Six Steps Methodology to Integrated Workforce Planning

integrated
six steps

better **skills**
better **jobs**
better **health**

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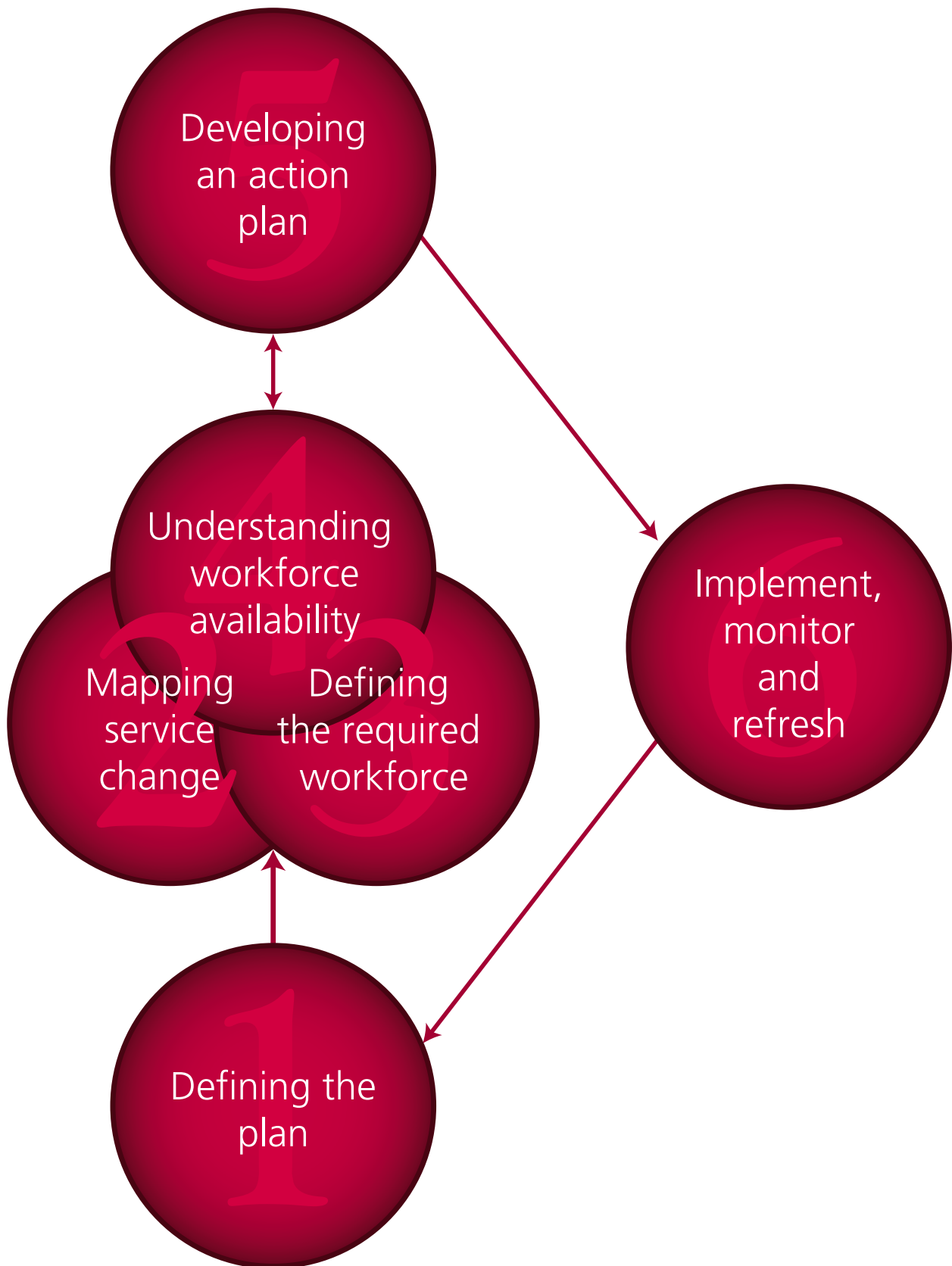
Foreword

High Quality Care for All - NHS Next Stage Review Final Report

The Department of Health (DH) has unveiled its vision for the NHS of the future. It highlights the achievements of the past ten years, whilst the Next Stage Review sets out a vision for the future which consistently delivers the highest quality of care to all its patients, enabling staff to offer treatments that are personal, effective and safe.

There are workforce planning implications throughout the document outlining the systems for high quality education and training, clear roles and a locally led approach to workforce planning. Details include:

- Reform of workforce planning and education by devolving decision making to the front line with clear accountability

- Meet the needs of patients by developing the workforce elements of the service plans

- The new system will require leadership and management of workforce planning and education commissioning based on strong and constructive partnership with all professions

- New professional advisory bodies to contribute to strategic workforce development at all levels

- Independent advisory non departmental public body Medical Education England (MEE) to advise DH on education and training of doctors, dentists, pharmacists and healthcare scientists

- Similar advisory bodies in each region

- Centre of Excellence to support national and local professional advisory bodies and wider healthcare system

- Centre of Excellence to provide objective long term scanning, capability and capacity development for workforce planning functions and development of technical planning assumptions

- Replace historical funding arrangements of MPET with a tariff based system where funding follows the trainee.

The full report is detailed at www.ournhs.nhs.uk.
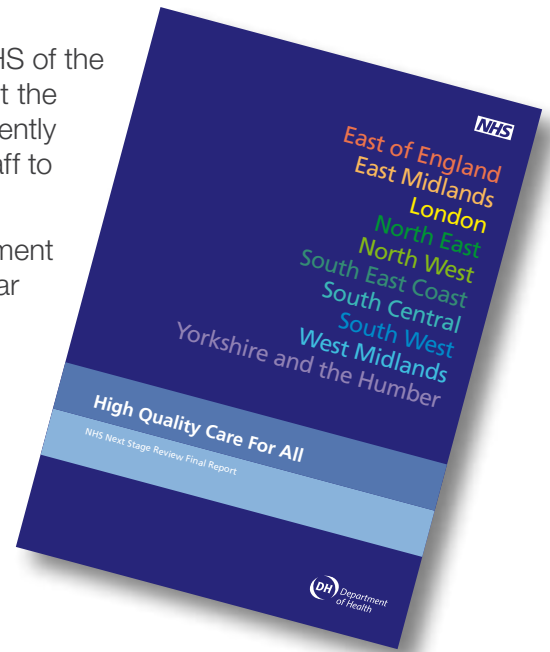
This methodology aims to support the Next Stage Review by providing a practical guide to sustainable and evidence based workforce planning. Six steps will be useful to anyone working in healthcare human resources, workforce planning, service planning or in designing new ways of working. It helps managers take into account the local demographic situation, impact on other services and provides practical hints, tips and case studies to work through plans.

Use of the guide across workforce planning will help ensure that decisions made around design and recruitment of new staff and teams are sustainable, realistic and fully support the delivery of high quality patient care.

Six Steps is supported by a range of resources aimed at increasing the capability of workforce planners in the NHS, details include:

- UK Wide Workforce Planning Competence Framework
- Workforce Planning Competence Tool
- Workforce Planning Development Café.

All available at www.healthcareworkforce.nhs.uk, and:

- Competence Application Tools
- Labour Market Information Resource

Available at www.skillsforhealth.org.uk.

Introduction

At its simplest, effective workforce planning ensures you will have a workforce of the right size, with the right skills, organised in the right way, within the budget you can afford, delivering services to provide the best possible patient care.

Workforce plans are prepared at many levels. At a departmental level, there are the plans (staffing rotas) prepared once a month by a ward manager to ensure that their ward has all its shifts covered by staff with the correct skills and competences to ensure that patient services are delivered safely and effectively.

At the most complex level, there are SHA level workforce plans which may be an aggregation of all the plans submitted by the PCTs and by provider organisations which are used to support strategic and financial planning and education commissioning.

You may need to plan your future workforce needs in the context of plans to reconfigure services. On the other hand, you may want to rethink the delivery of services in the context of an anticipated shortage of staff with particular skills.

The main aim of this six step guide is to set out in a practical framework those elements that should be in any workforce plan.

It is important to be very clear why the plan is needed and for whom it is intended.

Examples and case studies

As an appendix to this guide, there is a case study to demonstrate how effective workforce plans, dovetailed with service and financial plans, have been developed and delivered using the Six Steps methodology.

To help show how the steps may work out in specific service areas, a range of guides using the Six Steps methodology are available at www.healthcareworkforce.nhs.uk.
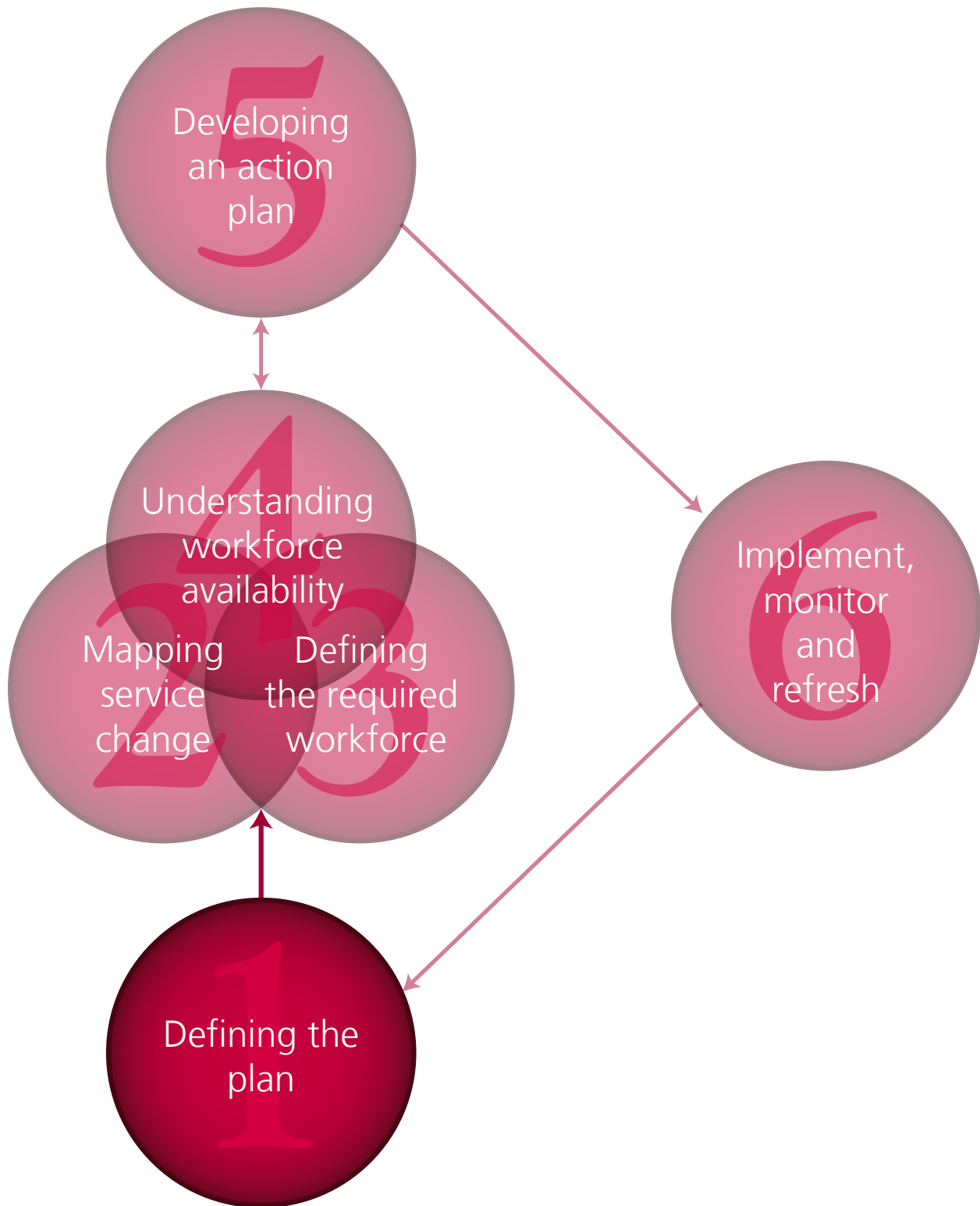
Generic Guide

