

NHS WORKFORCE PLANNING

Limitations and possibilities

Candace Imison

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First published 2009 by the King's Fund

Charity registration number: 1126980

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ISBN: 978 1 85717 587 5

A catalogue record for this publication is available from the British Library

Available from:

The King's Fund
11-13 Cavendish Square
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Email: publications@kingsfund.org.uk
www.kingsfund.org.uk/publications

Edited by Fiona Weston

Typeset by Peter Powell Origination & Print Ltd

Printed in the UK by The King's Fund

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Acknowledgements

The authors wish to acknowledge the support of and contributions from correspondents in the United Kingdom and elsewhere, as well as helpful comments from external reviewers.

Summary

Workforce planning for the National Health Service (NHS) is a large undertaking. The NHS in England employs approximately 1.3 million staff, 70 per cent of recurrent NHS provider costs relate to staffing, and more than £4 billion is spent annually on staff training.

Securing a sufficient number of staff with the appropriate skills and deploying them effectively is a highly complex challenge, and one that is all the more important now that the NHS is about to enter one of the most financially constrained periods in its history. If it is to thrive and survive, productivity will need to make a step-change, and much of the scope for improvement lies in the workforce.

This report considers the degree to which NHS workforce planning in England is likely to support the delivery of a workforce that is fit for the future. To inform this assessment, we examine current developments at national and regional level, highlight relevant international experience, and propose ways in which planning could be made more effective.

We begin by looking at the challenge of workforce planning (Section 2). At its heart is an aspiration to match the supply of staff to the need for them. This is technically difficult, as the periods over which forecasts are made, and the complexity of health care delivery, make it exceptionally hard to plan for let alone deliver. At least some of the so-called 'failures' of workforce planning in the health service have been less about problems with planning and more about unrealistic expectations on the part of policy-makers, who have not recognised the limitations of the planning process. Nevertheless, the system can be improved; in particular, a process is needed that continually and robustly identifies risks and trends, and can trigger flexible responses.

Effective workforce planning is also about more than getting the numbers right. It is equally important to ensure that current members of staff have the right skills to meet future demands; most of those who will be working for the NHS in 10 years' time are already employed by it. Planning cannot therefore be solely about new recruits; it must also consider how to develop new skills and new working patterns for those who are already in post.

In Section 3, we review recent policy developments. The inquiry conducted by the House of Commons Health Committee (2007) into NHS workforce planning and the Tooke report (2008) identified significant failings in the existing workforce planning and medical education systems. The Health Committee set out four significant challenges:

- a need to increase workforce planning capacity at national, regional and local levels – ensuring that plans reflect the wide range of factors that will affect supply and demand in the future
- a need for workforce planning to be better integrated – across the workforce (medical and non-medical), across the NHS (finance and service), and across health care (NHS and non-NHS organisations)

- to deliver a more productive workforce
- to deliver a more flexible workforce.

The NHS Next Stage Review initiated a specific examination of workforce and workforce planning (Department of Health 2008) to address these shortfalls. The review concluded that a leading role needed to be given to service providers and local commissioners, with the intention of bringing together workforce, service and financial planning. New national bodies – NHS Medical Education England (MEE) and the Centre for Workforce Intelligence (CWI) – were established to improve the quality of workforce forecasting and to provide expert support and oversight to local workforce planners. The existing funding arrangements under the multiprofessional education and training (MPET) budget were to be replaced by a more transparent tariff-based system.

While the NHS Next Stage Review work points to improvements, we believe a number of key questions remain to be addressed.

- Where does responsibility lie for acting on any workforce risks identified at national and local level?
- How will planning be integrated or aligned across professional/occupational groups, given the single-profession focus of MEE?
- How will the new approach involve other employers from the mixed economy of providers that is emerging in the health sector in England?
- How will the important links between workforce planning and other areas of workforce policy, including decisions on pay and conditions be made?
- The proposed tariff arrangements for MPET funding appear to present a number of risks. How will these be managed?

In Section 4, we review current workforce planning in England and the degree to which the issues identified by the Health Committee in 2007 have been addressed. We reach the following conclusions.

- **Workforce planning capacity** The workforce plans of different strategic health authorities (SHAs) vary in approach and scope. The effectiveness of workforce planning is also constrained by the resources dedicated to it. It is evident that a larger critical mass in terms of funding base gives more opportunity for a broader and more inclusive approach. This is important when considering the relative roles that SHAs, primary care trusts (PCTs) and trusts can play in workforce planning activities, and suggests that it might be more cost-effective for SHAs to undertake some of the more strategic and horizon-scanning elements of workforce planning activity.
- **Integration of workforce planning** The different dimensions of planning are still not adequately co-ordinated. Given the prospect of much tighter funding, there are particular risks in the failure to link financial and workforce planning at both local and national level. For example, the NHS may not be able to afford the number of doctors or nurses currently being planned. The divide between medical and non-medical planning is still to be bridged.
- **Workforce productivity and flexibility** There is now widespread recognition that the workforce will need to be considerably more productive if the service is to keep up with growing demand but tighter funding. However, although there is more of a focus nationally on productivity, we found a variable pattern of investment and attention within SHAs. Seven out of ten SHAs were investing less than 5 per cent of their budget on general workforce and leadership development. Across the country

as a whole, total SHA investment was £194 million for a workforce of 1.3 million in the NHS in England. The general assumption is that support for workforce development within organisations will be funded primarily by local providers, yet anecdotal evidence suggests that NHS trusts invest little in this area, and that it is often the first to be cut when finances are stretched. Given the tight funding cycle that the NHS is entering, this is a cause of major concern.

In Section 5, we review the international experience of workforce planning, concluding that no country has got it right over the long term, if success is measured by an absence of staff shortages or oversupply.

We then go on, in Section 6, to make a number of recommendations that seek to minimise the limitations of and maximise the opportunities for workforce planning in England.

Recommendations

- **Workforce planning at local and national level should be a core part of the productivity and quality improvement agenda.**

Workforce planners should undertake scenario modelling, workforce costing and supply-side projections, and future projections should include changes in the number, pay and mix of staff, in order to give employers and policy-makers the information they need to help improve productivity.

- **The annual assessment of priorities should look at the workforce in the round, not just the different professional groups and their sub-specialist elements.**

The assessment of risks should provide relevant information on:

- *education*
- *employment law*
- *pay*
- *working conditions*
- *national and international flows.*

There is a particular need to link pay policy to broader workforce goals.

- **The planning and funding of broader workforce development, including leadership skills, should be given a higher priority.**

As part of the annual risk assessment, management and leadership capacity should be given specific attention. Consideration should also be given to whether the balance of investment is correct between the clinical and non-clinical workforce, as well as between the current and future workforce.

- **The multiprofessional approach to workforce planning should be strengthened.**

The impact of recently established professional advisory machinery (MEE and equivalent) should be reviewed after one year to assess whether it is successfully supporting an effective multidisciplinary approach to workforce planning, commissioning and policy development, with a view to making any recommendations necessary to achieve the required integration/alignment across disciplines.

- **Planning capacity at regional/local level should be audited and improved.**

The Audit Commission should undertake a specific audit of the current workforce planning capacity in the SHAs, NHS trusts and PCTs. The findings should inform the development activities undertaken by the new CWI.

- **MPET's funding arrangements should be reviewed.**

The Department of Health and SHAs should review the impact of the proposed tariff arrangements for MPET after one year and consider whether a more flexible funding model is necessary. There might be particular merit in considering arrangements similar to those for Commissioning for Quality and Innovation (CQUIN), to give SHAs the capacity to stimulate innovation and quality improvement in training delivery.

- **There should be greater clarity of roles and responsibilities.**

There is a need to clarify roles within workforce, service and financial planning, and to identify and resolve current overlaps and gaps. The various parties, including the newly established health innovation and education clusters (HIECs), need to work together to ensure the appropriate intelligence and risk assessment. It is especially important to identify who should be responsible for acting on any risks that have been identified in the system. If the SHAs are to undertake a leadership role, this suggests that they should also be accountable for managing workforce risks.

- **There should be greater transparency about the degree of inherent uncertainty.**

The risks and assumptions in the workforce planning cycle should be made more transparent. Any annual assessment of workforce priorities needs to highlight and quantify the inherent uncertainties and risks in supply and demand.

- **Workforce planning information needs to be secured from all health care providers.**

The new national Electronic Staff Record (ESR) will provide an invaluable source of workforce planning information from NHS trusts, and the potential of this new resource must be maximised. Workforce information is also needed from organisations that do not submit data via the ESR, that is, non-NHS providers and independent contractors within primary care. It will be important to find robust ways of capturing their workforce data.

Conclusion

There is a need for new thinking in this area, and a risk that, even with the reforms arising from the NHS Next Stage Review, the result will essentially be more of the same.

The focus should be on developing a flexible approach that does not seek long-term predictive precision but can identify potential medium-term issues, and, most importantly, enable the current workforce to evolve and adapt to the inherently unpredictable health care environment.

1 Introduction

Workforce planning in the National Health Service (NHS) is a costly and complex challenge. Health care is a labour-intensive service industry: approximately 70 per cent of recurrent NHS provider costs relate to staffing (House of Commons Health Committee 2007). The safety and efficiency of the care delivered by every organisation in the health sector depends on the ability to secure a sufficient number of staff with the appropriate skills and deploy them effectively. However, health care professionals can require long periods of training before they are able to practise independently. When skills gaps arise, they are often attributed to failures in central workforce planning and frequently attract significant political attention.

The NHS is about to enter a period of extended financial constraint, while at the same time the health needs and expectations of the population are rising; this has fundamental implications for workforce policy and planning. NHS productivity will need to make a step-change from the recent annual average -0.4 per cent, to an annual average of more than 5 per cent (Appleby *et al* 2009), and much of the scope for improvement lies in the workforce.

This report examines the current and future context in which the NHS must operate, and assesses the degree to which NHS workforce planning in England will support the delivery of a workforce of the necessary size and skills base. To inform this examination and to help shape recommendations on improving the effectiveness of this vital function, we look at current national and regional/strategic health authority (SHA)-level developments in the NHS in England, and highlight international experience where relevant.

NHS workforce planning is a large undertaking. The NHS in England employs approximately 1.3 million staff and the independent sector a further 0.5 million, giving a total workforce of 1.8 million spread across more than 1,000 separate employers (Curson *et al* 2008). The supply pipeline to the health care workforce is significant, with more than £4 billion spent annually on staff training (Department of Health 2008). Given the shift towards more integrated working between health and social care, it is interesting to note that the social care workforce is of a similar size, at 1.4 million, but distributed over a much larger employer base – estimated at around 35,000 separate employers (Eboral and Griffiths 2008).

NHS workforce planning and policy have recently been high on the policy agenda and in the public consciousness. Media coverage and policy concern about problems with under- and oversupply of NHS staff (so-called ‘boom and bust’) led to a House of Commons Health Committee inquiry in 2007 (House of Commons Health Committee 2007), which highlighted a lack of alignment between workforce planning and service/financial planning, inadequate workforce planning capacity, and planning tensions in the NHS between the top-down pressures to meet national policy priorities, and the bottom-up pressures to meet local service and staffing priorities.

Similar issues were identified by the Tooke inquiry, which reported on the crisis caused in 2007 when there were difficulties with the new system of allocating NHS junior doctors to specialty training posts (Tooke 2008, p 12).

The government response to these inquiries has been bound up in the broader reform of the NHS in England, described in the NHS Next Stage Review (Darzi 2008).

However, the pace of change in the NHS will be limited by future funding constraints. Although NHS spending in England has more than doubled in real terms since 1999/2000, leading to significant staffing growth in the period up to 2006, the prospects for future funding now look bleak, with prospects of zero growth or even real-term cuts (Appleby *et al* 2009) as a result of the knock-on effects of economic recession.

This report therefore examines NHS workforce planning in the context of the reforms set out in the NHS Next Stage Review (Darzi 2008), but in the knowledge that the funding levels available for this labour-intensive sector will be constrained over the next few years. It assesses the extent to which lessons have been learned from recent failures of NHS workforce planning and examines whether the new proposals, including those for a new tariff-based system of funding for clinical placements, are likely to deliver a workforce planning approach that can reconcile the top-down and bottom-up tensions in a health system, particularly when funding is tight. In addition, the report assesses our current approach in the context of broader changes within health care, and the degree to which NHS workforce planning in England has adapted sufficiently to these challenges.

