staff are hard to identify as they are too numerous to mention. Suffice to say that all concerned have shown great commitment to make things work from the word go. There has been intense scrutiny from a number of directions – from the organisations to ensure that services are provided to the highest standard possible, from other disciplines to see HR leading the way to shared services by example and the staff, knowing that they only have one chance to get things right. One senior leader likened the process to being on a ***"five month interview"***.

Low Staffing Numbers

Due to the transitions key people were leaving each organisation via MARs and voluntary redundancy schemes, or because they had found positions elsewhere. Coupled with the fact that many staff were part-time or were on maternity leave this led to low staffing numbers. Setting up the shared service bridged these gaps to a large degree and staff provided ad-hoc services where necessary. However, it was important to stem the flow of important staff out of the service. This was addressed by highlighting the potential benefits of creating a sustainable business model, which could expand in future and would require expert, experienced staff in post.

Gaining Collaboration

The second wave of Trusts were in a much stronger position, and did not need to collaborate in order to survive. However it was seen as beneficial to the whole cluster for this to happen. Therefore they were given the extra encouragement required to join the service and convinced of the benefits to all involved. Mike Burrows, the Chief Executive (CE) at the head of the PCT Cluster, took a leading role in this. Using a soft approach and treating everyone as equal partners, he wrote to all the other CEs encouraging them to work together to find a way forward which enabled collaboration to take place.

Financial constraints

The service has to be funded within an existing cost envelope as well as contribute towards an overall 40% reduction in costs and needs to fit in with available funding via running costs. This will be achieved through sound financial management, establishment of budgets and working across Localities to determine the level of required cost efficiencies. The establishment of a finance work stream to monitor progress and inform project board of variances and exceptions has been key to ensuring that the service is economically viable and delivers the expected cost efficiencies.

Clinical

Failure to provide for Performer's List activities, Continuous Medical Education and general L&D activities could lead to performance failures and poor clinical practice. Therefore provision of these services needed to be ensured through maintaining commitment to support all L&D activity both in Primary Care and internally, to meet statutory & mandatory requirements as well as professional and developmental needs.

Statutory/Legal

There was a potential for discriminatory employment practices to arise and failure to follow statutory processes in consultations and redeployment of staff. This has so far been avoided by the Project board closely monitoring time scales of consultative processes and ensuring appropriate engagement of all stakeholders.

Staff Engagement

Initially there were tensions amongst staff, due to fear of change and redundancy, which could have led to a lowering of morale subsequent disengagement of the workforce. However the Project board closely monitored feedback from consultations, gauged staff morale and ensured effective communications processes were in place as well as meeting moral and legal obligations.

Brown Field Site

Being a brown field site was a challenge in that from the outset it was difficult getting staff to develop common working practices, whilst delivering a highly complex organisational change agenda. For example, the Business Services team came together to develop harmonised working practices whilst processing the final stages of transferring thousands of staff to different organisations under TCS. Another area of challenge was in the provision of sound HR advice consistently to each organisation at the same time with vastly reduced numbers of HR Managers and Advisors, most of whom had transferred out. Using a farming analogy, it was like ploughing, sowing, muck spreading and harvesting all at the same time.

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KEY LEARNING

What lessons were learnt from this process?

- It would have been better to have all the PCTs on board from the beginning. This proved difficult due to the different cultures of each organisation and their existing positions, but if more time and effort had gone into conducting a feasibility study, and collaboration had been gained earlier, then a two stage process could have been avoided.
- Subject Matter experts are invaluable and is wise to bring them as early as possible e.g. finance colleagues, data analysts.
- A clear vision and academic robustness are also vital so bringing in an experienced facilitator at the start, such as Peter Reilly, is a must.
- It is important to work together despite different approaches, leadership styles and politics. All organisational change can be chaotic at times, but so long as this is recognised it can be overcome.
- Costs are difficult to determine until staffing levels have been outlined, so the sooner this can happen the better.

NEXT STEPS

- Make sure that the management structure and skills mix are correct, and that people are in the correct roles.
- Continue to build on the effective interim arrangements to build a full shared service fit for purpose, to take the service further than resilience, against the significant drop in HR staff.
- Develop self-management amongst general staff as part of the Organisation Development Workstream i.e. build the skills of line managers and general staff to reduce the onus on HR. It is important to get the balance right however, so that people still value the HR service.
- A further four workstreams have been created and will be implemented.
- Work closely with clerical support service staff to ensure the long-term sustainability of the service and the streamlining of processes.
- Build a library of key documents, templates and letters which can be utilised across Trusts.
- Explore the possibility of subscribing to EHR. This is a piece of software which allows a HR knowledge base to be customised to any model of service delivery and provides tools such as pay calculators to staff, which reduces the amount of support they require from HR.
- Part of the consultation process with staff will explore options for co-locating the centralised business function and joint L&D function to reduce estates overheads, equipment costs and to facilitate better use of technology in streamlining admin processes.
- Ensure that a workforce consultation is carried out in a fair and transparent way, in full partnership.
- Monitor NHS reforms and continue to address new challenges or exploit opportunities as they arise. For example, around the clustering of SHAs or the introduction of the new Clinical Commissioning Groups (CCG). It is uncertain how these developments will affect the service, but as with past reforms, the service will have to be flexible in order to survive.
- Scope the potential to expand the service to other organisations such as further NHS Trusts, local authorities and prison services etc.
- Further evaluation will be conducted in line with the NHS North West progression of a single model for commissioning support and how the HR component of that offer will be taken forward.

SUPPORTING MATERIAL

The following resources are available as an appendix to this case study

- Business Case – Bob Champion
- Project Initiation Documents (PIDs) – overall and for each workstream

CONTACT FOR FURTHER INFORMATION

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