The table below summarises the six generic workforce planning steps. The detailed sections that follow give more information on applying each of the steps.

Six Steps	Brief Narrative	Key Headings	Overview
Step 1 Defining the Plan	Identify why a workforce plan is needed and for whom it is intended.	• Purpose • Scope • Ownership.	This is the critical first step in any planning process. You must be clear why a workforce plan is required and what it will be used for. You must determine the scope of the plan, whether it will cover a single service area, a particular patient pathway or a whole health economy and given this, be clear who is responsible for ensuring the plan is delivered and who else will need to be involved in the planning process.
Step 2 Mapping Service Change	Identify the purpose and shape of any proposed service change that will impact on future workforce requirements.	• Goals / benefits of change • Current baseline • Drivers / constraints • Option appraisal • Working models.	This is the first of three inter-related steps. This is the process of service redesign in response to patient choice, changes in modes of delivery, advances in care or financial constraints. You must be very clear about current costs and outcomes and identify the intended benefits from service change. You should identify those forces that support the change or may hamper it. There must be a clear statement about whether the preferred model better delivers the desired benefits or is more likely to be achievable, given anticipated constraints.
Step 3 Defining the Required Workforce	Identify the skills required and the type / number of staff to deliver the new service model (workforce demand).	• Activity analysis • Types / numbers • Productivity / New ways of working.	This step involves mapping the new service activities and identifying the skills needed to undertake them and the types and numbers of staff required. This will involve consideration of which types of staff should best carry out particular activities in order to reduce costs and improve the patient experience even where this leads to new roles and new ways of working.

Six Steps	Brief Narrative	Key Headings	Overview
Step 4 Understanding Workforce Availability	Identify current and future staff availability based on current profile and deployment (workforce supply).	• Understanding the current workforce • Workforce forecasting • Demographics • Supply options.	This step involves describing the existing workforce in the areas under consideration, its existing skills and deployment, plus assessing any problem areas arising from its age profile or turnover. It may be the case that the ready availability of staff with particular skills, or, alternatively, the shortage of such staff itself contributes to service redesign and steps 2 and 3 will need to be revisited. Consideration should be given to the practicalities and cost of any retraining, redeployment and / or recruitment activities that could increase or change workforce supply.
Step 5 Developing an Action Plan	Plan to deliver the required workforce (new skills in new locations) and manage the change.	• Gap analysis • Priority planning • Action planning • Managing change.	This step involves reflecting on the previous three steps and determining the most effective way of ensuring the availability of staff to deliver redesigned services, even if this means some further service redesign. A plan for delivering the right staff, with the right skills in the right place needs to be developed with milestones and timescales. You should also include in your plan an assessment of anticipated problems and how you will build a momentum for change, including clinical engagement.
Step 6 Implement, Monitor and Refresh	Implement the plan, measure progress and refresh the plan as required.	• Implementation • Measuring progress • Revisiting Six Steps.	After the plan begins to be delivered, it will need periodic review and adjustment. The plan will have been clear about how success will be measured, but unintended consequences of the changes also need to be identified so that corrective action can be taken.

Step 1: Defining the Plan

5 Developing an action plan

4 Understanding workforce availability

2 Mapping service change

3 Defining the required workforce

6 Implement, monitor and refresh

1 Defining the plan

www.healthcareworkforce.nhs.uk/step1

This is the critical first step in any planning process. You must be clear why a workforce plan is required and what it will be used for. You must determine the scope of the plan: whether it will cover a single service area, a particular patient pathway or a whole health economy and, given this, be clear who is responsible for ensuring the plan is delivered and who else will need to be involved in the planning process.

Purpose

- What are the aims / objectives of the plan?

Scope

- What services / organisations will the plan cover and over what timescales?

Ownership

- Who owns the plan?
- Who are stakeholders in the plan?

1.1. Purpose

It is important to answer a series of questions in order to be clear about the rationale for the plan and who needs to be involved.

- What is the problem you are trying to solve?
- What will a good plan enable you to do?
- Who initiated the plan and why?
- Who will the plan impact upon?

1.2. Scope

Once there is some clarity about the rationale for the plan and the decisions it supports, it should be possible to start defining its scope.

- What geographical area is covered by the plan?
- What services and organisations does it cover?
- What types of staff are covered?
- What client groups does the plan cover?
- Is this a short term or long term problem and solution?

Getting the scope right is important. If it's too narrow it will miss important factors, too wide and there is the risk that planning becomes unmanageable.

The scope should be sufficient to support the decisions the plan underpins. Typical planning timescales will be driven by the lead times for bringing about changes in the workforce.

As with all elements of the plan definition, the scope can be adjusted during the planning process. It is better to start with too narrow a scope and expand than to waste effort collecting lots of information.

1.3. Ownership

It is important to identify who owns the plan - who will be held to account if the plan is not achieved or congratulated when the plan is delivered successfully.

It is important to identify who needs to be influenced if the plan is to be successful because without their support it may never be implemented.

But it is also important to consider who else needs to be involved in the planning process as they will be involved in producing the plan or because their work will be affected by it.

- Who owns the workforce plan?

- Do these stakeholders understand their part / contribution to the delivery of the plan?

- Is everyone involved signed up to achieving the plan?

Step 1 Checklist

Before moving to step 2, it is important to have the following information in place.

Purpose

☐ What is the problem you are trying to solve?

☐ What will a good plan enable you to do?

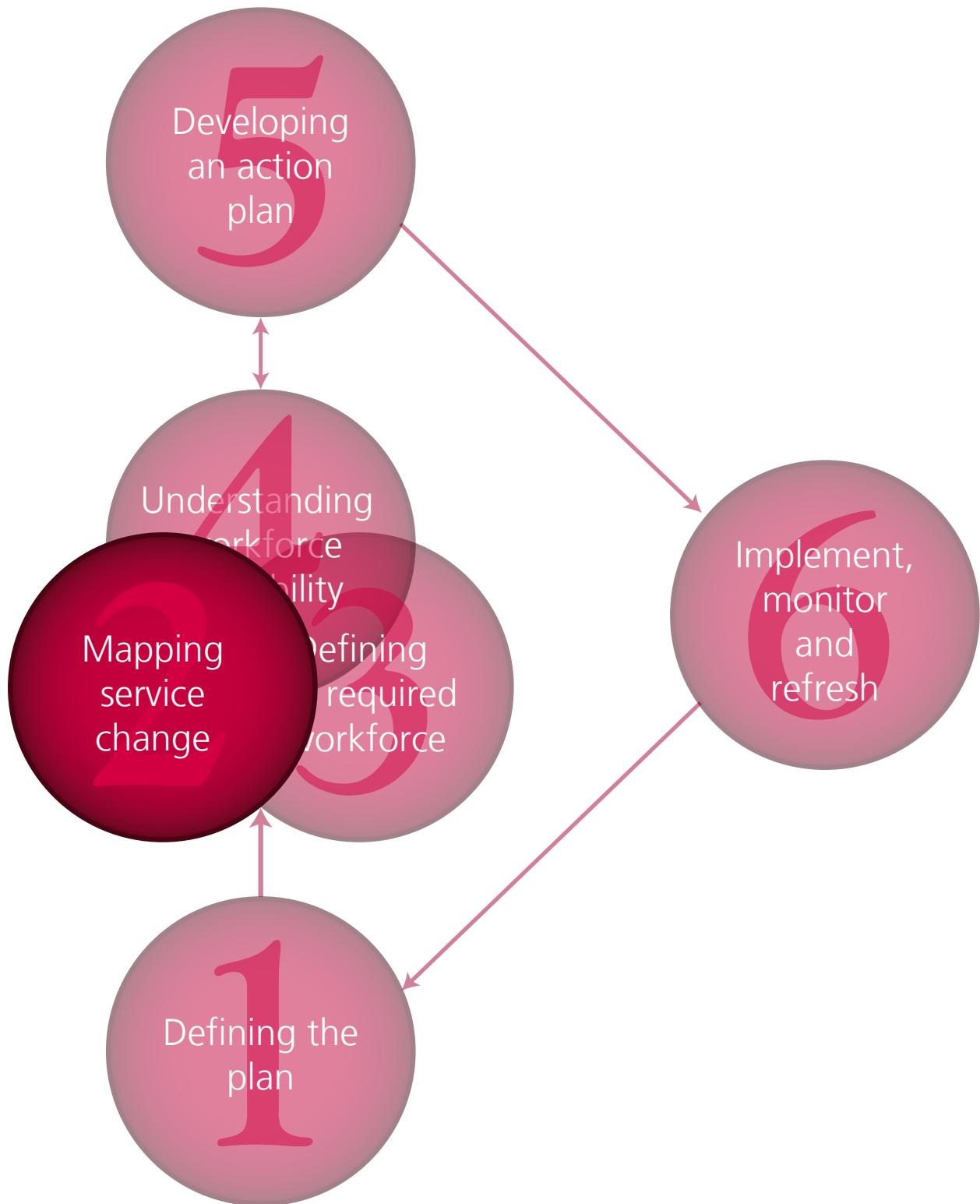☐ Who initiated the plan and why?