2 Workforce planning and its challenges

According to one overused description, workforce planning is about ‘getting the right staff with the right skills in the right place at the right time’ (*see*, for example, US Department of the Interior 2001; Department of Health 2004; Bradford Teaching Hospitals NHS Foundation Trust 2008).

As an overall objective, this can provide a useful focus, as long as the definition makes clear that this is not just a numbers game, but a forward-looking process that needs to address staff competence and location. However, basing an approach to workforce planning on this ‘ideal’ creates a number of problems, including:

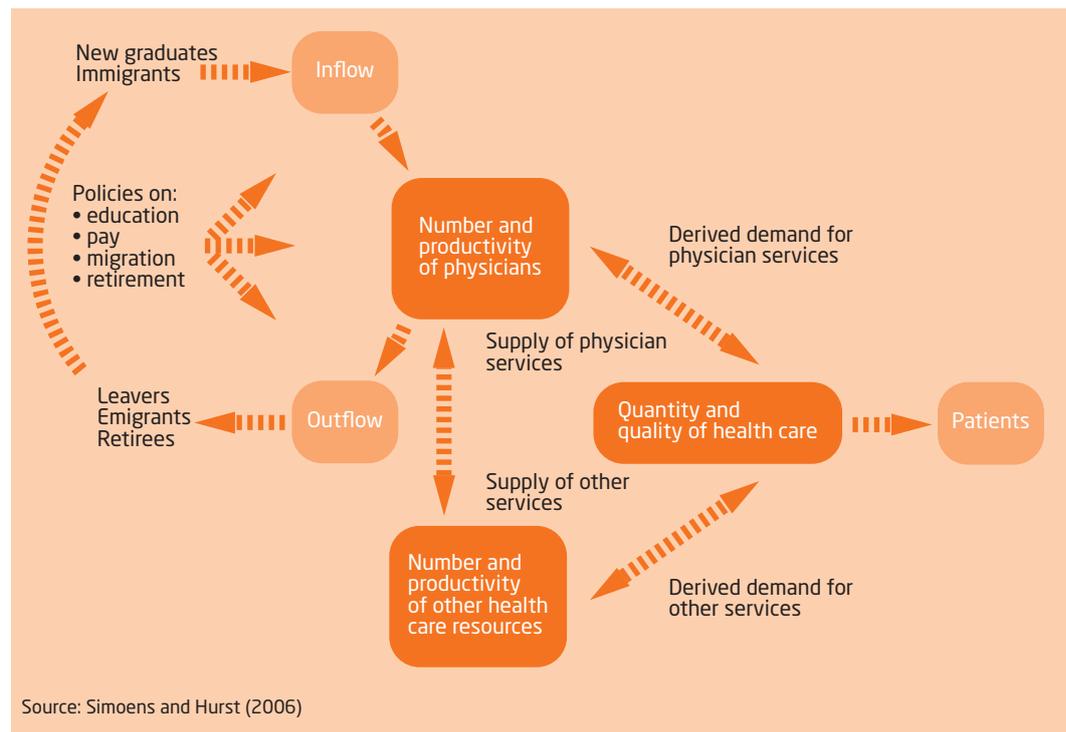
- how ‘right’ is defined – and by whom?
- how are the sometimes conflicting interests and priorities to be reconciled – and by whom?
- is it ‘right’ from the patient’s perspective, ‘right’ from the professional’s perspective, ‘right’ from employer’s perspective, or ‘right’ from the health care commissioner’s perspective?

A commissioner of health care will have an interest in maximising cost-effectiveness; a patient will want high-quality interaction with a highly skilled member of staff; a professional will have a need for job satisfaction and career development. Aside from these difficulties, the definition implies a level of certainty and predictive ability that, as we argue below, is unrealistic given the rapid rate of change within health care and the prolonged training periods required for some categories of health care staff.

What are the objectives of workforce planning?

The most common objective identified for workforce planning is to attain a balance between demand for staff and their supply – to estimate the future demand for staff required to deliver defined services, and to try to ensure that a sufficient (but not excessive) number of appropriately qualified personnel is available to meet this demand.

Simoens and Hurst (2006) provide a helpful schematic model showing the linkages between the different workforce policies and drivers, which can be used to inform workforce models for future supply and demand (*see* Figure 1 overleaf). Although the model was designed for the planning of physician services, it can equally be applied to those of other health care professionals.

Figure 1 Aligning workforce supply with demand

On paper, the approach looks relatively straightforward, but in practice the execution is usually difficult and complex. The stock-flow model shown in Figure 1, in which the stock (current number of staff) is modified by estimates and projections of future inflows and outflows to produce an estimate of actual or desired future stock, can be helpful in supporting decisions on policy change and allocation of funds for training, but it can easily provide erroneous predictions. In any model, a range of assumptions must be made about future demand and supply, which, over the 10–15 years that it takes to train a doctor, are vulnerable to unpredictable change.

Taking the example of the model on doctor supply/demand, estimates must be made about the future flow of doctors between the United Kingdom and other countries, and about the future participation rates of doctors, given the increasing feminisation of the medical workforce and changes in working practices and career pathways. The model can be sensitive to relatively small shifts in the balance of inflow/outflow from the country, and changes in participation rates can have a significant impact on the balance between supply and demand.

In relation to assessing future demand, there are also complex judgements and estimates to make. A range of factors, some impacting in opposite directions, need to be considered, and the net effect is difficult to judge. For example, changing models of care can reduce reliance on particular types of skills or staff, while demographic change and new treatments can drive up demand.

The impact of external policy changes, such as the implementation of the European Union (EU) Working Time Directive, must also be considered, along with the fact that staff productivity is likely to change as variations in case mix or approaches to treatment drive it up or reduce it. Aside from these broader changes in health care, the National Health Service (NHS) faces frequent and major national initiatives that can undermine the best-made planning assumptions (Curson *et al* 2008).

Attempting to capture and assess the net effect of these different and sometimes conflicting dynamics is a major challenge for traditional workforce planning approaches.

This is particularly the case where the focus has a long time-horizon, and/or the actual size of the occupational group under examination is relatively small. It is unrealistic to assume, for example, that the results emerging from a traditional workforce planning process will accurately predict exactly how many obstetricians will be needed in 2018, or how many intensive care nurses to train in 2010. Such certainty is simply unachievable.

Even when these challenges are taken into account, it should also be noted that some of the 'failures' of NHS workforce planning that have been identified have been less about system problems than about a failure of policy-makers and politicians to be realistic and comprehend the limitations of the NHS workforce planning process and what it can, and cannot, achieve.

Given the complexities, the workforce planning process is a balancing act that requires the ability to respond flexibly and adjust to changes in the relative effect of different supply and demand factors over time. It is less about long-term predictive precision than it is about an adaptive and flexible process (*see*, for example, Bramham 1994; Hall and Mejia 1978; O'Brien-Pallas *et al* 2001; Australian Health Workforce Advisory Committee 2004; Bosworth *et al* 2007; Buchan 2007).

At all levels, there is also a need to recognise that workforce planning should not be conducted in isolation. The Simoens and Hurst model shows how related policies – such as those on education, pay, migration and retirement – can be critical to achieving the right balance of supply and demand. The success of workforce planning in the health sector in any country will depend on the degree to which planning can accommodate the impact of these factors in the short term, and can influence their policy direction in the longer term.

In addition to aligning supply and demand, workforce planning needs to support a number of other objectives. The health sector operates in an environment of resource constraint, and workforce planning must support the NHS to function effectively within those constraints, which, as was noted earlier, will become even more stringent over the next few years. Planning for workforce growth, which was the primary focus in the period between 2000 and 2006, is being replaced by planning for workforce productivity. In order to improve workforce productivity, the workforce planning process must connect effectively with service and financial planning.

Finally, there is a risk that traditional planning approaches that focus on the 'front end' – on equipping new entrants with the appropriate skills – miss the critical challenge of ensuring that the members of the existing workforce continue to have the right skills, using revalidation, retraining and redeployment. The planning process must recognise that most of the staff who will be working in the NHS in 10 years' time are already NHS employees. Planning cannot focus solely on new staff – it must also encompass the need for new skills and new work patterns for existing staff.

All of this underlines the complexity and challenge of the task in hand. NHS workforce planning is highly complex and multilayered, and involves different timelines for different professions and occupations. It is moving from a policy context of workforce growth, to one where funding constraints concentrate policy attention on workforce productivity. It involves a wide range of activities, many of which require a high level of skill (*see* box overleaf).

Some of the key components of workforce planning

- The provision of data and information on a range of subjects, including staff numbers, training requirements and demographic, technological and policy developments.
- Analysis of future supply and demand, looking at how many and what type of staff are likely to be required in the future, and how many and what type of staff are likely to be available.
- The creation of workforce plans that set out how future supply and demand will be matched, covering, for example, the number and type of staff to be recruited, the amount and nature of training to be commissioned, and the amount and type of workforce development activity that will take place.
- Decisions about the level of funding that will be available to support workforce planning and development activities and how it will be distributed.
- The commissioning of education and training, including undergraduate, postgraduate and vocational training across a range of professional and occupational groups.
- A wide range of workforce development activities, including the introduction of new and extended clinical roles, redistribution of staff responsibilities, increasing productivity and efficiency.
- Negotiation of contracts, including service contracts and employment contracts.

Source: House of Commons Health Committee (2007, p 114)

3 Recent policy developments in workforce planning in the NHS in England

Origins and limitations of the current system

Over the past 10 years, National Health Service (NHS) workforce planning in England has been in a state of flux. A brief period at the beginning of the decade when NHS workforce planning had a distinct identity within regional ‘workforce development confederations’, was superseded by the absorption of workforce planning functions into the strategic health authorities (SHAs). This, in turn, was changed when the number of SHAs was reduced from 28 to 10. Most recently, the emphasis has been on further decentralisation, with primary care trusts (PCTs) taking up greater workforce planning responsibility as part of the stated policy objective of moving away from national planning led by the Department of Health, to a process that is more locally driven, with central functions supporting local decision-making.

NHS workforce planning has generally been focused around modelling future supply on a single profession basis, with most national effort given to the medical workforce, and most of the attention on the supply side. It has often lacked the sophistication of models such as that set out by Simoens and Hurst (2006), as described in Section 2. Future workforce numbers have been modelled using information on the current workforce number ‘stocks’, and adjusted by estimates of ‘flows’ from retirement (based on age) and new entrants (based on training numbers).

The estimates of future demand have been largely driven by projections made by individual professional groups. The main emphasis has been to try to calculate the number of particular types of health care professionals needed, either for the purposes of commissioning undergraduate training places, or for securing a sufficient number of postgraduate training posts. Such decisions, particularly for medical staff, have often been taken at regional or national level (for example, by deaneries or national committees) rather than at the level of individual provider organisations. There has also been a lack of overall clarity about roles and responsibilities, a lack of cohesiveness about linking planning for different groups, and a lack of accountability for workforce planning decisions.

These limitations were noted by the House of Commons Health Committee in its report in 2007, which highlighted significant failings in NHS workforce planning (House of Commons Health Committee 2007). The committee identified that there was insufficient focus on long-term strategic planning, that there were too few people with the ability and skills to plan effectively, that the planning system was poorly integrated, and that there was a lack of co-ordination between workforce, activity and financial planning.

The committee reported that it did not believe that the health service as a whole, including the Department of Health, SHAs, acute trusts and PCTs, had made workforce planning a sufficient priority. The specific recommendations of the committee are shown in the box overleaf.

Specific recommendations of the House of Commons Health Committee

- Make workforce planning a priority for the health service, with greater emphasis given to long-term and strategic planning.
- End the constant reorganisation of workforce planning. Instead, ensure that the organisations responsible for planning do their jobs properly.
- Dramatically improve the integration of workforce, financial and service planning.
- Improve the productivity of the workforce, particularly through better use of the new staff contracts.
- Make sure that the 10 new SHAs improve their understanding of workforce demands, and take collective responsibility for improving planning at national level.
- Ensure that as commissioners, PCTs help SHAs to analyse future workforce demand, and ensure that service planning and workforce planning become integrated and complementary processes.
- Shift the balance of the health service workforce towards primary care.
- Ensure that planning decisions cover the whole workforce rather than looking at each staff group separately.
- Recruit workforce planners of the highest calibre.
- Stop the Department of Health's micromanagement of the planning system, and encourage an oversight capacity to ensure SHAs are giving workforce planning the priority its importance requires.

Source: House of Commons Health Committee (2007)

In summary, the committee set out four significant challenges for NHS workforce planning in England:

- to increase workforce planning capacity at national, regional and local levels – ensuring plans reflect the wide range of factors that will affect workforce supply and demand in the future
- to better integrate workforce planning across the workforce (medical and non-medical), across the NHS (financial and service) and across health care (NHS and non-NHS organisations)
- to deliver a more productive workforce
- to deliver a more flexible workforce.

The identified failings of NHS workforce planning were restated in 2007/8 in the report of the Tooke Inquiry, an independent review led by Professor Sir John Tooke that examined the framework and processes underlying modernising medical careers (MMC). Although the inquiry focused primarily on system failures associated with matching junior doctors with specialty training posts in the revised career structure driven by MMC, the Tooke report (2008) also identified a range of problems with the extant system of medical education and career structure, including:

- a lack of consensus about the role of the doctor, which undermined any attempt to plan for future requirements

- weak Department of Health policy development, implementation and governance
- limited and under-resourced workforce planning capacity
- tensions and overlaps between local, SHA-level and national planning processes
- concern about a lack of effective national oversight of SHA-level plans.

It thus reinforced some of the key points made by the Health Committee.

The Tooke report also contributed to the debate about centralised versus decentralised workforce planning. It saw the advantages of a decentralised medical workforce planning system as being that it would be demand-led and locally responsive, while the disadvantages were that without reform it might mean only the allocation of a ‘currently inadequate function’, that it hampered national oversight, and that the track record of decentralised commissioning was not altogether positive – pointing to examples where training budgets had been spent elsewhere.

Among other recommendations, it argued that workforce policy objectives must be integrated with training and service objectives, and that ‘SHA workforce planning and commissioning should be subject to external scrutiny’. It advocated the establishment of a new body – NHS Medical Education England (NHS MEE) – which would act as the professional interface between policy development and implementation, holding a ring-fenced budget for medical education, and scrutinising the medical education and commissioning plans of the SHAs (Tooke 2008, pp 10–11).

As the Tooke report was focusing on only one profession, it is not surprising that it had less to say on the integration of planning, which was highlighted by the House of Commons Health Committee, but the policy response to Tooke (discussed in the next section) has to a significant extent meant that the long-term division between ‘medical’ and ‘non-medical’ workforce policy and planning has been reinforced, rather than curtailed, in the NHS in England. As such, full integration of NHS workforce planning across the professions is not now on the agenda.

In response to this and other criticisms, the government set out its proposed reforms to the system of workforce planning in 2008 as part of the NHS Next Stage Review, which we consider below.

A new approach to NHS workforce planning? Darzi and the NHS Next Stage Review

In 2007, Lord Darzi was asked to lead a major strategic review of the NHS. Known as the NHS Next Stage Review, its conclusions were published in *High Quality Care For All: NHS next stage review final report*, which laid out a wide range of initiatives and policies designed to drive up quality and clinical engagement within the NHS (Darzi 2008).

A specific review of workforce and workforce planning was undertaken as part of the NHS Next Stage Review, the results of which set out the future direction of workforce planning and development (Department of Health 2008). *A High Quality Workforce: NHS next stage review* is partly a response to the problems identified in the House of Commons Health Committee report and the Tooke Inquiry, and partly an attempt to provide the workforce element of the Darzi proposals for placing clinicians at the centre of the process of planning, managing and delivering care.

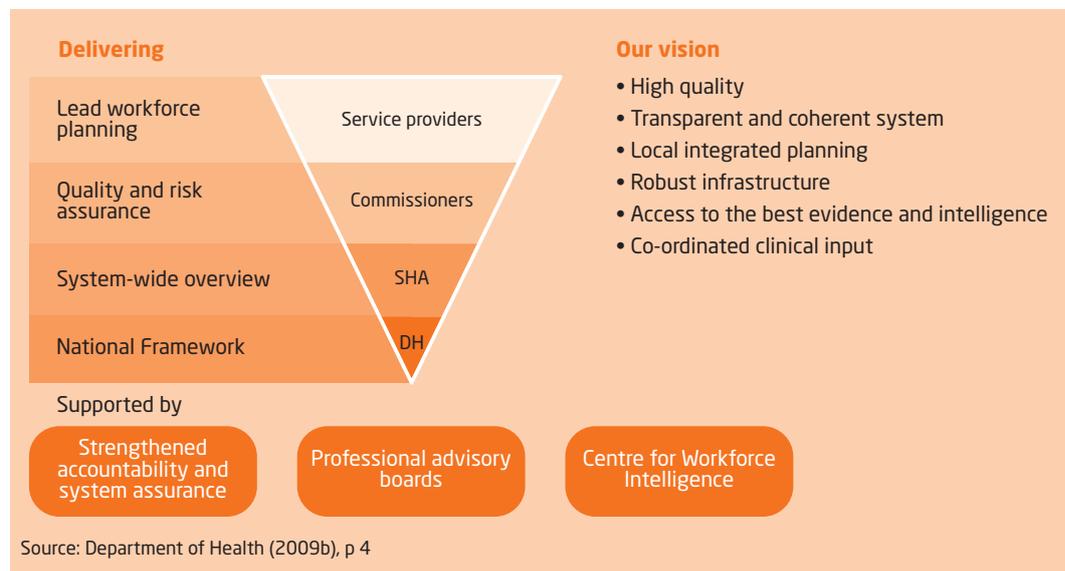
The broad vision for workforce planning outlined in *A High Quality Workforce* comprised the following.

- Planning must be based on a clear, clinical vision built around patient pathways.

- PCTs, providers and SHAs must work together to ensure that workforce plans reflect future health requirements, and that workforce, activity and financial plans are aligned.
- Regional and national professional advisory bodies will offer coherent evidence-based clinical input, particularly on long-term developments and the effect on future workforce requirements.
- A Centre of Excellence (since renamed the Centre for Workforce Intelligence [CWI]) will be established as a major objective resource for the health and social care system.

This approach entails new responsibilities locally, regionally and nationally for the Department of Health, SHAs, PCTs and service providers – and recognition that the success of the new system is dependent on all parties working together (see Figure 2).

Figure 2 The vision for workforce planning in *A High Quality Workforce*



In relation to workforce planning, *A High Quality Workforce* states: ‘our approach to reforming the workforce planning, education and training system mirrors the approach for the NHS itself – a belief that quality is best served by devolving decision making as close as possible to the front line in an environment of transparency and clear accountabilities’ (Department of Health 2008, p 31, para 101).

The report sets out a bottom-up approach to NHS workforce planning and commissioning, a system that should be ‘focused on quality, patient centred, clinically driven, flexible, locally led, and clear about roles’ (Department of Health 2008, p 31, para 101).

It also explicitly argues that the approach to planning has to be inclusive of other employers: most planning will ‘therefore be carried out at a local provider level and will involve social care’ (Department of Health 2008, p 32, para 104).

The report proposes a range of new responsibilities and changed roles for the different stakeholders in the planning and commissioning process. One key element of the new system is increased responsibility at local level (NHS, foundation trust, independent sector provider and PCTs) to ‘plan needs for workforce based on patients’ needs by pathway and model of care’ (Department of Health 2008, p 32, figure). This local level planning is also intended to involve social care and other health/care organisations such as general practitioner (GP) collaboratives.

The NHS Next Stage Review also proposes the establishment of health innovation and education clusters (HIECs), which would provide a new focus for education provider and employer linkages on workforce development and research issues (Jarrold 2008). Current plans are that the first full wave of HIECs will be formally announced in early December 2009 (Department of Health 2009a). It is hoped that the new clusters will create greater strategic synergy between health, education and research organisations, and facilitate greater workforce and service innovation.

However, this local focus does not signal the end of a regional/national infrastructure for planning. The SHAs are to continue to be responsible for workforce planning, education commissioning and quality assurance of health education in their regions. SHAs will undertake the commissioning process with local education and training providers, and will have a key responsibility in relation to non-medical professions: 'Workforce planning for the other professions is and will continue to be carried out primarily at SHA and local level' (Department of Health 2008, p 35, para 115).

One key element in the NHS Next Stage Review was the proposal to establish a centre of excellence to act as 'a major objective resource for the health and social care system' (Department of Health 2009b, p 3), and to provide 'strategic oversight and leadership on the quality of workforce planning' (Department of Health 2009b, p 8). The resulting body, the CWI, which is due to be operational from October 2009, will achieve these aims by exercising its responsibilities across three functions:

- aligning the whole system around a shared endeavour to improve and use high-quality data, analysis and modelling
- horizon-scanning for innovation and future service, workforce and labour market issues that are likely to have an impact on the health and social care workforce and new care pathways
- providing leadership for capability building by supporting local organisations to use workforce information and tools effectively, promoting best practice in workforce planning, challenging the NHS and social care services to improve performance, and setting standards for resources and tools (Department of Health 2009b, p 8).

The role for the Department of Health in the new system set out by the NHS Next Stage Review is:

- to commission medical and dental undergraduate training (scrutinised by national professional advisory bodies)
- to secure and allocate funding for workforce development, education and training against quality assurance of SHA workforce plans
- to identify national risks through a strengthened, well informed bilateral process with SHAs
- to undertake long-term strategic workforce planning and policy development (Department of Health 2008, p37, paras 122–125).

The recommendation in the Tooke report to establish an independent, advisory, non-departmental public body to provide a professional voice at national level in the planning, education and training process for medical staff, dentists, health care scientists and pharmacists has now been achieved with the foundation of the NHS MEE. Its remit is to 'bring a coherent professional voice on education and training matters... and will advise the Department of Health on policy. MEE will provide high-level scrutiny of, and advice on, the quality of workforce planning at national level' (NHS Medical Education England 2009).

The Department of Health has stated that, by the end of 2009, it 'will have set up similar bodies to ensure that nurses, midwives and allied health professionals have the same input' (Department of Health 2009c, p 39). The extent to which these other bodies will have the same remit, resources and influence as NHS MEE is not yet clear, however.

Overall, the NHS Next Stage Review (Department of Health 2008) sets out an annual cycle of planning that begins with PCTs and local councils commissioning services to meet the health needs of their local populations. Service providers will need to demonstrate that they have integrated service and workforce plans in place, including proposals for training and development, so as to assure the commissioners of their ability to provide the services they are offering. Based on service provider plans, PCTs will then produce combined service and workforce plans for their local economies, which they will send to the SHAs.

SHAs will combine PCT plans into a single regional plan, and will develop integrated service and workforce plans for their region, which will be the basis for commissioning education and training. The SHA regional plans, which will cover all staff groups, will be sent, via the CWI for synthesis and analysis, 'to the relevant national and regional professional advisory boards for scrutiny and advice' (Department of Health 2008, p 37, para 124).

The current historic funding arrangements under the multiprofessional education and training (MPET) budget will be replaced by a tariff-based system. The tariffs will be based on activity and costs in financial year 2009/10, adjusted for a geographic allowance (market forces factor and London weighting for the relevant areas).

The impact on service increment for training (SIFT) allocations for medical students is expected to be significant. Historic funding arrangements mean that funding per student year can vary from £10,000 to £110,000 (Jeffries, personal communication, 2009). Teaching hospitals are expected to lose the most under the new arrangements. The impact on medical and dental education levy (MADEL) funding for junior doctor placements is less clear. Current proposals are to change the percentage of salary reimbursement for junior doctors of different seniority, so that there is a shift towards a greater subsidy for the more junior posts.