☐ Who will the plan impact upon?

Scope

☐ What geographical area is covered by the plan?

☐ What services and organisations does it cover?

☐ What types of staff are covered?

☐ What client groups does the plan cover?

☐ Is this a short term or long term problem and solution?

Ownership

☐ Who owns the workforce plan?

☐ Who needs to be influenced if the plan is to be successful?

☐ Do stakeholders understand their part / contribution to the delivery of the plan?

☐ Is everyone involved signed up to achieving the plan?

Step 2: Mapping Service Change

5 Developing an action plan

4 Understanding workforce availability

2 Mapping service change

3 Defining required workforce

6 Implement, monitor and refresh

1 Defining the plan

www.healthcareworkforce.nhs.uk/step2

This is the first of three inter-related steps through which service reconfiguration is matched with changes to workforce.

There may be a number of drivers behind service redesign. It may be a response to patient choice, to advances in care or therapies, or to financial constraints and the need for enhanced productivity. It may result from changing population needs or from anticipated changes to legislation.

At the start, you must be very clear about the costs and outcomes under current models and be able to fully describe the intended benefits from the service change. This is critical if the impact of the changes is to be effectively measured.

You should identify those forces that support the change or may hamper it. This is critical if the change is to be delivered.

There must be a clear understanding about whether the preferred model delivers the desired benefits more effectively than other models or is simply more likely to be achievable, given anticipated constraints.

Service change may be necessitated by workforce shortages (eg fewer junior doctor hours as a result of Working Time Directive (WTD) or problems in retaining staff). On the other hand, service change may be prompted by a ready supply of skills at a particular level (eg assistant practitioners within an organisation completing their training).

However, it is important to have a clear and shared understanding of the future service configuration based on the patient experience, patient outcomes and financial realities. Too much focus on the available workforce can too often lead to limited thinking and a mere reproduction of current models.

Goals/benefits of change

- What are the objectives and anticipated benefits of the proposed service change?

Current baseline

- What are current service costs and current performance measures?

- Drivers/constraints

- What context must the new service operate within? What forces will support the change in services and what resistance is expected?

Option appraisal

- What different scenarios for service change have been considered/costed?

- Working models

- What is the preferred model(s) and why?

2.1. Goals / benefits of change

Vision: It is important to establish a vision, a picture of what the service or workforce will look like when you have achieved the desired outcomes. The process of developing a vision is generally an excellent way of ensuring engagement of all the stakeholders in the planning process.

Benefits: You should be clear about the improvements you expect when the vision is achieved eg improved patient access to services, reduced patient pain or anxiety, reduced costs, improved staff retention etc. And you need to be able to measure whether things have been improved.

Goals, targets and objectives: In order to make progress towards the vision more measurable and to ensure that the desired benefits are realised, it is common to define specific targets and objectives. For example, improved access may be measured by the achievements of specific targets for reductions in waiting times.

Competing benefits: Sometimes, there may be improvements in one aspect of the service, but at the expense of another. For example, productivity may be enhanced and there may be more activity for the same cost but the patient experience is worsened. It is important, therefore, to have a range of measures by which to evaluate whether overall improvements have been achieved. Key perspectives may include service, workforce, customer and financial and a useful checklist may include the following (although different service areas will develop their own checklists):

- Staff costs for the service area
- Readmissions rates
- Clinical incidents
- Proportion of patients presenting who are admitted
- A&E breaches
- Impact on training
- Patient complaints.

When it appears that certain benefits will only be achieved at the expense of other areas eg A&E breaches can only be minimised within cost parameters by having staffing rotas that are so tight that staff training time is reduced, stakeholders need to agree which benefits are the more critical.

2.2. Current baseline

In order to be able to ensure that changes to service configuration achieve the desired benefits, it is critical to understand current costs and current performance measures.

If the indicators highlighted in section 2.1 were to be used in evaluating a particular service change, for example, the organisation must understand the performance levels of the current model in order to be able to determine whether the planned change brings about the intended improvements or whether improvements in one area are offset by a reduced performance in others.

2.3. Drivers / constraints

It is important to be clear about what is driving change. There will be the most obvious driver(s) that led you to start considering the service change in the first place, but there will be a wide range of further drivers which will also impact on future services and an understanding of these is critical if you are to fully understand the changes that may be required.

There may be policy drivers such as requirements to improve productivity, or to bring care closer to the patient's home. There may be changes in technology or therapeutic advances that are anticipated, or there may be changes in workforce skills or supply that have not in themselves prompted the reconsideration of service shape, but nevertheless must be taken into account in planning for any changes.

Often these drivers are in conflict and it is important to identify and understand them.

There are a variety of methods for identifying external drivers:

Brainstorming techniques can be used where the main figures involved in the planning process are brought together to capture as many of the drivers as possible that are likely to impact on the services being planned.

Another technique, which can help ensure that all the different kinds of drivers are considered is a PEST analysis (political, economic, social, technological), in which potential factors that may impact on service delivery are looked at in turn to ensure the likely impact on services are being planned for. An example of some potential drivers using PEST are listed below:

Political	Economic
• Legislation	• Winter pressures
• European legislation	• Patients' priorities
• Government policies	• Financial positions.
• Funding requirements.	
Social	Technological
• Demographics	• Information technology
• Labour market intelligence	• Innovation
• Patient attitudes	• Medical research
• Ethical issues.	• Replacement solutions.

It should also be noted that a range of organisations are actively involved in researching the drivers for change across the health sector or broader economy and many of them describe this as 'horizon scanning'. The information gathered by these exercises is available in a variety of forms - web sites, reports, databases etc. The healthcare workforce portal www.healthcareworkforce.nhs.uk provides information on a number of these sources.

One of the best ways of understanding the impact of change drivers on the system is to look at the significant changes that have happened in the past and why they happened. In looking at past trends and changes it is always a good idea to go back at least as far as you intend to plan into the future. As a workshop exercise it is useful to pose the following questions:

- What are the most significant changes that have happened (to the workforce?)

- Which of these were a surprise?

- What were the key factors which brought about these changes?

- Are there any which we don't understand?

In relation to the most relevant past changes, it may be valuable to commission or carry out research into the factors which brought about the changes, particularly if they are poorly understood.

Some drivers can be used as levers that help bring about the desired changes, so it is important to understand how much control you have over them:

- Fully controlled

- Controlled, but need the support of others

- Not directly controlled, but may be able to influence

- Not within our control at all.

Workforce availability may be a driver that can become a lever, for example by adjusting training numbers, pay levels, HR policies, skill mix etc.

Changes to service models may also be used to alter the demand for particular workforces, where such workforces are unlikely to be available in the required numbers or with the required skills. Steps 3, 4 and 5 examine in greater detail the various levers that can be used to balance workforce supply and demand.

There are also forces that will resist change. Staff may feel uncomfortable about developing new skills or taking on new responsibilities, or moving from established ways of doing things. Managers may also fear loss of authority. Organisations may be reluctant to relinquish responsibility for an aspect of the patient pathway that generates significant income for them, which may be more effectively delivered elsewhere. Patients may be reluctant to see particular services change even if there is evidence that a new service delivered elsewhere will be better for them.

Sometimes it is the forces that we least understand or that are least predictable that make certain forms of service reconfiguration unworkable or unachievable.

In exploring how forces are likely to impact, it is often the ones that are both high potential impact and high uncertainty that we should pay most attention to. In some cases better information or understanding may reduce the uncertainty, but other factors will remain

unpredictable. To deal with the latter, we need to develop scenarios covering the range of potential impacts that they might have, and develop strategies that can cope with each of these scenarios.

The next stage in the analysis is to map how the various drivers might bring about change. A useful starting point is a cause/effect analysis, grouping together those drivers or causes which are likely to bring about a desired effect or outcome. A common way of capturing this is through the fishbone or Ishikawa diagram (example below):

WTD Cause and Effect
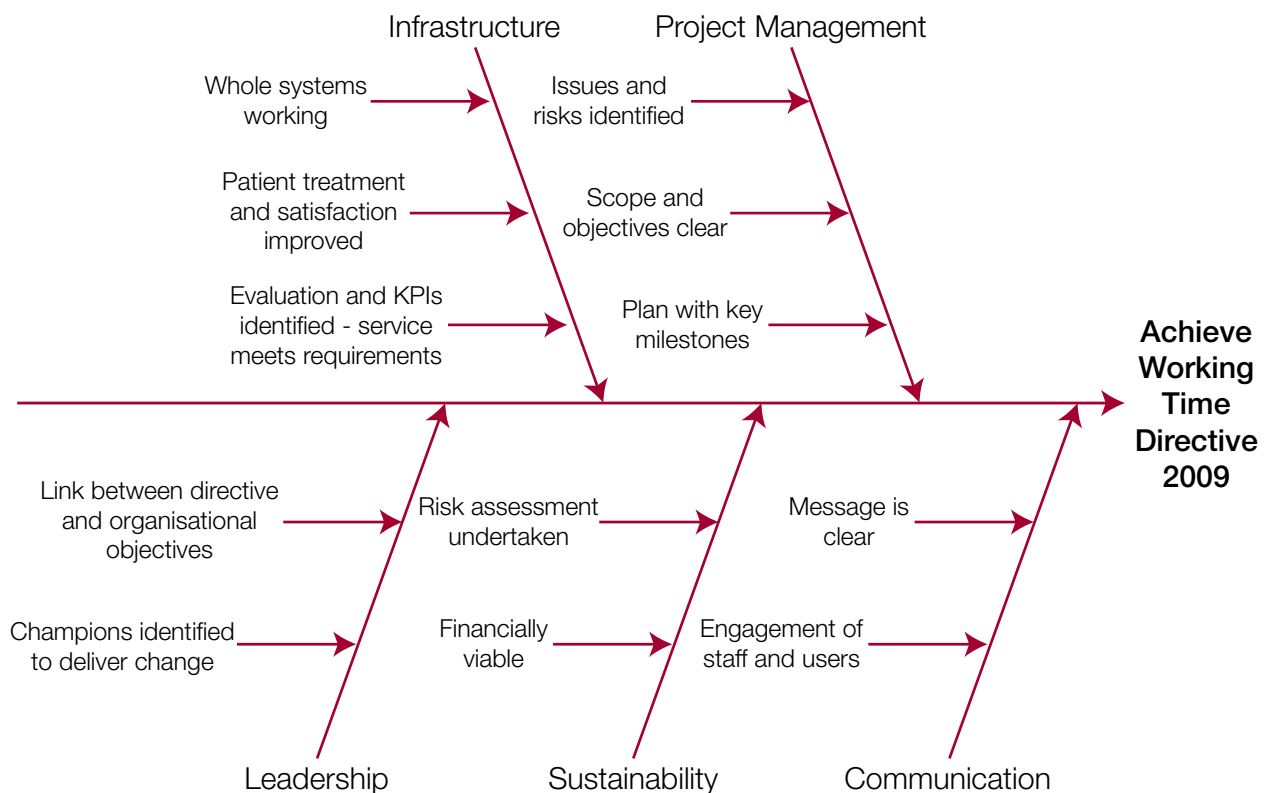
Another common approach is force field analysis, where factors are grouped according to whether they are likely to aid or oppose the achievement of the goals. Where there is a lot of interaction between the various forces, systems thinking and systems modelling can often help you to understand them.