The proposed new approach raises several unanswered questions. First, where does responsibility lie for taking action on any workforce risks identified at national and local level? Is there clarity about who contributes what to the overall risk assessment process? What will be the relative power and influence of PCTs, NHS trusts and SHAs in the new workforce planning process?

There has been open debate about this issue (Jarrold 2008), with some commentators advocating an approach that is more explicitly employer-led than that currently being set out (Snow 2008). One SHA published its regional workforce and commissioning plan shortly after the national NHS Next Stage Review workforce report came out, giving rise to comments that this signified the 'strong role' of SHAs in action (Santry 2008).

Second, how will planning be integrated or aligned across professional/occupational groups given the single-profession focus of some of the recommendations around the establishment of NHS MEE? This organisation is up and running, and separate bodies for the other health professions are planned (Department of Health 2009c, p 39), but, as noted above, these feel like an afterthought and have not yet been fully established. Although a multiprofessional focus is of increasing importance given the necessity to improve productivity through team working and skill-mix change, there is little sign of a real shift towards effective integrated planning across professions and disciplines. Separate professional bodies, with varying levels of power and influence, will serve only to shore up this divide.

Third, how will the new approach involve other employers from the ‘mixed economy’ of providers that is emerging in the health sector in England? How will non-NHS employers be involved in the planning process, and will NHS foundation trusts wish to go their own way on staffing issues and have real employer-led planning?

One immediate issue is that foundation trusts and primary care independent contractors do not have to submit workforce data to the national Electronic Staff Record (ESR) system. If a sufficient number of these organisations do not contribute to the ESR and other workforce data aggregation exercises on the grounds of cost or confidentiality, this could undermine any policy analysis and planning effort. For example, the 2009 January–March NHS staff earnings survey, which was based on ESR data, noted that two foundation trusts did not provide data. The specification for the new CWI takes account of support for planning across these sectors, but in practice there is little track record to build on, relatively little integration of services, different roles, job categories and terms of employment, and different and incompatible workforce data sets (or, for some sectors, virtually no workforce data on which to base planning). It is also far from clear what the incentive is for non-NHS employers (or indeed foundation trusts) to participate fully in such data gathering.

Fourth, there are important linkages to be made between workforce planning and other workforce policies, including decisions on pay and conditions. It is not clear how these linkages will be made.

Finally, what are the implications of the proposed tariff arrangements for MPET? Will it change the distribution of training placements? If it did, would it then trigger service reconfiguration? If some trusts were to reduce the number of trainees, particularly the more senior trainees, would there be adverse consequences on the quality of patient care? Or would it encourage greater reliance on trained doctors and improve care? No one seems clear what it will drive, but a number of people we have spoken to are afraid of unintentional consequences.

In summary, the NHS Next Stage Review workforce report attempted to address the key concerns of the House of Commons Health Committee and the Tooke Inquiry. In doing so, it has set out a new structure for NHS workforce planning that promotes closer alignment between service and workforce planning. Although advocating a bottom-up locally led approach, it also sets out key roles at SHA and national level. Despite the aspirations, it is not clear how these roles will be fully realised or aligned.

In the new system, a range of organisations is involved in workforce planning at a national level in the NHS; some are new, some are already in existence but with changed responsibilities (*see* Appendix A), sometimes with overlapping interests. There is a continuing assumption that the establishment of a further new body – the CWI – will, in itself, somehow lead to greater clarity, while at local and SHA level there is varying, and sometimes inadequate, capacity to support effective workforce planning.

In the next section, we review more fully the current SHA plans in order to assess what insight this gives into the current limitations and possibilities for workforce planning in England, and we explore further the tensions between bottom-up and top-down planning.

4 The current position of workforce planning in England

Introduction

The previous section set out what is expected of the new planning system, which has yet to be fully implemented. In this section, we look at how planning is currently working in practice at regional and local levels where, if the aspirations of the National Health Service (NHS) Next Stage Review are to be realised, the primary focus of workforce planning should be.

We look specifically at the role in England of the strategic health authorities (SHAs), which now hold the devolved Department of Health training budget, and lead workforce planning at a regional level. It appears clear at the time of writing that, despite an overall commitment in the NHS Next Stage Review to devolved decision-making, in practice the SHAs will continue to play a major role in the workforce planning and commissioning process, but with greater national/central oversight and support from the Centre for Workforce Intelligence (CWI) and NHS Medical Education England (NHS MEE), along with input from the other similar professional bodies when they are fully established – all of which raises questions about the extent to which there can be ‘real’ localised and employer-led planning.

In order to inform our assessment of the current situation, we have reviewed all the publicly available workforce strategies and investment plans of the 10 SHAs (*see* Appendix B) to assess the degree to which they address the core challenges posed for NHS workforce planning as articulated by the House of Commons Health Committee in 2007, namely:

- a need to increase workforce planning capacity at national, regional and local levels – ensuring that plans reflect the wide range of factors that will affect workforce supply and demand in the future
- a need for workforce planning to be better integrated – across the workforce (medical and non-medical), across the NHS (finance and service), and across health care (NHS and non-NHS organisations)
- to deliver a more productive workforce
- to deliver a more flexible workforce.

We also reflect more broadly on the role the SHA should have in the system, and the degree to which the system is and should be driven either from the bottom up or the top down.

We begin by describing the funding flows for education and training as they are pertinent to the role the SHA can play in workforce planning and development.

SHA funding and investment decisions

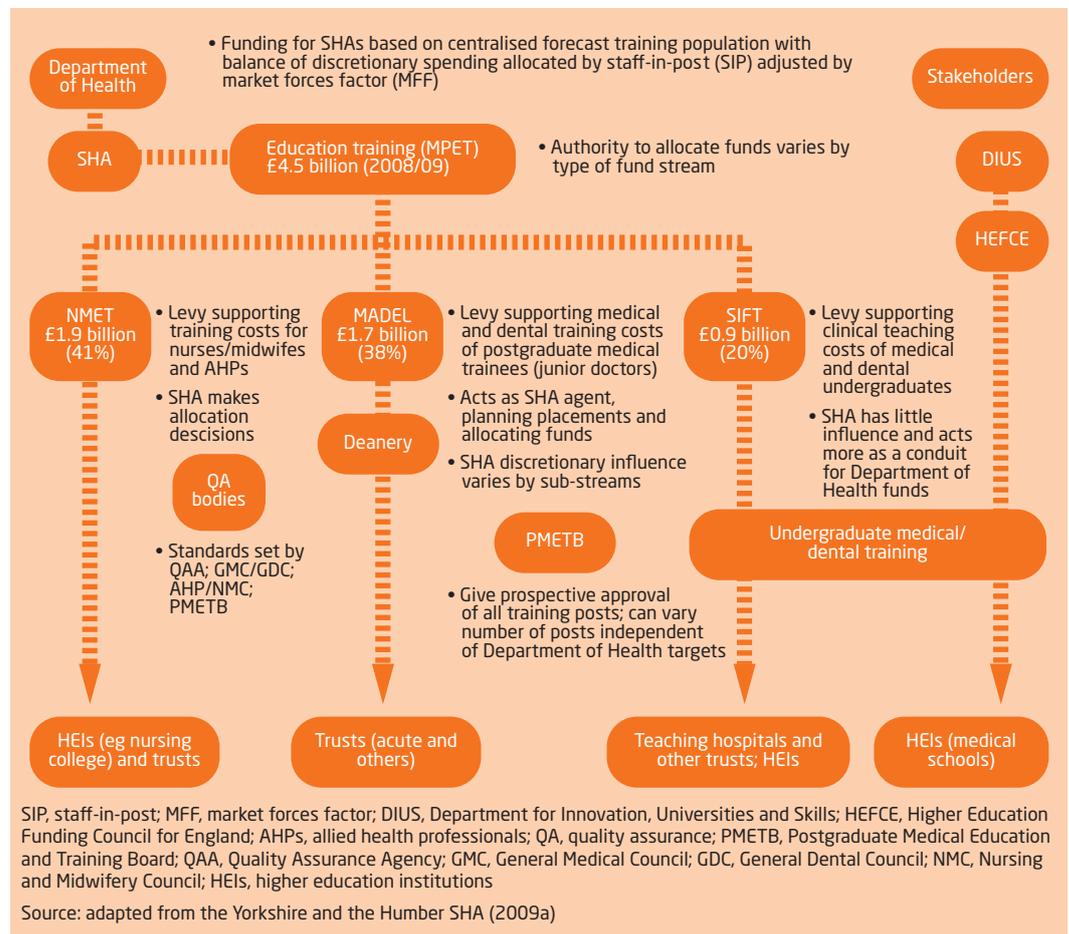
In 2008/9 £4.5 billion was allocated to the 10 SHAs under the multiprofessional education and training (MPET) budget. The levy is allocated to support strategic investment in

education, training and development of the health service, together with a specific allocation for dental vocational trainees, and comprises the following elements:

- the medical and dental education levy (MADEL)
- the service increment for training (SIFT)
- non-medical education and training (NMET)
- student grant unit (SGU)
- money for projects and developments
- management costs.

Figure 3 gives an overview of the funding flows.

Figure 3 Education funding roles and responsibilities: overview of funding flows for 2008/9



In 2008/9, each SHA received between £247,000 and £1,091,000 in MPET funding, with six of the 10 SHAs receiving between £300,000 and £500,000 (see Appendix C for a full breakdown).

As Figure 3 shows, the SHAs have only limited discretion in how some elements of the funding are allocated. The majority of MPET funding – 59 per cent – supports medical placements and training through funding allocated to trusts. Teaching hospitals particularly benefit from SIFT payments, given their higher number of medical students. The non-medical allocation provides funding for places at higher education institutions, salary support and student grants.

As noted earlier, the Department of Health plans to replace the historical funding for SIFT and MADEL with a tariff-based system that is to be implemented by April 2010. As outlined currently, the new tariffs will not allow SHAs any flexibility to vary payments to reflect quality of training or other local factors. There are national plans to create quality metrics for both medical and non-medical trainees/students.

Workforce planning capacity

A review of 2008/9 SHA budgets (*see* Appendix C) suggests that the amount spent on management and administrative support for workforce planning varies considerably between the SHAs. This is partly a factor of size – the smallest spend in absolute terms was £1.6 million (South East Coast SHA), and the largest just under £12 million (London SHA). As a proportion of total spend, amounts varied from 0.5 per cent to 2.3 per cent. In London SHA, for example, the spend amounted to 1.1 per cent of its total allocation of £1,091 million. London SHA has undertaken a broad range of strategic analyses and engaged a wide range of stakeholders in its work, presumably benefiting from this larger resource.

As noted earlier, undertaking workforce scenario and/or projection modelling is not an easy task. Quantifying the implications of diffuse and sometimes poorly understood demand drivers is particularly challenging. London SHA's StaffScope initiative is an interesting example of an attempt to deal with these uncertainties using a 'soft futures' approach (*see* Appendix B). This study of the future out-of-hospital workforce revealed that, despite a consistent view that out-of-hospital care will grow, people from different organisations have different visions for how it would be delivered and by whom, including:

- expansion of primary care – delivered by general practitioners (GPs) working in large practices or by the new entrants into the primary care market
- acute trusts providing care via satellite hubs to their main hospital facilities
- an evolution of the role of the independent and private sectors
- integration with social care and a multiplicity of providers working together in integrated supply chains that would include social and domiciliary care providers.

Each of these different visions would have very different implications for the workforce. The first would suggest expansion of GP and primary care team numbers, while the second might suggest growth in staff in the acute sector to enable them to deliver the new model of care. This reinforces a point made earlier that, when aiming for the 'right staff' with the 'right skills', there can be very different definitions of what is 'right'. Our understanding is that the current national assumption is that the shift to out-of-hospital care will require a significant expansion of the GP workforce.

A broadly based work programme and wide stakeholder engagement will be critical for identifying the wide range of factors that will affect workforce demand in the future, and creating alignment between workforce, financial and service plans. The Workforce Review Team (WRT) has already undertaken some demand-modelling work, but such an approach can be driven by the views of the professional bodies, and may not challenge traditional patterns of working or current configurations of service. Our review of current SHA plans and strategies found that, although most SHA strategy documents identify some of the future demand drivers, only two had published detailed modelling and quantified the implications for the health care workforce.

Furthermore, few SHAs have explored the tangible implications of examining future scenarios about different staff mixes and ways of working. One way of dealing with the uncertainty of the future, including the likelihood of funding constraints, is to create

a range of plausible scenarios and assess the impact and policy implications of each. London is one SHA that has made use of scenario-based workforce modelling to inform policy and planning. It has incorporated a range of assumptions about demand and supply-side factors into its examination of possible future service and workforce profiles. On the supply side, it has included the following assumptions about the workforce:

- age profile
- career progression
- participation rates
- inward flows from education (limited analysis so far)
- turnover rates.

In general, our review of current SHA plans suggests that far less attention has been paid to supply-side modelling, with a lack of linkage between supply and demand projections, and suggests a potential deficit in current workforce-planning capacity at regional level. While the majority of SHAs acknowledge the need to improve their local processes, only three have signalled additional investment to develop their capacity.

The House of Commons Health Committee (2007) stated: ‘We heard serious doubts about whether the new SHAs have either the will or the skill to undertake effective workforce planning’ (p 33). Our assessment of current SHA plans would suggest a growing commitment to undertaking planning, but generally little evidence of any increased skill in that area.

Better integration of workforce

The House of Commons Health Committee (2007) signalled three areas in which better integration of NHS workforce planning was required:

- across workforce, financial and service planning
- between medical and non-medical workforce planning
- between NHS and non-NHS providers.

Workforce, financial and service

All the SHAs highlight in their strategy documents the need to achieve close integration between workforce, financial and service planning. Some have developed workforce strategies based on their approach to *High Quality Care for All* (Darzi 2008). Most identify the need to develop planning capacity within primary care trusts (PCTs) to create processes that enable better workforce data capture and facilitate closer linkage with local providers, but many are at an early stage in this process, and it is too early to judge the effectiveness of the approaches they are taking.

Despite this closer integration at a local level, there is potential for some significant mismatches between financial and workforce planning. If this is to be avoided, there will need to be significant changes to the assumptions about workforce planning that were made at the time of the review by Derek Wanless in 2003/4 (Wanless 2004). The assumptions in the Wanless report suggested a growth in the pay bill from £33.5 billion in 2004/5 to £93.1 billion by 2031, equivalent to real growth per annum of around 4 per cent (*see* Table 1 overleaf). The assumption at the time was that NHS funding would also continue to grow at around 4 per cent per annum. The growth in the pay bill under these assumptions now looks totally unaffordable given the prospects of 0 per cent

overall growth and the fact that trusts are currently being told to anticipate year-on-year reductions in tariffs.

Table 1 below sets out the projected pay bill costs given the base medical supply scenario and non-medical workforce growth based on the Wanless assumptions. It also sets out an estimate of the long run (1971–2007 growth in real NHS expenditure). A trend in expenditure covering the period since 1999 would show higher average growth.

Table 1 Projected growth in pay bill under the Wanless assumptions

Workforce category	Pay bill 2004/5 (£ million)	With accredited specialist grade paid 75% of the rate of a consultant		All CCT holders become consultants	
		Projected pay bill 2030/3 (2004 prices, £ million)	Average real annual growth (%)	Projected pay bill 2010/31 (2004 prices, £ million)	Average real annual growth (%)
Medical pay	9,525	21,688	3.2	24,684	3.7
Non-medical pay	24,006	68,416	4.1	68,416	4.1
Trend in NHS expenditure (1971/99): low					3.2
Trend in NHS expenditure (1971/99): high					4.1
Assumptions					
<ul style="list-style-type: none"> ■ Non-medical pay bill growth assumes staff growth is 2.2% per year (equal to Wanless demand minus 0.5%) ■ Hospital staff pay drift assumed to be 1% per year ■ GP pay drift assumed to be 0% ■ Annual pay settlement assumed to be inflation + 0.5% ■ Accredited doctor grade assumes newly qualified CCT doctors can earn 75% of current consultants 					
CCT, Certificate of Completion of Training					
Source: written evidence to House of Commons Health Committee (2007), Ev 209					

We could find no reference in the SHA documents to any assessment of scenarios that might require the need to cut back on medical training numbers. At a national level we understand that planning assumptions are being reviewed, but a major uncertainty is the increasing numbers of women in the medical workforce and the potential reduction in participation rates. This provides another example of the inherent imprecision in workforce planning predictions, because if the national assumptions prove to be incorrect, England could face the spectre of unemployment for medical staff, particularly new graduates.

Medical and non-medical

The continued separation of medical and non-medical funding streams within MPET and the fact that medical training numbers are set nationally in isolation from broader workforce considerations does not help the integration of medical with non-medical workforce planning at SHA level and below. Current workforce commissioning plans suggest that they are largely achieved by looking at supply/demand factors within single profession ‘silos’. Some SHAs have signalled future plans to develop a more competence-based approach to workforce plans, but this is currently an aspiration rather than in place, and, as noted earlier, there is now a single-profession focus at national level, through NHS MEE, which might make local multiprofessional planning more difficult.

NHS and non-NHS

The NHS Next Stage Review is explicit in extending the workforce planning remit to cover social services/local authorities and GPs. However, as we have noted, a range

of other independent, non-governmental organisation (NGO), private and voluntary sector providers also operate in the health and social sectors. The emphasis placed on PCTs undertaking an assessment for the whole of their local health economies carries with it the implicit message that all of these 'non-NHS' providers should be included in the process, but there is no detail about how this is to be achieved. Only three of the 10 SHAs make explicit reference to drawing in non-NHS, voluntary and independent sector providers to help develop their workforce plans.

Greater workforce flexibility

Changes in health care over the next few years in England, partly driven by funding constraints and the identified need to improve productivity, will require increased flexibility in the workforce. This could encompass new working patterns, new ways of working, new work locations and new roles. For example, staff are increasingly being expected to work across a variety of clinical settings with different levels of clinical support and back-up, and future requirements might include supporting the majority of medical and nursing staff, who have traditionally worked in an acute hospital setting, to develop the skills to work more independently in a community setting.

Other changes include services being reoriented to offer longer opening hours or alternative locations, and group sessions being offered in place of one-to-one consultations. These changes have major implications for the skills profile of new entrants to the workforce, and also require the training and development of existing workers.

It is evident from current workforce investment plans that relatively little of the resources allocated by SHAs supports this critical aspect of workforce development. Seven out of the 10 are investing less than 5 per cent of their budget on this type of broader workforce development, with the maximum proportion invested being 9 per cent. Across the whole of England, £194 million is spent on broader workforce development for a total workforce of 1.3 million people.

The general assumption is that this type of support will be funded primarily by local NHS providers, yet anecdotal evidence suggests that trusts tend to invest little in this area, and it is often the first area to be cut when finances are stretched. Given the tight funding cycle that the NHS is entering, this is a major cause for concern.

Greater productivity

The global economic downturn has had, and will continue to have, significant implications for the NHS. In contrast to the past 10 years, during which health care funding enjoyed continuous expansion, the prospects now are for a period of low growth if not real reductions. Improvements in productivity will be an imperative in this environment if quality of care is to be protected, with recent estimates suggesting that annual productivity gains of 3.4–7.4 per cent will be needed to bridge the prospective funding gap (Appleby *et al* 2009).

Pay policy will, of course, be a major influence on future productivity gains, but local working practices are equally critical. In our review of workforce strategies, only five of the 10 SHAs had clear strategies to drive improvements in productivity, and at the time of writing there was little, if any, local investment earmarked to do this.

Much more attention is being paid to productivity issues at a national level. A national programme of work is under way, with practical guidance offered by the NHS Institute for Innovation and Improvement.

The changed financial assumptions and their implications for health care staffing underline the importance of integrating workforce, service and financial planning. They also call into question the current balance in funding between the current and future health care workforce, between medical and non-medical staff, and the relatively small investment made in the training and development of managers and leaders.

Bottom-up vs top-down approaches

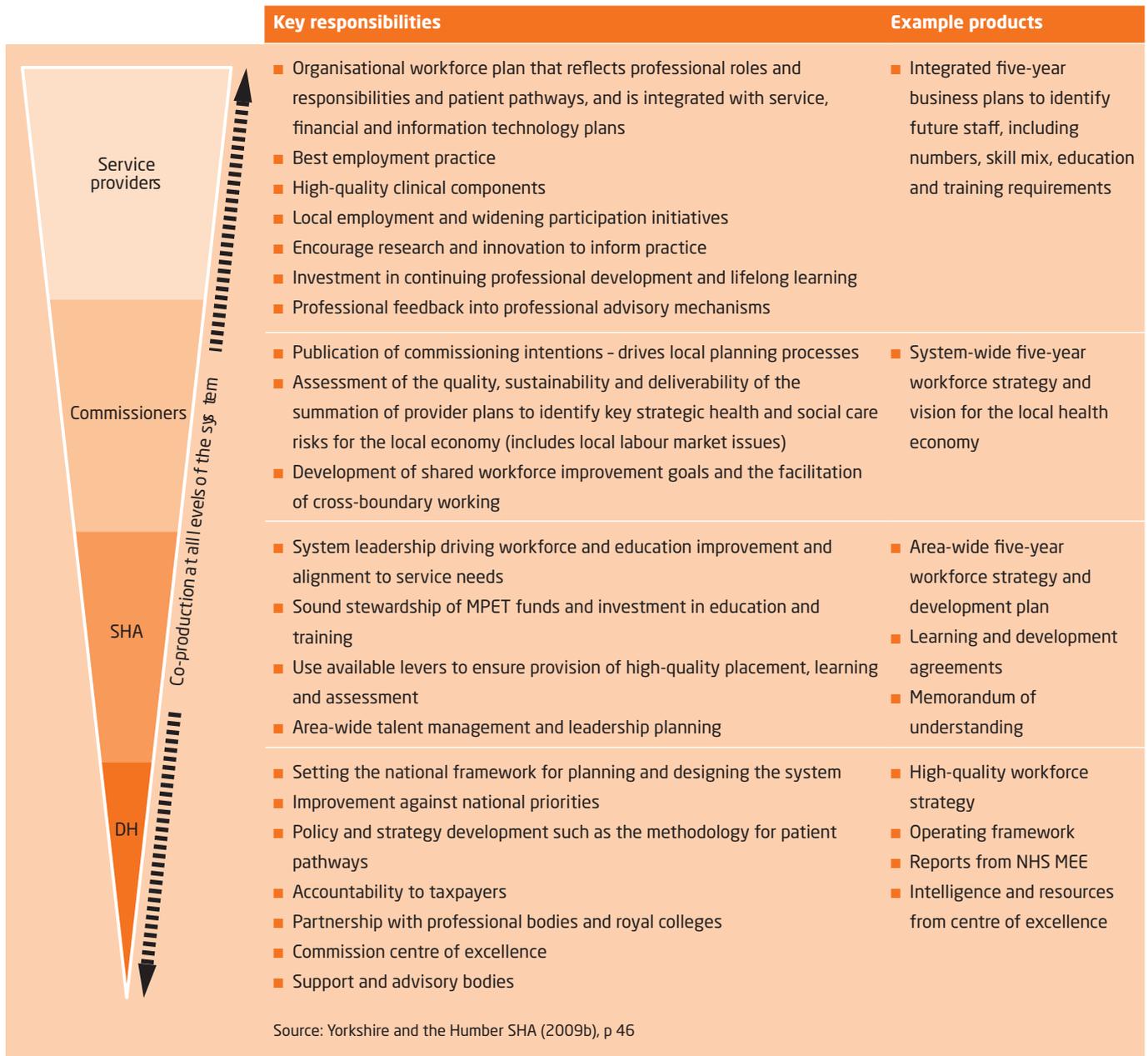
The NHS Next Stage Review set out a vision for a workforce planning process that was provider-led. However, in reality, no workforce planning system that is underpinned by central funding for commissioning and in which an organisation the size of the NHS is the major employer can ever be solely local in workforce planning. Estimating current and future workforce requirements, and overseeing expenditure to ensure that public money is used to plan, develop and sustain the workforce necessary to deliver publicly funded care, are functions that must necessarily have some central government involvement. Even in market-oriented systems such as that in the United States, central government plays a major role in allocating funding for medical training.