2.4. Option appraisal

Once the vision, benefits and goals have been defined and the levers and constraints identified, a range of hypothetical scenarios can be created.

As an example, commissioners are required to identify the health needs of their populations and then to specify the services they wish to commission to meet these needs. However, the same service can be provided in a number of ways and locations and, increasingly, both commissioners and providers are reviewing care pathways, focusing on the patient experience, to see how services can be delivered more effectively. An analysis of drivers, levers and constraints in these circumstances is helpful in determining what service model is likely to be realisable.

Some scenarios may be better at achieving certain benefits, others might have a more realistic chance of success because they are less likely to meet resistance.

It is important that the scenarios capture all the possible future changes and that a wide range of stakeholders, including staff affected as well as patient representative groups are engaged in the process of assessing the alternatives.

The NHS Institute for Innovation and Improvement have developed a scenario generator to allow simulation of whole health and social care systems. It comes pre configured with population and prevalence data, and with a number of generic pathways of care. Users can modify all the defaults, change existing pathways or create new ones and develop any number of hypothetical scenarios. The tool can be found at www.institute.nhs.uk/scenariogenerator.

2.5. Working models

A preferred model must have the best chance of being realisable as well as achieving the optimum range of benefits. It may not be possible to achieve all the desired goals and therefore the risks associated with a particular model must be identified.

There must be clear measures of how you will assess whether the new model is achieving the benefits described for it, including clear milestones and timelines for achieving the changes.

Step 2 Checklist

Before moving to step 3, it is important to have the following information in place.

Goals and benefits of change

☐ What are the drivers behind the service change?

☐ What are the costs and outcomes under current models?

☐ What are the intended benefits from the service change?

☐ How will the change be effectively monitored?

Drivers / constraints

☐ What are the forces that support the service change?

☐ What are the forces that hamper the change?

Option appraisal

☐ What different scenarios for service change have been considered?

Working models

☐ Does the preferred model deliver the described benefits more effectively than other models?

☐ Or is the model simply more likely to be achievable given the anticipated constraints?

☐ Is there a clear and shared understanding of the future service configuration based on the patient experience, patient outcomes and financial realities?

Step 3: Defining the Required Workforce

5 Developing an action plan

4 Understanding workforce availability

2 Mapping service change

3 Defining the required workforce

6 Implement, monitor and refresh

1 Defining the plan
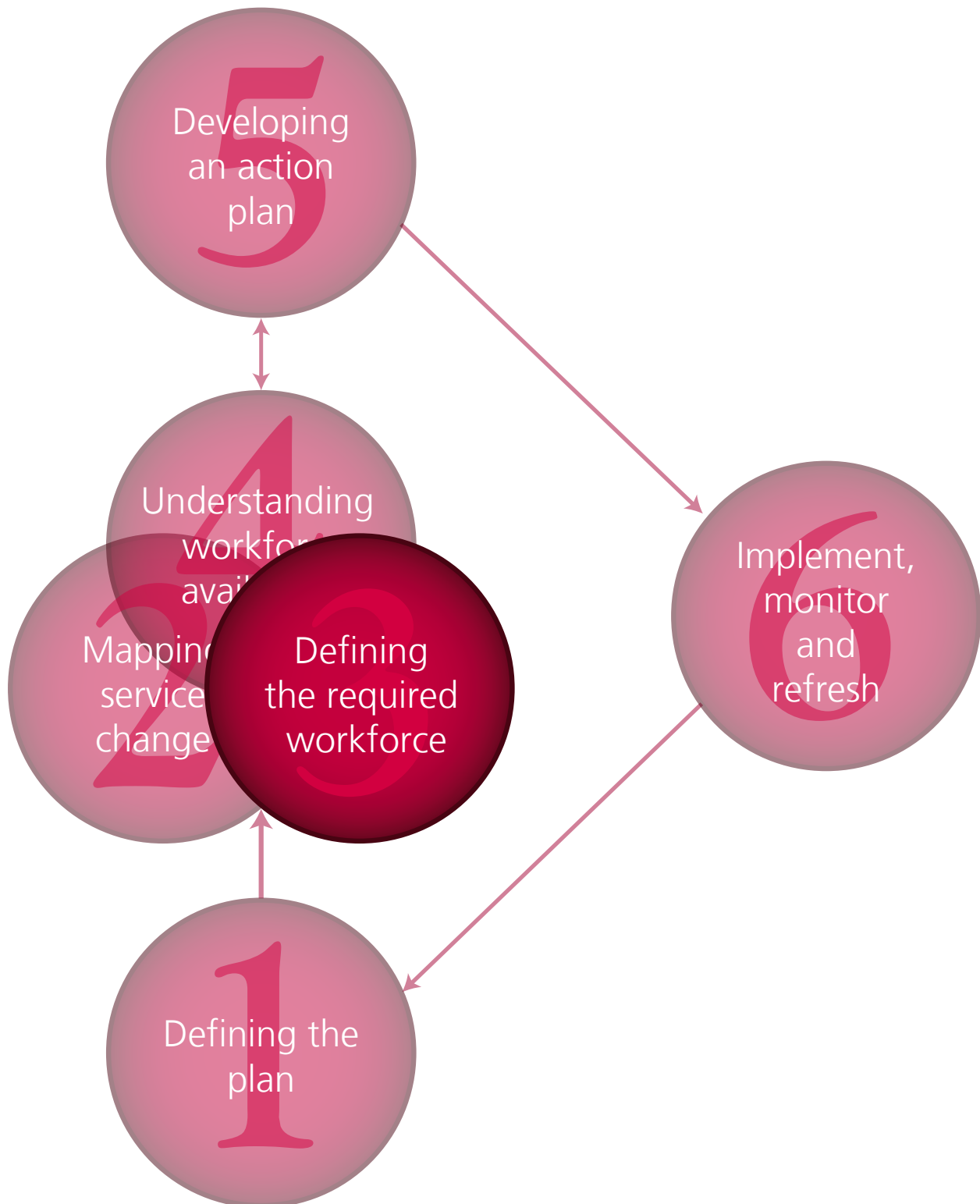
www.healthcareworkforce.nhs.uk/step3

This step involves identifying the workforce needed to deliver the reconfigured services, the skills needed by the workforce and the types and numbers of staff required. This will involve consideration of which types of staff should best carry out particular activities and may lead to consideration of new roles and new ways of working.

The types and numbers of people needed to achieve planned service activities can be described as 'workforce demand'.

Planning workforce demand needs to be done as an integral part of the wider service and financial planning process. Workforce demand will be driven by the planned delivery of services but workforce is also a limited resource, like finance, which may constrain the services that can be delivered.

Thus, whilst you work out the workforce demand from the new service model, you must also take into account your existing workforce and the challenges of changing its deployment and skills. On the other hand, if you give too much emphasis to the skills and deployment of the current workforce, there is a danger that you give insufficient imagination to new ways of working and to new methods of service delivery.

The sections in this step take you though an analysis of workforce demand:

Activity analysis

- What are the key tasks within the new service delivery model?

Types / numbers

- Can the required numbers of different staff with the required competences be modelled?

Productivity

- Can new ways of working be considered and can the costs of different blends of skill mix be measured?

3.1. Activity analysis

Building a picture of what activities are required usually involves some form of activity analysis. This normally involves a combination of direct evidence gathering and judgement from experienced practitioners.

Information on how long tasks take and how they relate to other activities is generally collected directly through observation, diaries or similar approaches.

Information on what needs to be done to achieve required clinical standards, or what skills are required may be drawn from research evidence, but in most cases will depend on a degree of professional judgement by experienced practitioners.

Activities can be broken down into:

- Skills required to perform them

- Time taken to complete them

- Whether they can be carried out by an individual or require two or more working together

- The standard to which they need to be carried out

- Whether they need to be linked to other activities as part of a larger process.

How roles are constructed: What duties and responsibilities you give to a post will depend on the pattern of staffing required for particular activities. If analysis suggests that only one or two people are needed to cover a particular set of activities, it makes little sense to use highly specialised roles. You would look to create broad jobs that require a sufficiently wide range of skills to cover all of the activities required.

Services that require larger staff numbers will allow more differentiation of roles by clustering activities in terms of level and type of skill required.

While a desirable goal is to develop greater flexibility in the workforce and to design roles around patient needs, a large part of the workforce will continue to be drawn from established professional groups.

Thus there are likely to be a number of different new roles that you need to identify:

- Those that fully match the skills profile of a current professional category eg mental health nurse, cardiologist, therapeutic radiographer etc

- Those that are enhanced roles drawn from a specific professional group with training in additional skills eg nurse practitioner

- Those that could be filled from more than one professional group but require additional training and development to fulfil the role eg some mental health roles which can be drawn from mental health nurses, occupational therapists or social workers

- Roles that can be filled by staff who are not professionally qualified eg assistant practitioners.

Significant progress has been made, led by Skills for Health, in mapping healthcare activities and the skills and competences needed to undertake them. Functional analysis maps the activities and their associated skills for a given service area and has been completed for a large part of the service. This is followed by the more detailed establishment of national occupational standards (NOS) which set out the required levels of competence in the skill and how these can be measured and tested.

This information is available on the Skills for Health website (www.skillsforhealth.org.uk) and healthcare workforce portal (www.healthcareworkforce.nhs.uk).

3.2. Types and numbers of staff required

The key to ensuring that service planning and workforce planning talk a common language is to plan in terms of the units through which the service is delivered: the ward, department, team etc.

The case load and case mix that can be expected of individual service units can be identified, as well as how it will change. The source of this information will vary in each organisation, however the Department of Health, and the Royal Colleges amongst others provide details and guidance. This can be used as the basis for assessing the size and composition of the team needed to deliver the service.