There is also a significant issue relating to 'critical mass'. Our analysis of current SHA investment and capacity shows that, even at this level, a sizeable budget is required before management costs levied at around 2 per cent can support more than basic administrative support for workforce planning. In addition, even at SHA level, the commissioning numbers for some of the non-medical courses can be small (fewer than 50), particularly for medical scientists, and would be unfeasible to commission for smaller population sizes. This reinforces the point that the SHA configuration is not always the best size and 'fit' with training node location and labour market boundaries.

In general, it is also the case that providers/employers are better placed to assess and influence future demand, while national and regional bodies are better placed to quantify and influence future supply. This underlines the need for effective two-way communication between local/SHA and SHA/national elements within all levels of the system. Figure 4 opposite shows how this might work in practice.

Figure 4

System management approach to workforce planning and development, and education commissioning



Our assessment of the SHAs’ work plans demonstrates a high level of variability among 10 organisations that might be expected to have some commonality of approach. Our analysis suggests a number of limitations for workforce planning, some being inherent in the current system, some being constraints imposed by weak local capacity. It also reveals some significant opportunities, which we explore in our concluding section.

5 Learning from other countries

Discussion

The National Health Service (NHS) Next Stage Review signalled changes to workforce planning in England that were intended to address many of the shortfalls identified by the House of Commons Health Committee inquiry (2007). The focus was on giving the leading role to service providers and local commissioners, to bring together workforce, service and financial planning, while also establishing new national bodies – NHS Medical Education England (NHS MEE) and the Centre for Workforce Intelligence (CWI) – to improve the quality of workforce forecasting, and provide expert support and oversight to local workforce planners. In practice, as we have argued above, it is clear that the strategic health authorities (SHAs) have retained a critical role in the process of planning, yet currently offer various approaches and variable capacity.

We have recognised in this report that workforce planning can be a technically difficult and complex task, and that the time periods over which forecasts are made, along with the complexity of health care delivery, mean that it is impossible to get it right all the time. But this does not detract from the need for an approach that continually assesses workforce risks, and can trigger flexible responses to them.

The financial constraints envisaged for the future mean that, in planning terms, the need for integration and flexibility has never been more urgent. Financial, service and workforce plans must be more effectively aligned, as it is a waste of resources and manpower if we create an oversupply of new entrants to the workforce. Systems and approaches that maintain current inefficiencies or shore up professional silo-led approaches will not deliver the level of workforce productivity improvements that are required. Equally important will be the linkages between workforce planning and pay.

As part of this review of workforce planning, we have also examined the approaches used in five other countries – Australia, Canada, Germany, Sweden and the United States – in order to identify any lessons for improved practice in the NHS (*see Appendix D*). The review revealed that most Organisation for Economic Co-operation and Development (OECD) countries share the challenge faced by the United Kingdom of an ageing health workforce (with projections on an increased need for replacement due to retirement) caring for an ageing population, which is making increased demands on health workforce planning. A variety of planning approaches has been taken in other countries, varying from what amounts to *laissez-faire* reliance on market forces at national level in the United States (aside from significant funding for aspects of training), through to federated systems in Canada and Australia (*see also OECD 2008*).

Our key conclusion is that no country has systematically ‘got it right’ long term in terms of its health workforce planning system. All countries occasionally have staff shortages or oversupply, and current OECD estimates are highlighting concerns about a growing gap between supply and demand in most OECD countries, despite the fact that many of these countries control the numbers entering medical education (OECD 2008).

All countries that are actively engaged in workforce planning also face the tension between national and local/regional/state planning. Generally speaking, in the countries examined, national policy has tended to focus more on medical workforce planning than on that of other health specialties. Given the costs, political implications and length of training this is perhaps unsurprising. However, in the United States, national planning is limited, and this has been seen by some commentators as a major constraint, particularly in the development of the primary health care workforce.

In some federated countries where states have significant autonomy, there is currently a focus on better alignment of national and local efforts. In Australia, for example, the current health care reforms are recommending better co-ordination of workforce planning, education and regulation at national level, including the establishment of a National Clinical Education and Training Agency, which will have a remit:

- *to advise on the education and training requirements for each region;*
- *to assist with planning clinical education infrastructure across all service settings, including rural and remote areas;*
- *to form partnerships with local universities, vocational education and training organisations, and professional colleges to acquire clinical education placements from health service providers, including a framework for activity-based payments for undergraduates' clinical education and postgraduate training;*
- *to promote innovation in education and training of the health workforce;*
- *as a facilitator for the provision of modular competency-based programs to up-skill health professionals (medical, nursing, allied health and Aboriginal health workers) in regional, rural and remote Australia; and*
- *to report every three years on the appropriateness of accreditation standards in each profession in terms of innovation around meeting the emerging health care needs of the community.*

(National Health and Hospitals Reform Commission 2009, pp 31–2, para 101)

New Zealand has also recently announced the establishment of a multidisciplinary national Clinical Training Agency Board 'to unify workforce planning in New Zealand' and to achieve 'better integration of health education and training with less duplication and clearer focus' (Ryall 2009).

The Scottish Executive Health Department has recently established a new Health Workforce Programme Board, which will focus on all staff groups with the aim of co-ordinating workforce planning. It has also highlighted that a 'bulge' of graduates that is expected to result from Modernising Medical Careers will lead to 'oversupply in nearly all specialties', meaning that a reduction in the number of junior doctors is planned from 2010 (Health Workforce Directorate, Workforce Planning and Development Division 2009, p 2, paras 5–6, cited in Buchan and Seccombe 2009, p 3), and that there will be related implications for nursing roles (Buchan and Seccombe 2009, p 3).

A point that is often overlooked, but which emerges from a comparison of the workforce planning approach in the NHS in England with that of other countries, is that England is too large for planning to be a two-tier (national and local) process, but the third, intermediate, level has often been the target for reforms. One of the main characteristics of the structure of the English NHS is that it has three main organisational levels: national/policy level; the intermediate strategic/regional level; and the local operational/delivery level. NHS reforms over the past 20 years have often focused on restructuring and reshaping the intermediate level. The NHS workforce planning system in England has

had to be changed and adapted to fit these successive restructures, but it has rarely been managed effectively and has often been *post hoc*.

The intermediate/strategic level in the English NHS has not always been logically delineated in terms of labour markets and location of training nodes, and this has added to the difficulty in establishing an effective strategic-level approach. Smaller countries such as New Zealand and Scotland may not have the same need for an intermediate level, and federated countries such as Australia tend to have a 'fixed' intermediate level (state or province); as such, many comparable countries, in the United Kingdom and elsewhere, have had greater stability in planning systems, and not seen the same degree of change in planning focus and remit at the intermediate level.

In the final section, we make a number of recommendations that seek to minimise the limitations and maximise the opportunities for NHS workforce planning in England. They suggest a need for action and improvement at national, regional and local level. Despite the aspirations of the NHS Next Stage Review for workforce planning to be locally led, we believe that there is a need for strong leadership by the Department of Health to ensure a coherent approach that maximises the impact of the relevant workforce intelligence and ensures policy leverage. The new CWI can play a facilitative role, but there is a risk that it will be regarded as the 'solution' to the problems and challenges outlined in this report. No single organisation can make the changes required, but the CWI will be well placed to support some of the types of system change that are required.

6 Recommendations and conclusion

Recommendations

Workforce planning at local and national level should be a core part of the productivity and quality improvement agenda.

Changes in workforce numbers, pay, skills and distribution will all be necessary to improve productivity in the National Health Service (NHS). Reviews of workforce planning assumptions should be part of this process, as should a recognition that relatively more effort must be put into improving existing skills and supporting current staff to be as effective as possible.

Consideration also needs to be given to the role that pay can play in driving up relative productivity. Workforce planners should undertake scenario modelling, workforce costing and supply side projections. Future projections should include changes in the number, pay and mix of staff, in order to give employers and policy-makers the information to help bring about improved productivity.

The annual assessment of priorities should look at the workforce in the round, not just the different professional groups and their sub-specialist elements.

Despite the complexities of the workforce-planning task, some features of the NHS give planners and policy-makers considerable scope to influence or control the supply of health care workers. The Department of Health, in association with other departments and agencies, has access to key policy levers that influence workforce supply: education, employment law, pay, working conditions and international migration. However, in practice, there has been a failure to maximise this potential benefit, as a result of the lack of planning capacity and poor integration across different policy areas. This has been a particular problem in the lack of effective and sustained connection between workforce policy/planning and financial planning at both local and national levels. In addition, the annual assessment of priorities needs to look at the workforce in the round, not just at different professional groups and their sub-specialist elements.

The planning and funding of broader workforce development, including leadership skills, should be given a higher priority.

Most of the planning and funding activity evident in the NHS is focused on doctors and other health professionals. Much of the responsibility for management and leadership development rests with local employers; this creates significant disadvantages for the non-clinical workforce. Given the impact of poor management and leadership on the rest of the service, this disadvantages the system as whole.

The risks are magnified in a tight financial environment, when the need for strong management and leadership to drive up productivity is critical, but the threats to

investment in these groups become greater. There are opportunities to review how the current budget is allocated with a view to increasing investment in the current workforce. Consideration should also be given to whether the balance of investment is correct between the clinical and non-clinical workforce, as well as the current and future workforce.

The multiprofessional approach to workforce planning should be strengthened.

The retention by the 'centre' – the Department of Health and NHS Medical Education England (MEE) – of commissioning the number of undergraduate medical workforce trainees, and the introduction of other single-profession advisory bodies might not facilitate a multiprofessional focus within workforce planning. It might also add to the confusion about roles and responsibilities. The recently established professional advisory machinery (NHS MEE and equivalent) should be reviewed after one year to assess whether it is effective in supporting a multidisciplinary approach to workforce planning, commissioning and policy development so as to achieve the required integration/alignment across disciplines.

Planning capacity at regional/local level should be audited and improved.

Our review of strategic health authority (SHA)-level workforce plans has shown variations in both approach and capacity. The first is acceptable, the second is not. The effectiveness of workforce planning in the NHS in England, both locally and nationally, continues to be constrained by limitations in technical and strategic capacity. Now that the new framework for NHS workforce planning has been set out, but not yet fully detailed, there is a critical need to audit the current capacity, particularly at the local level in NHS trusts and primary care trusts (PCTs), but also in the SHAs, and to fund the necessary improvements through training, recruitment and development.

Career pathways for workforce planners need to be more fully integrated into the broader NHS management structure so that there is more of a two-way flow: of managers taking on workforce planning responsibilities, and of workforce planners having broader managerial experience.

The Audit Commission should build on its current activity and undertake a specific audit of the current workforce planning capacity in the SHAs, NHS trusts and PCTs, so as to inform the development activities undertaken by the new Centre for Workforce Intelligence (CWI).

Multiprofessional education and training (MPET) funding arrangements should be reviewed.

The proposed tariff arrangements for the service increment for training (SIFT) and medical and dental education levy (MADEL) will give welcome transparency to the allocation of funding for clinical placements. However, the new arrangements create a degree of rigidity in funding allocations and could have a series of unintended consequences. There may be particular merit in considering arrangements similar to those for Commissioning for Quality and Innovation (CQUIN) to give SHAs the capacity to stimulate innovation and quality improvement in training delivery.

The Department of Health and SHAs should review the impact of the proposed tariff arrangements for MPET after one year, and consider whether a more flexible funding model is necessary.

There should be greater clarity of planning roles and responsibilities

National leadership for workforce planning is needed to:

- ensure that public funds are used effectively
- ensure that health workforce policy is aligned with broader policies around pay, migration, employment and the economy
- enable consistency in planning approaches in national health care labour markets
- support relevant workforce information and databases in order to facilitate the networking of ideas, innovations and practices
- harness the necessary political impetus to ensure effective involvement of all stakeholders.

Our international case studies highlight that strong national leadership is critical to ensuring a coherent approach.

There will be continued tensions between top-down pressures to meet national policy priorities, and bottom-up pressures to meet local service and staffing priorities. It is easier to see some of the supply-side pressures – such as migration trends and participation rates – at national level, while local intelligence might provide a clearer vision of future demand.

A clear reconciliation process between national and local plans is required. The SHAs provide a good intermediate tier to do this, but they will be effective only if they have the necessary intelligence from national and local level, and have the necessary skills and capacity to undertake the reconciliation task. They will also need to support and facilitate establishment of the new health innovation and education clusters (HIECs) to foster local innovation.

There is a need to clarify roles within workforce, service and financial planning and to identify and resolve current overlaps and gaps. The various parties, including the HIECs, will need to work together to ensure the appropriate intelligence and risk assessment. It is especially important to identify who should be responsible for acting on identified risks in the system. If the SHAs are to undertake a leadership role, this suggests that they should also be accountable for managing workforce risks.

There should be greater transparency about the degree of inherent uncertainty.

Currently the Workforce Review Team (WRT) publishes an annual risk assessment of likely planning outcomes for different staff groups and occupations. This gives some insight into the relative level of likely shortages and oversupply in different occupations, and identifies policy ‘pinch points’. However, there is no other access to annual planning output that can enable stakeholders to assess assumptions, scenarios and policy implications. The risk assessment approach needs to be extended.

The risks and assumptions in the workforce planning cycle should be made more transparent, with any annual assessment of workforce priorities highlighting and quantifying the inherent uncertainties and risks in supply and demand.

Workforce planning information needs to be secured from all health care providers.

Currently, nearly all NHS trusts supply valuable planning data through the new national Electronic Staff Record (ESR) system. However, a more 'mixed economy' of providers is emerging in the health sector in England, with an increasing number of non-NHS-employed health sector workers providing NHS-funded care. These non-NHS providers and independent contractors within primary care do not submit data via the ESR, and foundation trusts also do not have to provide workforce data to national systems.

There needs to be greater recognition of the effects on the provision of workforce data and the consequent planning and performance implications that the more plural provision of health care in England will have. In addition to workforce data, robust service and financial data will be required that commands the confidence of the professions. This will require sustained energy and investment.

Conclusion

We have made a number of recommendations to improve the current approach to NHS workforce planning in England. If these are not considered, we believe that, even after the NHS Next Stage Review reforms, there will be a risk that the current workforce planning system will continue to drive investment towards 'more of the same' as an output from planning. This will not change the supply-led, single-profession approach that has dominated the NHS, and contributed to its inefficiencies and past problems of 'boom and bust'.

There is a need for new thinking based on the recognition that the workforce should have the skills and potential to respond flexibly to a population with changing health care needs, be able to work effectively in teams to deliver new models of care, and be able to work with new technologies. These should be core policy objectives at any time but, in the constrained funding situation that the NHS will be in for the foreseeable future, they must become key factors in ensuring its survival.

The focus should be on developing a flexible approach that does not seek long-term predictive precision, but can identify and respond to potential medium-term issues, enabling the workforce to evolve and adapt to the inherently unpredictable health care environment.

Appendix A

Mapping the current workforce planning landscape: key organisations, roles and responsibilities

The information for this appendix has been adapted from Dixon *et al* (2009).

Workforce Directorate Analysis Team (WDAT), Department of Health

WDAT is a small team within the Workforce Directorate at the Department of Health. One of its functions is to provide analytical support on workforce capacity issues, including workforce planning. In this area, WDAT acts as the technical liaison between the Department of Health and the National Health Service (NHS) Workforce Review Team (WRT), and helps to specify and peer review the research and analysis undertaken by the WRT on behalf of the Department of Health.

WDAT does not typically undertake the kind of specialty-specific analysis that the WRT performs. Its work often has a more aggregate perspective, such as in supporting the development of the Department of Health's overall workforce strategy, which informs spending review discussions with the Treasury. This includes some demand-horizon scanning functions, but these could be developed further. In addition, WDAT contributes analytical input to the Department of Health in consideration of specific workforce policy issues.

WDAT does not normally lead on the creation or development of new tools or models for use in workforce planning, though this might sometimes be necessary for specific issues (such as the forthcoming comprehensive spending review process, although the respective roles of WDAT and the WRT have yet to be defined), but it does engage in collaborative working on model development with partners such as the WRT.

WRT

The WRT is a group of dedicated workforce planners, including information analysts, data modellers and professional advisers (covering medical, dental, pharmacy, allied health professions, nursing and midwifery, and health care science), who produce reliable data and analysis covering the whole registered workforce of the NHS in England.

The WRT's primary purpose has been to provide supply and demand modelling, to inform and support workforce planning and commissioning in the strategic health authorities (SHAs), and to inform and influence policy discussions and decision-making in both the Department of Health and the allocation of the multiprofessional education and training (MPET) budget.

The WRT operates an ongoing data and intelligence gathering and review process, collating information from a variety of census and other data sources, but also drawing

together direct input from its extensive network of stakeholders to ensure that its recommendations are aligned with service reality. The WRT has built up and continues to develop mutually beneficial relationships with the SHAs (both individually – each SHA has two dedicated contacts within the team – and collectively through such forums as the workforce planners, commissioners and finance leads meetings), professional bodies (including the royal colleges), service leads, social care representatives, academics, independent and third sector representatives, and other workforce bodies (including all those listed below). The principal purpose of this process is to identify the key workforce priorities (current and emerging) for the NHS, which are published annually, following wide consultation.

The WRT supplements its data analysis through its development of technical models and tools, including the ongoing production of ‘Christmas trees’ and the SHA maps, and recent examples such as the audiology and endoscopy tools (Workforce Review Team 2009) for internal and external use. The WRT aims to develop workforce planning capacity and capability in the NHS through the wide distribution of its tools, as well as through its induction course for workforce planners.

Skills for Health (SfH)

SfH is the Sector Skills Council (SSC) for health care. There are 25 SSCs, licensed by the Secretary of State for Education and Skills, each covering a different area of employment skills. The key goals of the SSCs are to:

- address skills gaps and shortages
- improve learning supply, productivity and performance
- increase opportunities to boost skills (Skills for Health 2009a).

The specific aims of the SfH are to:

- develop and manage national workforce competences
- profile the UK workforce
- improve workforce skills
- influence education and training supply
- work with its partners (Skills for Health 2009a).

SfH aims to meet the challenges facing the health care workforce (such as an ageing population and increasing emergency hospital admissions) by developing ‘a highly skilled, occupationally competent and flexible workforce... that is capable of responding to the rapid advancement of the global economy and the changing characteristics of labour markets and health care across the United Kingdom and Europe’ (Skills for Health 2009b, p 11), to the benefit of staff and patients alike.

This includes the expansion of SfH’s labour market information and intelligence (LMI) function, as SfH looks to develop into the single most important authority on LMI around the UK health workforce, through the identification of trends and issues in the UK and international health care workforce and effective application of LMI in workforce planning. Part of this work is to develop a database of national workforce competences, which will prove especially useful given the increasing focus on pathway-based planning.

SfH includes the Workforce Projects Team (WPT, formerly National Workforce Projects), which offers a range of workforce planning tools, techniques and approaches (including the widely used ‘Six Steps Methodology Towards Integrated Workforce Planning’

[Healthcare Workforce 2009]) to provide support to workforce planners and to facilitate in the development of workforce planning capacity and capability throughout the NHS. The WPT runs an introduction to workforce planning course and a more advanced postgraduate qualification (PGCert), as well as a number of workshops and masterclasses on topics such as the 18-week wait.

In August 2005, the WPT was awarded the contract to help the NHS develop, pilot and make available solutions to the challenges raised by the need to comply with the European Union's Working Time Directive (WTD), which had to be fully implemented by August 2009.

Skills for Care (SfC)

SfC (England) 'works with social care employers and training providers to establish the necessary standards and qualifications that equip social care workers with the skills needed to deliver an improved standard of care' (Skills for Care 2009) and ensure that the social care employer's perspective is reflected in policy discussion and development.

SfC is developing the National Minimum Data Set for Social Care (NMDS-SC), which is to become a database for information about social care services and staff as a resource for employers to help them to plan their workforce. SfC supplies robust workforce data to employers to help to develop new ways of working and delivering services, helping to 'improve the image and status of the social care workforce' to aid recruitment and retention. This includes a national annual awards event to celebrate the achievements of innovative employers.

SfC has nine supporting regional committees, which act as brokers for funding dedicated to workforce development training and activities – an amount in excess of £25 million per year. The regional committees build relationships and develop partnerships with local employers to help them exploit the resources available in the most effective way.

NHS Institute for Innovation and Improvement (NHS I³)

The NHS I³ aims to provide 'a national co-ordinated focus to the biggest challenges of the service' (NHS NII 2009) and to improve the productivity of its organisations. The NHS NII prioritises the rapid development and dissemination of new ways of working and technologies in order to assist in the improvement of NHS systems, processes and working practices, investigating innovation and best practice across health and social care systems, nationally and internationally.

A key part of the NHS NII's work is the development of capacity and capability for a 'self-improving' NHS, and to enable change management within NHS organisations. It offers learning opportunities, practical advice and tools for both organisations and individuals (programmes include specific teaching for 'transformation leadership'). It also manages the NHS Graduate Management Training Scheme, which consists of four related management specialisms: general, finance, human resources and informatics.

NHS Employers (NHSE)

The NHSE 'represents trusts in England on workforce issues and helps employers to ensure the NHS is a place where people want to work' (NHS Employers 2009). The NHSE aims to reflect the views, look after and promote the interests of, and act on behalf of, NHS employers. Specifically, it covers issues concerning pay and negotiations, employment policy and practice, state of the workplace, and recruitment, although it also acts as a co-ordinating body to ensure that the employer's perspective is acknowledged in all key policy discussions.

As well as giving employers a voice in policy-making on national workforce issues through the Social Partnership Forum, NHSE also supports employers with their workforce planning through the provision of advice and information on issues such as how to manage temporary staffing effectively, achieving the 18-week target, and implementing role and system redesign.

The NHSE also manages the recruitment website NHS Jobs (www.jobs.nhs.uk), provides general careers support to current and prospective NHS employees, and works with trade unions and the Department of Health to help effect the most efficient use of resources in terms of NHS expenditure on the workforce.

The NHS Information Centre for Health and Social Care (ICHSC)

The ICHSC acts as the hub of comparative national statistics and data pertaining to England's health and social care workforces, passing information on to third parties, such as the WRT, the National Institute for Health and Clinical Excellence (NICE) and local decision-makers, for use and analysis.

The ICHSC is responsible for the verification (with trusts) of the information recorded in the Electronic Staff Record (ESR). It collects data on NHS staff numbers, earnings, turnover, vacancies, and sickness and absence; it uses this data to provide its annual workforce census. Both the ESR and the ICHSC census are vital sources of data for workforce planners throughout England.

A specific goal of the ICHSC is to improve the integration of data from the NHS and independent/private sector providers to align information and enable comparison. The ICHSC is also working with SHAs to develop comparative financial performance indicators (piloting with NHS Yorkshire and the Humber) and build understanding of the analytical tools and data available to SHAs (piloting with NHS North West) to assist them in management of the SHA.

High on the ICHSC's agenda is a three-year project to promote the development of social care data, which has historically been less well developed and less readily available than data on the health care workforce, which is expected to aid the integration of health and social care data and planning. Part of this work is to develop a proposal for the creation of a national information and intelligence service for social care.

Professional bodies/associations

Professional associations can be an excellent source of workforce data: they have access to their members' details and also have the ability to focus on smaller sections of the workforce in greater detail. The WRT has seen an increasing trend towards more detailed data and analysis emerging from some professions as their representative bodies put more effort into recording and analysing the status of their members. For example, the Institute of Physics and Engineering in Medicine (IPEM) is achieving improved results in its annual census of its members, partly because it now requests more information. However, the roles and responsibilities taken on by different professional bodies and associations are very varied.

This is exemplified by the attitudes and activities of the various royal colleges, the majority of which perform some form of workforce data collection or planning function, and some of which produce their own workforce censuses.