In building up models of how many staff are required, you also have to build in time for training and development, planning and communication, record keeping and administration, which can take up significant amounts of an individual's time.

3.3. Productivity and new ways of working

Productivity improvement is about achieving more service activity for a given level of workforce input or achieving the same service activity with a smaller workforce without compromising quality. This is not about making people work harder. While improved motivation will, no doubt, produce some productivity improvements, the significant gains come through using the workforce resource more effectively. The main ways in which this can be achieved are:

Technology: The introduction of new technology is an important mechanism for improving productivity. It can enable tasks to be eliminated or completed in a shorter time. While some simple technologies may be introduced without major changes, significant technological developments will require a rethink of ways of working and the service delivery process.

Therapeutic advances: Medical advances such as minimally invasive surgery and new drug treatments have been significant drivers of increased productivity.

Patterns of working: Another way to improve productivity is to try to eliminate dead time or duplication of effort. Dead time can be eliminated by better deployment of personnel to ensure that staffing matches predictable peaks and troughs in activity. A variety of tools exist to support better deployment and rostering of staff.

Service models: A prime driver of increased productivity is change in the service model. For example the main driver of reducing costs in acute trusts has been reduction in length of stay and the shift to day case surgery.

Redistributing tasks: Research suggests that more highly skilled workforces are more productive where individuals are able to perform tasks more effectively, with less errors and rework, and also have less need to refer decisions to more highly skilled individuals. However, there is also evidence that many of the tasks performed by highly skilled staff could be safely undertaken by less skilled staff at reduced cost. Staff at any level typically spend a large part of their time undertaking tasks that don't require their level of training or skill. These tasks can often be successfully transferred to other workers. Where these other staff are already employed in the organisation, this is often referred to as changing the skill mix. In other cases the transfer of tasks may require the development of completely new roles.

Significant effort has been put into trialling new ways of working. Skills for Health have taken over the work of the former Changing Workforce Programme which supported the development of a range of specified new roles that were considered to have national relevance. Details are available from their website www.skillsforhealth.org.uk.

The healthcare workforce portal www.healthcareworkforce.nhs.uk also has a collection of case studies and 'how to' guides.

However, new ways of working do not always increase productivity or reduce costs. There are a number of reasons for this:

- People are likely to find a job stressful if they are being asked to work at their maximum skill level continuously, so there is a limit to how tasks should be transferred to others

- Delegating tasks can lead to problems in terms of communications and duplication of effort. In many cases it is more efficient for one person to undertake a complete set of activities

- While productivity may be increased for the staff group from whom tasks are transferred, overall team or organisational productivity may fall because those brought in to carry out the delegated tasks take longer, are less effective or are not qualified to make key decisions.

Effective role redesign must follow a set of fundamental principles:

- The changes should be based on the use of care systems, pathways and protocols linked to the development and delivery of services. Any changes must ensure clarity of role, the accountability of individuals and organisations, plus improved safety and quality for the patient

- Assessment of the impact of changing roles or new roles on other roles and services provided must have taken place and wider changes made if needed

- Wider people management requirements such as employment law and the contractual rights of staff must be taken into account

- All role redesign must take account of the need for continuing personal and professional development and there must be a clear career structure

- Role redesign should build on the growing evidence and experience of good practice

- Consideration must be given to the requirements of professional regulation.

It is crucial during the time of change that all parties recognise that role redesign is not a way of getting staff to do more work for less. Role redesign needs to be presented as an answer to the widening gap between service demand and delivery, which cannot be met by the current workforce structures and numbers.

Step 3 Checklist

Before moving to step 4, it is important to have the following information in place.

Activity analysis

☐ What are the key tasks within the new service delivery model?

☐ Have the activities been broken down into skills, time, individual or team?

☐ Has the standard required been identified including links with other activities?

☐ How are roles constructed including duties and responsibilities?

☐ Have new roles been identified?

Types / numbers

☐ Have the units through which the service is delivered been identified - ward, department, team?

☐ Have the case load and case mix been identified for individual service units?

☐ Has an assessment of the size and composition of the team needed to deliver the service been identified?
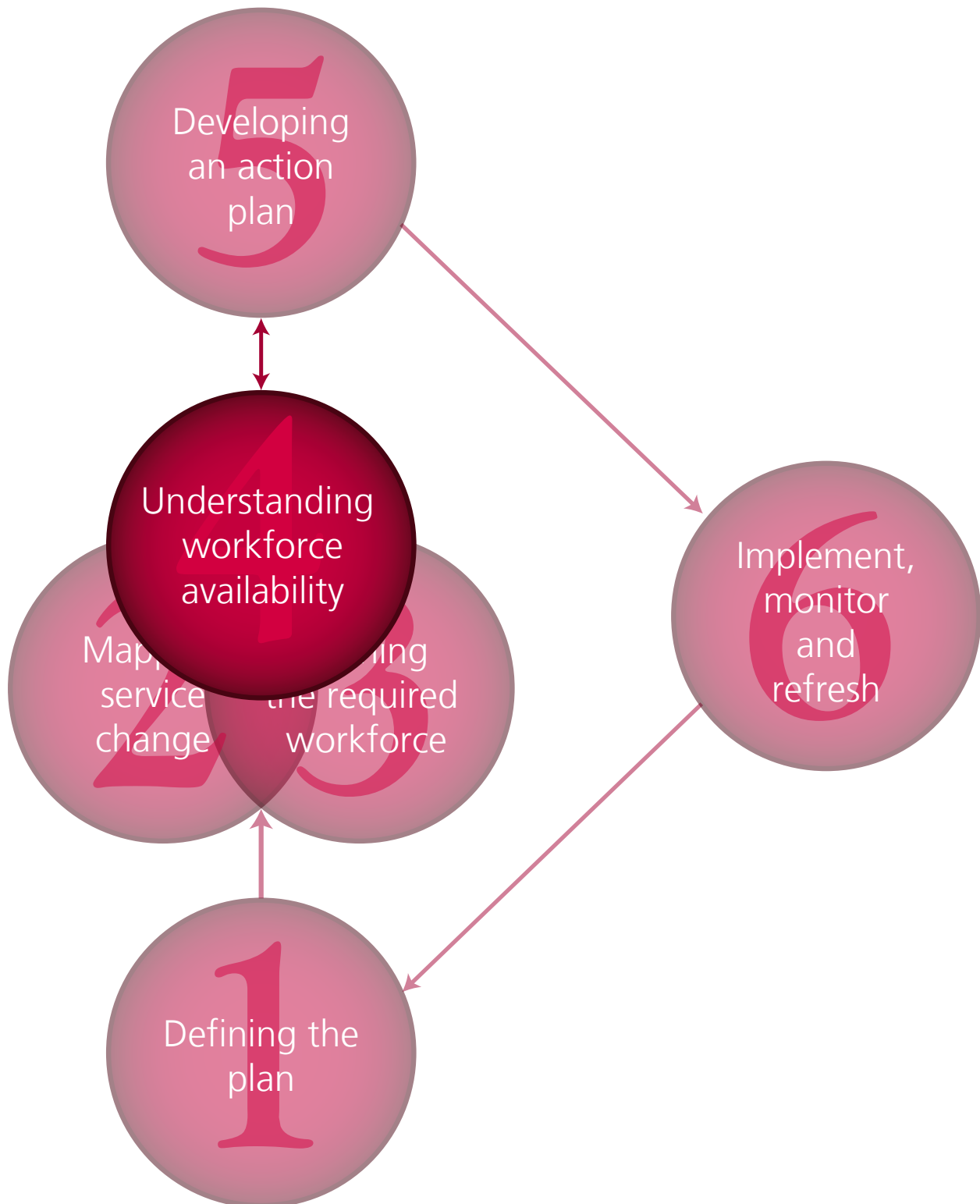
Productivity and new ways of working

☐ Have productivity implications been considered based on technology, therapeutic advances, patterns of working, service models and redistribution of tasks?

☐ Have different blends of skill mix been measured?

☐ If new ways of working have been identified have the fundamental principles in section 3.3 been applied?

Next Step

Once you have described the workforce you need in future, you should look at the workforce that is likely to be available if changes are not made. That is described in the next section.

However, once you have looked at workforce availability / workforce supply, you may need to revisit the realism or achievability of your proposed new service model.

Step 4: Understanding Workforce Availability

5 Developing an action plan

4 Understanding workforce availability

2 Mapping service change

3 Defining the required workforce

6 Implement, monitor and refresh

1 Defining the plan

www.healthcareworkforce.nhs.uk/step4

This step involves describing the existing workforce in the areas under consideration and its existing skills and deployment. It is important to understand the impact of the age profile of the current workforce and levels of staff turnover in order to understand what workforce is likely to be available in the future if no changes to roles or deployment take place.

As has already been stressed, it may be the case that the ready availability of staff with particular skills, or alternatively, the shortage of such staff itself contributes to service redesign and that steps 2 and 3 will need to be revisited in the light of the analysis of the current workforce.

Whilst there is always the potential opportunity to reshape the workforce to better support redesigned services, consideration should also be given to the practicalities and cost of any retraining, redeployment, and/or recruitment activities that might be needed.

The current workforce

- What are the characteristics of the current workforce, wherever it is located?

Workforce forecasting

- What turnover, vacancies, recruitment patterns do you anticipate and what might impact on this even without service change eg WTD, demographic changes etc.

Options for changing supply

- What initiatives for retention, retraining, recruitment, redeployment etc can realistically be developed.

4.1. The current workforce

Since the largest component of the future workforce is the current workforce, it is important to map what exists at the current time.

One reason we suggest working on future demand before collecting information on the current workforce is that it helps you focus on what you need to know about your current workforce.

Thus you should characterise the workforce in the way demand is expressed, if demand is expressed in numbers by a broad professional group, this may be all that is needed. However, if demand has been identified in terms of key skills then data on who possesses them in the current workforce will be required. If demand is identified by service unit, data will be required down to this level.

The detail required will depend on the detail of the demand assessment, but the following are likely to be key characteristics:

- A quantification of the overall workforce contribution, even down to the actual hours put in. This means not just the contract whole time equivalent (WTE), but also the input from overtime, bank and agency staff, and the impact of absence. If covering peaks and troughs has been identified as a problem, it will be necessary to collect data on the available workforce by time rather than a single baseline figure.

- If possible, you should identify establishments, ie the approved and funded posts for a given unit or activity that has been approved for budgetary purposes. Not all units will be able to identify a funded establishment but these can give an indication of the staffing the unit should have. Differences between establishment and actual staffing may not be reflected in advertised vacancies since units may be using the money to cover the gap in other ways.

- If the information you require is not collected or is unreliable, you may need to set up a special data collection. By doing the demand assessment first, you will be able to show managers why the information is required to ensure enhanced service delivery.

4.2. Workforce forecasting

To forecast the future workforce and to control supply so it meets demand, we need to understand the flows into and out of the workforce. The numbers in the workforce at any point in time will result from the balance between leavers and joiners.

Your workforce profile will be adjusted by the number of staff who leave and the numbers who join, change job and are retrained.

A forecast of leavers can be made by looking at past staff turnover, although wastage due to retirement will depend primarily on the age profile of your existing workforce. In some areas, such as community nursing, there is a high level of staff in their 50s and wastage from retirements can be forecast to increase significantly.

Younger staff typically have higher wastage rates than those in their forties. In their twenties they are likely to be more mobile. The key to understanding these patterns is information on past wastage rates in your organisation by age.

Wastage also typically peaks quite soon after people start a new job. This is often called the induction crisis. High levels of recruitment for example, to staff a new unit, may lead to high levels of wastage. Information on past wastage by length of service should therefore also be reviewed.

Clearly, you can influence wastage rates. You might wish to look at flexible retirement schemes to retain older staff or look at reasons for staff turnover to try to reduce it.

A major factor influencing both recruitment and wastage is the relative attractiveness of an employer compared with others. You might wish to review your employment packages and practices. Pay levels are important but the non financial rewards of the job and the ability to offer working arrangements and career opportunities that meet individuals' needs are also key factors. You might therefore wish to review whether your staff turnover rates are any different to those of comparable organisations and make adjustments to your workforce forecast if you consider you can improve your wastage rates.

You can also adjust your workforce by increasing or decreasing recruitment activity. You must take into account those students on training programmes to whom you have a commitment and those of your current staff who are in the process of gaining additional skills and qualifications.

You will also want to review whether you are likely to face difficulties in recruiting replacement staff. Competition from other employers might increase. For example, there might be significantly increased international recruitment for British based nursing staff. As a further example, in some metropolitan areas, competition for graduate level skills is forecast to increase.

It might also be the case that changes to the population, eg a fall in the number of school leavers may influence your ability to fill vacancies.

4.3. Options

Having established the existing workforce and the likely changes as a result of flows in and out, we need to understand what we can do to influence future supply so that it meets demand.

In the recent past much of the workforce planning effort has focused on determining the numbers entering professional training. The difficulty with this is that the lead times are generally long and other actions will have been taken to address supply in the short term which may invalidate the assumptions behind the training commissions. It is important, therefore, that all the options for changing supply are considered together.

International recruitment, campaigning for former staff to return to the health service, developing schemes for local school leavers can all complement the recruitment effort.

You can also explore ways to optimise the contribution of your current staff.

Increasing the skills of the existing workforce not only makes them more effective in their current jobs but also creates a potential pool of staff for promotion and enhanced roles. Even where formal training is not provided on promotion, there is effectively a cost associated with their development as individuals become more proficient at the job.

If absence levels are high, efforts to reduce absence can increase the time available from existing staff.

Reductions in turnover will mean fewer recruits are needed. However, some turnover is inevitable and desirable to enable people to progress and widen their experience.

Step 3 of this guide looked at the ways in which new ways of working can be used to modify demand. On the other side of the equation, new ways of working can also be used to enhance supply. Many supply problems arise as a result of the long lead times associated with training people to fulfil traditional professional roles. Developing new roles can enhance supply in a number of ways:

- Tapping new pools of potential recruits to healthcare: graduate mental health workers tap into an underexploited pool of graduates with relevant degrees, enhanced paramedic roles can attract male entrants who might be put off nursing and traditional therapy professions

- Maximising the potential of the existing workforce: current staff are generally more committed to the organisation, so developing their skills to enable them take on enhanced roles is often more cost effective than recruiting from outside

- Improving the intrinsic rewards of the job: many staff feel that their skills or potential are underutilised. Enabling them to take on enhanced roles can be an effective way of retaining them

- Offering flexible working patterns can also be very attractive for new recruits and potential returners.

The healthcare workforce portal www.healthcareworkforce.nhs.uk includes more detailed information on new ways of working and assessing the impact on workforce supply, including a number of workforce profiling tools, including the assessing workforce supply tool and the service reconfiguration tool.

Step 4 Checklist

Before moving to step 5, it is important to have the following information in place.

Current workforce

☐ What are the characteristics of the current workforce?

☐ Has this been described in terms of numbers of certain types of staff, skills or service unit?

Workforce forecasting

☐ What turnover / attrition is expected and what numbers are in the commissioning pipeline?

☐ What influences on supply are there even with no service change (eg shorter working hours and the Working Time Directive)

☐ What is the local labour market?
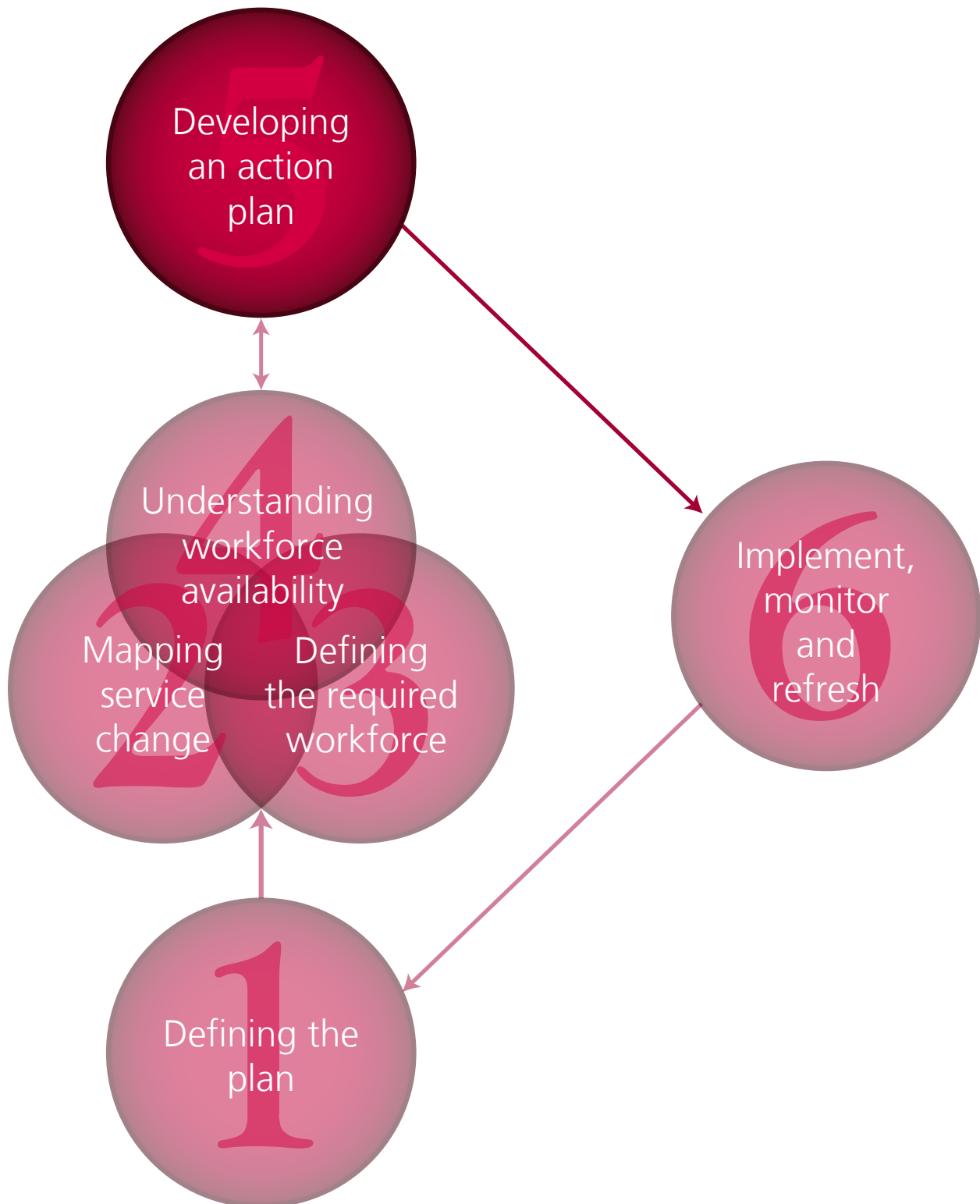
☐ What is the anticipated competition for skills?

Options

☐ What models for retention can be developed to increase supply eg redeployment, retaining, recruitment?

☐ Have options been analysed and costed to increase workforce availability?

☐ Have the options for working differently been analysed and costed?

Next Step

Now you have looked at workforce availability / workforce supply, you may need to revisit the realism or achievability of your proposed new service model.

Step 5: Planning to Deliver the Required Workforce

Developing an action plan — 5

Understanding workforce availability — 4

Mapping service change — 2

Defining the required workforce — 3

Implement, monitor and refresh — 6

Defining the plan — 1

www.healthcareworkforce.nhs.uk/step5

This step involves reflecting on the previous three steps and determining the most effective way of ensuring the availability of staff to deliver redesigned services, even if this means some further service redesign. A plan for delivering the right staff, with the right skills in the right place needs to be developed with milestones and timescales. You should also include in your plan an assessment of anticipated problems and how you will build a momentum for change, including clinical engagement.

Gap analysis

- What key changes are needed to the current workforce?

Priority planning

- What are the most significant areas for change?

Action planning

- How do education and other strategies support the main plan?

Managing the change

- How do you build options into a plan and how do you build momentum for change?

5.1. Gap analysis

Steps 3 and 4 have given a picture of what workforce is required for the future and what workforce is likely to be available. By comparing these forecasts you can get a picture of where gaps between supply and demand are likely to occur over the period you are considering. Gaps can occur in the overall numbers of staff available but also in the skills they have. More subtle gaps can arise in terms of the flexibility of the workforce eg overall numbers may be satisfactory, but it may be difficult to cover peaks and troughs of workload because of unsuitable deployment.

One set of options is around challenging the way care is delivered at present and questioning whether the traditional staffing patterns are still appropriate. This is where workforce planning and service planning are tightly aligned.

Increasing the productivity of the existing workforce can reduce demand for new and additional staff. This can be done by re engineering the care processes or by creating new roles and adapting the skill mix. It can also be achieved by deploying the staff more effectively by changing shift arrangements or by using annualised hours or self rostering methods.

Options for increasing supply were examined in step 4 of this guide.