Good examples are the Royal College of Pathologists (RCPath) and the Royal College of Physicians (RCP), which are particularly active. The RCPath has its own workforce database, which members are asked to update individually, and its own workforce

department, which collects workforce data for use by the WRT and other relevant professional groups, and advises the college on trends in recruitment and pathology specialties. For the past 17 years, the RCP has produced an annual consultant census based on individual response forms, which is used to help define the supply of consultant physicians and helps the college to identify key trends within the physician workforce. The RCP also helps to define demand for the general medical specialties.

However, workforce functions are less mature in some of the other colleges. For example, the Royal College of Radiologists (RCR) planned to carry out its inaugural census of members during the autumn of 2009 to give, for the first time, accurate data on the composition of the UK workforce in clinical radiology. The college will share this data with the WRT and others with a legitimate interest in medical workforce planning.

Appendix B

Publicly available workforce strategies and plans

■ NHS East of England

www.eoe.nhs.uk

- *Towards the Best, Together*
- *Workforce and Leadership Investment Plan 2008/11*
- *Multiprofessional Education and Training (MPET) Investment Plan 2009/12*

■ NHS East Midlands

www.eastmidlands.nhs.uk

- *From Evidence to Excellence*
www.eastmidlandsdeanery.nhs.uk
- *Focus on Workforce: A high quality workforce for the East Midlands*
- *Education Commissioning Plan 2009/10*
- *Business Plan 2009/10*

■ NHS London

www.london.nhs.uk

- *Healthcare for London: A framework for action*
- *Workforce for London: A strategic framework*
- *Workforce for London: Scenario modelling*
- *Developing a 10 Year Medical Workforce Strategy for London*
- *Analytical Based Workforce Review of Community Focused Care and Diagnostics*
- *StaffScope: Understanding the future need for London's health and social care workforce – a 'soft' futures approach*
- *Clinical Workforce Productivity in London*
- *2009/10 Business Plan and Budget*

■ NHS North East

www.northeast.nhs.uk

- *Our Vision, Our Future: Our North East NHS*
- *NHS Education North East: Key roles and responsibilities*
- *Multiprofessional Education and Training Revenue Budget 2009/10 Finance Report*
- *North East Education Northern Deanery Three Year Strategic Plan 2006/2009*

- **NHS North West**
www.northwest.nhs.uk
 - *The Workforce, Education Commissioning and Education and Learning Strategy*
 - *Workforce and Education Investment Plan 2008/9*
 - *Budgetary Performance for the Period Ending 31 May 2009*

- **NHS South Central**
www.southcentral.nhs.uk
 - *Fit For The Future: A strategy to develop the health care workforce in NHS South Central 2008–13*
 - *Multiprofessional Education and Training Levy Investment Plan 2008/9*
 - *Budget Setting 2009/10*

- **NHS South East Coast**
www.southeastcoast.nhs.uk
 - *Tomorrow's Workforce: A strategic framework for the future*
 - *Workforce Profile (2008/9)*
 - *Quality, Innovation and Productivity, board paper (24 June 2009)*
 - *Report on the Education and Training Resource Plan 2009/10 of the Clinical and Workforce Development Directorate, board paper (24 June 2009)*

- **NHS South West**
www.southwest.nhs.uk
 - *The Strategic Framework for Improving Health in the South West 2008/9 to 2010/11*
 - *The NHS South West Workforce Development Investment Framework 2009/10*

- **NHS West Midlands**
www.westmidlands.nhs.uk
 - *Investing for Health. Step 2: Delivering our clinical vision for a world class health service*
 - *NHS West Midlands Multi Professional Education and Training Commissioning Plan 2008/9*

- **NHS Yorkshire and the Humber**
www.yorksandhumber.nhs.uk
 - *Workforce Ambitions 2009–14: A strategy for workforce and education*
 - *Working for Health: Strategic Framework for Workforce and Education in Yorkshire and the Humber, 2008–13*
 - *The Profile of the NHS Workforce in Yorkshire and the Humber in 2007*
 - *Yorkshire and the Humber SHA Finance Report: 2008/9 financial position and 2009/10 plan (3 March 2009)*

Appendix C

SHA budgets

Table C1 Breakdown of SHA workforce training budgets by source of funding

SHA	Source	NMET		MADEL		SIFT		Total
		£ '000	%	£ '000	%	£ '000	%	£ '000
East of England	Board finance report 20/06/2008	174,923	49	144,206	41	34,409	10	353,538
East Midlands	Business plan 2009/10	139,647	41	127,800	37	75,122	22	342,569
London	Financial report December 2008	387,433	36	397,717	36	305,838	28	1,090,988
North East	Budget management 2008/9	78,245	32	104,000	42	65,857	27	248,102
North West	Board finance report 06/03/2009	282,728	43	244,191	37	136,550	21	663,469
South Central*	Education and training levy plan 2008/9	139,465	46	113,421	37	51,724	17	304,610
South East Coast	Financial performance M10 2008	112,056	46	112,772	46	20,948	9	245,776
South West	Board finance report 28/02/09	144,095	42	137,385	40	64,212	19	345,692
West Midlands	Board finance report 24/03/2009	216,007	47	172,538	38	68,689	15	457,234
Yorkshire and the Humber	Board finance report 03/06/2009	205,097	42	180,446	37	102,250	21	487,793
	Total	1,879,696	41.41	1,734,476	38.21	925,599	20.39	4,539,771

*Included in NMET figure: £1,482 for National Workforce Review Team, £2,832 for other MPET budgets
 NMET, non-medical education and training; MADEL, medical and dental education levy; SIFT, service increment for training; MPET, multiprofessional education and training

Table C2 Breakdown of SHA workforce training budgets by area of spend

SHA	Source	SIFT and MADEL		Non-medical		Broader development initiatives		Overheads		Total
		£ '000	%	£ '000	%	£ '000	%	£ '000	%	£ '000
East of England	Board finance report 20/06/2008	178,615	51	136,366	39	30,492	9	8,065	2.3	353,538
East Midlands	Business plan 2009/10	202,922	59	126,225	37	5,246	2	8,176	2.4	342,569
London	Financial report December 2008	703,555	64	305,657	28	70,009	6	11,767	1.1	1,090,988
North East	Budget management 2008/9	169,857	68	70,848	29	1,691	1	5,706	2.3	248,102
North West	Board finance report 06/03/2009	380,741	57	256,599	39	22,157	3	3,972	0.6	663,469
South Central*	Education and training levy plan 2008/9	165,145	54	108,179	36	24,462	8	6,824	2.2	304,610
South East Coast	Financial performance M10 2008	133,720	54	107,326	44	3,158	1	1,572	0.6	245,776
South West	Board finance report 28/02/2009	201,597	58	134,642	39	2,348	1	7,105	2.1	345,692
West Midlands	Board finance report 24/03/2009	241,227	53	187,701	41	25,894	5	2,412	0.5	457,234
Yorkshire and the Humber	Board finance report 03/06/2009	282,696	58	192,568	39	8,831	2	3,698	0.8	487,793
	Total	1,734,476	38.00	1,626,111	35.82	194,288	4.28	59,297	1.31	4,539,771

*Included in NMET figure: £1,482 for National Workforce Review Team, £2,832 for other MPET budgets
SIFT, service increment for training; MADEL, medical and dental education levy; NMET, non-medical education and training; MPET, multiprofessional education and training

International approaches to workforce planning

In reviewing international approaches to workforce planning, we have looked at five countries with varying approaches to market mechanisms in the operation of their health systems and workforce deployment. Table D1 gives an overview, including England for comparison, and is followed by summaries of the five different approaches.

Table D1 Summary of international approaches to workforce planning

Country	Health care provision	Health care funding	Workforce pay	Health care workforce planning
England	Primarily public	National health system funded through taxation	National pay agreements	National planning for medical workforce; regional planning for non-medical workforce
Australia	Public/private	National/state health system funded through taxation, with subsidised insurance for elective care	Local and some national pay bargaining; fee-for-service for general practitioners	National planning for medical workforce; regional planning for non-medical workforce
Canada	Public/private	Statutory health insurance through taxation	Collective bargaining for nurses; fee-for-service for doctors	Most planning done at province/regional level
Germany	Public/private	Statutory health insurance through employer/employee income contributions	Mix of public tariffs and local pay rates	No formal workforce planning; medical workforce controlled by limit on number able to practice
Sweden	Primarily public	Public health system funded through national and local taxation	Collective bargaining for different professional groups at municipality level	Most planning and strategy at regional level; training numbers set nationally
United States	Primarily private	Mix of private insurance through employer, and tax-financed for priority groups	Some collective bargaining for nurses; fee-for-service for doctors	No national planning; variable degree of planning at state level

Source: Mable and Marriott (2001); Bloor and Maynard (2003); Tooke (2008)

Australia

Australia has invested in workforce planning at national and state level, and has mechanisms in place to support co-ordination between national and local approaches. The National Health Workforce Taskforce is a national body with a remit to undertake project-based work and advise on and develop workable solutions for workforce innovation and reform, as well as the improvement of workforce data.

The Australian Health Ministers' Advisory Council and the Australian Medical Workforce Advisory Council are the two main workforce-planning groups in Australia and, uniquely, focus on a 'models of care' approach based on the competencies needed to enable the

delivery of best practice health care (Bosworth *et al* 2007, p 24). The report by Bosworth and colleagues (known as the Warwick report) concluded that ‘the competencies approach may help to facilitate flexibility in staff deployment, but it makes workforce planning much more complicated’ (Bosworth *et al* 2007, p 24).

Australia is attempting to support a more integrated approach across disciplines, although medical and non-medical workforce training numbers are still largely planned independently. There is little evidence of integrated workforce, financial and service planning at a local level. Despite some innovative practice in workforce planning, the country still faces skills gaps in the medical and non-medical workforce.

Canada

Canada has relatively good data about the health care workforce at both national and provincial level. Provinces in Canada, each with separate government systems, undertake the main responsibilities of workforce planning, regulation and supply. The Canadian system currently suffers from a lack of investment in workforce planning at a national level, and poor co-ordination between approaches at province level. Work is ongoing to address these problems, however.

There are some examples of good practice in supply and demand modelling, and initiatives to develop new ways of working at provincial level. For example, the Nursing Health Services Research Unit (NHSRU), which is a collaborative project between the Faculty of Nursing at the University of Toronto and the School of Nursing at McMaster University, conducts research to provide the information necessary for evidence-based policy and management decisions about the effectiveness, quality, equity, utilisation and efficiency of health care and health services in Ontario, with a particular focus on nursing services. Patterns and trends are documented both locally (province-wide) and nationally, particularly with regard to issues such as recruitment, retention and working practices in nursing. One recent focus of attention was around the shift to a graduate nursing workforce.

Medical and non-medical workforces are largely planned independently. As in Australia and the United States, Canada is forecasting significant skills gaps in the future and has no clear strategy to address them.

Germany

Germany is relatively unique in having no formal approach to workforce planning. As a consequence, it has, also rather uniquely, experienced an oversupply of doctors. While this created immediate budgetary pressures, it has ultimately resulted in downward pressure on medical pay, and a relatively higher numbers of doctors. The lack of workforce planning and control over training has also created problems in modernising working practices.

Sweden

The major focus for health care workforce planning in Sweden is the medical workforce. There is little evidence of integrated approaches across the health care workforce, and Sweden has not invested heavily at a national or local level in centres of expertise to support workforce planning. There has been little development of new health care workforce roles, and shortages of health care professionals have primarily been addressed through international recruitment. At a local level, the dominance of public provision facilitates integrated service and workforce planning.

United States

The US system is characterised by some pockets of excellent practice, particularly with respect to demand and supply modelling. There are individual organisations carrying out high-quality data analysis and undertaking modelling that has the potential to be used effectively to inform policy. There are several centres for health workforce studies based in academic institutions across the country, which collate and interpret datasets covering the health workforce, and provide relevant analytical capacity.

However, the federated structure and dominance of independent private providers creates significant difficulties for co-ordination across states and between national and local initiatives. There is little evidence of integrated workforce, financial and service planning, and medical and non-medical workforces are largely planned independently. The US is forecasting significant skills gaps in the future and has no clear strategy or means to address them.

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