5.2. Priority planning

You must identify what are the most significant areas for change. The future is not programmable, particularly in healthcare with changes to political priorities and breakthroughs in therapies, and it is impossible to predict the future in detail. You must focus therefore on the most significant areas.

You must consider the likely impact of each option under consideration and how much it will cost.

The list of options for increasing supply or reducing demand needs to be moderated by assessing what each solution is likely to achieve in terms of its impact. Some solutions may incur additional costs while some may avoid wasting investments already made in the workforce.

Training courses and backfill can be expensive and of course, large scale recruitment will have numerous direct and indirect costs. Retention measures on the other hand may be demonstrated to be saving the past investment made in training of staff, by avoiding the recruitment and induction costs for new staff, as well as retaining the 'intellectual capital' of your current employees.

Some solutions will have an immediate effect while others may take years to be realised.

This analysis is best done with the managers concerned. You'll need to consider an impact assessment as well as the costs of the various solutions. More radical solutions may encounter organisational resistance. Such forces need to be tested and factored in.

It can be helpful to do a risk assessment at this point. This means systematically identifying and prioritising the potential risks to the achievement of the selected workforce options and establishing an agreed action plan to manage those risks. By going through this process you can help maximise the chances of plans becoming a success in the implementation stage.

The risk assessment makes the plans less 'abstract' as it directly involves managers and other stakeholders and focuses on some of the practicalities.

You cannot possibly get the plan absolutely right because there are too many variables and the environment is always dynamic. Thus you have to focus on key decisions and build in flexibility and review.

5.3. Action planning

By this stage, the organisation will have already identified and selected the options that will have the greatest chance of reducing the gap in supply and demand, are affordable and achievable and allow for the greatest degree of flexibility in the future, as organisations can never anticipate exactly what future requirements might be.

The organisation will need to set out clearly what the selected strategies are, how much they will cost (or cost avoid), what the timeframes involved will be and how they complement each other. Organisational requirements can also be identified, such as training placement capacity and support, or an illustration of a new care pathway, showing the workforce implications.

The final stage in developing the plan is to check that it will work. This requires checking:

• Are the required actions within our control?

• Do we have the resources to carry them out?

• Is the plan sufficiently robust to cope with a range of possible eventualities?

By a robust plan we mean one that is able to stand up to whatever comes its way. It does not mean a rigid plan. In fact the most robust plans are those which have considerable flexibility built into them, allowing adjustments to be made in response to contingencies.

The best way to test plans for robustness is the use of scenarios. Scenarios are pictures of what the world in which we are operating might look like under different assumptions about how unknown factors might play out. If chosen well, scenarios can be useful in testing a plan or strategy to see how well it would stand up in different circumstances. While they cannot test every eventuality they are able to show which strategies appear more able to cope with different challenges.

Remember to document these steps. It will come in useful in the monitoring and review step when we come to assess what to do about the real contingencies that arise.

5.4. Managing change

If all has gone well with the planning process there should be full engagement from all the stakeholders to make it happen. However, at this point it is worth checking that all the conditions for success are in place:

- Does the plan still have a mandate from top management?

- Are the stakeholders still signed up to its goals and outcomes?

Where the stakeholders are universities or training agencies, have the commissions been adjusted to match your future needs?

- Have you fully addressed the organisational development issues in bringing about the changes?

- Do you have the required financial resources to carry out the planned actions?

If the answer to any of these questions is 'no', it will be necessary to revisit some of the earlier stages of the plan to make sure that they are put back in place.

All organisations need to change over time. Organisational change may be necessary for a number of reasons and the way that change is managed will impact on the way the change is received by the people involved.

Organisational change is an unsettling process for the staff involved and this element is often ignored in the process of redesigning the workforce to meet the changing service needs. The needs of staff are different as are their working styles and reactions to change. These differences must be understood and recognised if there is to be a smooth transition from one way of working to another.

When planning the workforce to meet future service needs it is important that the impact of any changes to traditional roles and ways of working are understood by the organisation and the current workforce. As part of the change management process it is important that staff recognise the reason for the change and the benefits that change will bring. They will need to understand how any changes will impact on them personally and how it will improve patient care.

The healthcare workforce portal www.healthcareworkforce.nhs.uk contains information, guidance and tools on how organisations can deliver transformational change including the WTD pilot projects. Other useful resources include the integrated service improvement programme website www.isip.nhs.uk and the NHS Institute for Innovation and Improvement www.institute.nhs.uk.

Step 5 Checklist

Before moving to step 6, it is important to reflect on the previous three steps and determine the most effective way of ensuring the availability of staff to deliver redesigned services, even if this means some further service redesign. Therefore, the following will need to be in place:

Gap analysis

☐ Have you undertaken a gap analysis of each scenario?

☐ What changes are needed to the current workforce?

Priority planning

☐ What are the key hotspots that need the most significant change?

☐ What cold spots need the least change?

Action planning

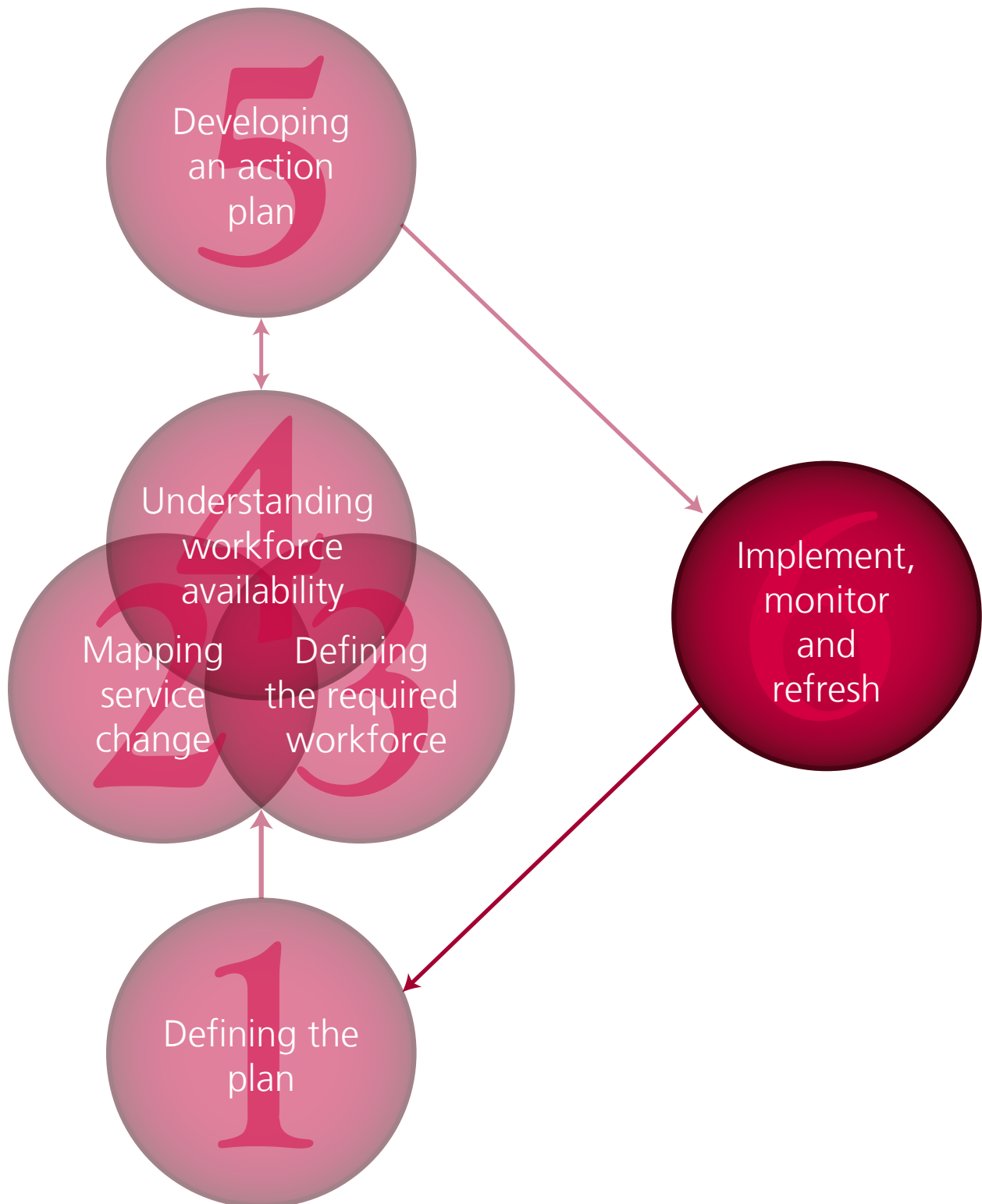☐ What is the plan based on your 'best' option?

☐ How do education and other strategies support the plan?

Managing change

☐ How do you build momentum for change?

☐ How do you sustain the momentum for change?
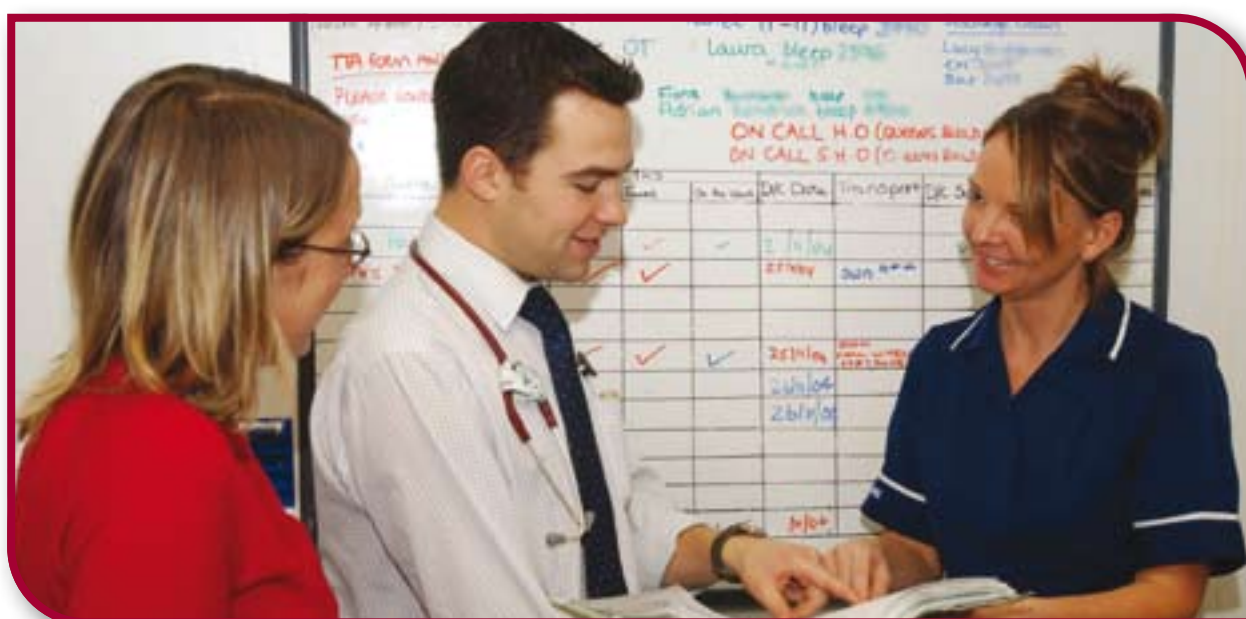
Step 6: Implement, Monitor and Refresh

www.healthcareworkforce.nhs.uk/step6

The plan must be delivered effectively and will need periodic review and adjustment. The plan will have been clear about how success will be measured and may have tried to anticipate any unintended consequences of the changes. However, there needs to be periodic monitoring and review so that any corrective action can be taken.

6.1. Implementation

The change project must be championed by senior managers, be adequately resourced and have stakeholder buy in otherwise the best designed plan will fail.

A review body needs to be established to monitor progress against the plan and to authorise any corrective action if milestones are not being achieved.

The frequency of review must be established. Short term plans (less than three years) will probably require monitoring quarterly or even monthly. Long term plans (more than five years) may only require annual review.

There will need to be a mechanism to collect the data by which progress is measured as well as ensuring that stakeholder units or organisations return the information accurately and on time.

6.2. Measuring progress

There are a variety of approaches which can be used to measure progress toward goals. These include trajectories, traffic lights, balanced scorecards etc. The Workforce Projects Team contains guidance on using a number of these. The balanced scorecard is especially useful where there are a number of interlinked goals that need to be achieved rather than a single target. By measuring against a set of indicators (see step 2 above) you can try to ensure that there are no unintended consequences; that you aren't achieving improvements in one area but with a reduced performance in another area or indicator.

If the monitoring processes are effective, they will throw up early warnings when the plan is not on course to achieve its goals. However good the planning, there will always be a degree of uncertainty in predicting the outcomes of the actions in the action plan.

When warnings are received, the first thing to do is review the action list:

• Has the action actually been implemented?

• Have we over or under estimated the impact of the action?

• Is it taking longer to produce its outcomes than expected?

• Has something happened that we did not anticipate?

If the problem has been spotted early enough, it may still be possible to adjust the action to put things back on course. For example, if wastage from training has been higher than anticipated, it may be possible to increase numbers entering training to compensate and to take corrective action to reduce the wastage of subsequent cohorts. Alternatively, it may be possible to take corrective measures by adjusting some of the other actions on the action list. For example, shortfalls in output from training may be compensated for by using alternative sources of recruitment at home or overseas.

In more complex areas, such as the introduction of new ways of working, we may have underestimated the level of resistance to change in the organisation and may need to invest in additional OD activities to win acceptance for the change.

A workforce evaluation tool is available on the healthcare workforce portal www.healthcareworkforce.nhs.uk, which allows users to set measurable organisational goals in four key areas: service, workforce, customer and financial. These can then be mapped against actual organisational performance.

6.3. Revisiting the Six Steps - refreshing your plan and actions

Corrective action can only take us so far. If the scale of the problem is such that we cannot make adjustments to bring us back on course, the only option is an overall review of the plan.

The advantage of using a systematic step approach to planning such as the one set out in this methodology is that a clear process has been mapped. It is therefore relatively easy to retrace your steps to find out which part of the planning was 'flawed' or insufficiently robust.

Even where problems are not occurring, it is sensible to schedule a review of the plan periodically to account for changes since the original plan was made.

The review process is not just about producing an updated plan but is also a learning exercise. A methodical approach will ensure that you learn what was good and what was less so in the original approach.

- Don't be tempted to throw the old plan away and start from scratch, you will lose the learning

- Do go through every step of the planning process again, even if you have a inclination where the problem lies. You can learn from what went right as well as what went wrong

- Do make sure that you have kept all the assumptions, modelling, data, etc from the original planning and check or update them

- Re engage with all the stakeholders and involve them in the process to make sure that they are still signed up to the goals and assumptions.

Step 6 Checklist

How to ensure your plan is delivered

☐ What are the key milestones of your plan?

☐ How are the outcomes and unintended consequences going to be measured?

☐ What is the process for revisiting your plan and refreshing any requirements?

Six Steps Online

You've read the methodology, now put the Six Steps into action for yourself with even more support from the healthcare workforce portal.

Each step is fully supported with a range of tools and resources to help develop your workforce plan, as well as a handy checklist to make sure you cover everything you need to.

You can also leave your feedback, which we'd would love to hear.

Visit www.healthcareworkforce. nhs.uk/sixstepsonline

Case Study

Plymouth Primary Care Trust (PCT)
Helen Mooney

"By implementing this programme, we have changed the culture of the organisation in terms of how people think about workforce planning from it being seen as something HR do, to something that all managers and budget holders do," says Plymouth Primary Care Trust's director of workforce development, Helen Allen.

Over the past year the PCT has become the first in the country to use the Skills for Health - Workforce Projects Team Six Steps Guide to Workforce Planning across the organisation; and according to staff at the PCT, the decision to implement the guide is really paying off.

The PCT started to implement the programme in February 2007, when the board decided to introduce workforce planning across the whole organisation. The PCT set up a multidisciplinary team drawn from the workforce planning and development, finance, and public health teams within the organisation in order to kick start the methodology.

Ms Allen was charged with spearheading the programme across the PCT, she said: "We originally tried to look at workforce planning in the mental health directorate and used the guide to do this, but this work did not take off because we had not tackled workforce planning on an organisational wide basis. There were already pockets of good practice in the PCT, eg in public health, but as a whole it was patchy."

Ms Allen says that setting up a dedicated team to roll out the use of the programme across the organisation was invaluable, especially as it secured the support of the finance department.

The PCT's 230 managers and budget holders were then invited to an awareness programme to introduce the Six Steps Workforce Planning Methodology and explain to them how they would be required to produce plans over a one year, two year and five year timescale.

"The team developed and delivered a one day programme to managers and clinical leads across the PCT, and this was followed up with strategic and pragmatic input at all levels within the organisation," said Ms Allen. All managers were expected to feed their planning into a tailored workforce planning template to reflect the current and future workforce predictions within their teams.

> "...We have changed the culture of the organisation in terms of how people think about workforce planning..."

The PCT used the elements of the Six Steps guide to introduce a straight forward framework for all their workforce planning. In broad terms the guide was applied by asking each manager to define their workforce plan, outline forces for change, assess demand, assess supply, undertake a gap analysis and subsequent action planning and carry out implementation and a review of the plans.

One of the PCT's public health consultants Kevin Elliston was involved in the programme from the start and formed part of the multidisciplinary team. Mr Elliston explains how he was instrumental in introducing the Six Steps guide to the PCT having investigated workforce planning for public health within the organisation.

"I thought that using the Six Steps in public health and then more widely across the PCT would be fantastic," he said.

Mr Elliston revealed that the PCT created a 'hub and pod' model to share best practice, he said: "There were some pockets within the PCT where there was already some reality excellent activity taking place and it was up to us as the central team to facilitate the sharing of that best practice to different teams."

> Over 70 percent of the 230 budget holders within the PCT have now completed workforce plans...

The PCT ran a one day masterclass for all budget holders where the Six Steps tool was introduced, along with the Workforce Projects Team e-learning and Six Steps self assessment toolkits.

Plymouth PCT's assistant director of workforce development Colette Davies is upbeat. "The Six Steps guide is not rocket science but once everyone had been convinced to use it it acted as a catalyst for change," she said.

Ms Allen says that the PCT has learnt some valuable lessons about the culture of the organisation whilst implementing the guide. It found that while some managers are very skilled in workforce planning, the majority needed support to link together the financial, workforce and planning elements of the process. She admits however that not all team took up the planning process with 'equal enthusiasm'.

To address this, the PCT linked the workforce planning model to operational issues, including recruitment and management training, in order to show how planning is key to processes on a day to day basis.

Over 70 percent of the 230 budget holders within the PCT have now completed workforce plans, all of which have been incorporated into the PCT's local delivery plan for 2008/2009. Ms Allen says that she is confident that the efforts on workforce planning across the organisation will continue, as it has been made mandatory in terms of recruiting new staff, she said: "Using the Six Steps model which has user friendly tools managers were able to see what they had in terms of workforce, what it cost and what they would need in the future.

The guide gave us something we could use to benchmark and we developed a staged approach to this, which is a good way of doing it because it makes you stop and think about your workforce," she adds. Ms Allen says that workforce planning across the PCT, rather than just at HR level has now become the rule rather than the exception.

The PCT's head of workforce planning and education David Priscott says that using the guide helped to 'focus minds' on workforce planning, but he cautions that it is important for organisations using the model to tailor it their individual need, he said: "We had to tailor it so it was relevant to all budget holders, those who work on one year, two year and five year plans."

The tool was tailored for the PCT's 230 budget holders, then 'coalesced' to the next level to those in charge of 10 to 30 budget holders, then to associate director level and finally to director level.

The team is now in the process of developing an effective workforce planning scorecard for use within the PCT. This will detail financial and workforce development information including:

- Financial variance
- Current up to date workforce information
- Mandatory and essential training completion
- Sickness and Bradford scores
- Bureau usage
- Prediction of retirees
- Occupational mix index.

"This can be used at organisational and directorate level, ultimately during the process what we have not said to managers is 'there you go' and left them to do it themselves, with the aid of the Six Steps guide we have helped to develop and implement this," Ms Allen said.

Mr Priscott adds: "Ultimately it has been really enjoyable to implement. As an organisation we now have fifteen categories for the scorecard and we continue to work with managers to help them tackle these workforce issues."

Local achievements at Plymouth PCT

- Trust wide workforce planning, using electronic staff record and planning tools
- Workforce planning is now part of day to day trust business
- Detailed workforce plans across clinical and non clinical directorates
- Increased awareness of financial position, age profiles, and workforce risk assessment
- Developing a more efficient workforce by reviewing skill mix and succession planning
- Integration of workforce planning in to the corporate management programme.

Rationale behind using the Six Steps guide

- Commons Health Select Committee's critical report on workforce planning in the NHS 2007
- Streamlining of workforce planning with the LDP process
- Payment by results / national benchmark price
- South West demographics ageing workforce.

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