

A Consultancy Report  
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Health

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# Proposals for a Centre of Excellence for workforce strategy and planning

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## **Acknowledgements**

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## Introduction

Health and social care are labour-intensive service industries. Approximately 70 per cent of recurring costs in the NHS are wage costs. It is therefore vital to the success of every organisation delivering health and social care that they are able to secure sufficient numbers of staff with appropriate skills.

NHS workforce planning has been in the spotlight in recent years. The Health Select Committee published a report in 2007 highlighting significant failings. They identified that not enough thought is given to long-term strategic planning, there are too few people with the ability and skills to plan effectively, the planning system remains poorly integrated and there is a lack of co-ordination between workforce and financial planning.

Workforce planning has generally been supply focused, often driven by estimates made by professional groups. The main task has been to calculate accurately the number of particular types of health care professionals either for the purposes of commissioning undergraduate training places, or securing a sufficient number of postgraduate training posts. The focus has not been at the level of individual provider organisations but often at regional or national level where such decisions have been taken (ie, by deaneries or by national committees).

Overall there has been a lack of clarity about roles and responsibilities and a lack of accountability for workforce planning. The Health Select Committee believed that the health service as a whole, including the Department of Health (DH), strategic health authorities (SHAs), acute trusts and primary care trusts (PCTs) had not made workforce planning a priority.

In response to this and other criticisms, the government set out its proposed reforms to the system of workforce planning as part of the NHS Next Stage Review through the publication of *A High Quality Workforce* (Department of Health 2008).

## **The NHS Next Stage Review: *A High Quality Workforce***

The NHS Next Stage Review set out a vision for the NHS workforce where the talent and capability of all is realised, and staff are empowered to take responsibility for improving services and delivering consistent, sustainable, high-quality patient care.

Critical to this is that the NHS is able to recruit and retain the best candidates, has the capability both nationally and locally to accurately forecast workforce requirements, and that workforce planning and service commissioning processes are aligned, so that the right workforce can always be in place at the right time to respond to patient and community needs.

*A High Quality Workforce* sets out a new approach to workforce planning, education and training, which recognises that quality services and care are best delivered by devolving decision making as close as possible to the front line, but in an environment of NHS-wide coherence, transparency and accountability.

This approach entails new responsibilities locally, regionally and nationally, for DH, SHAs, PCTs and service providers – and a recognition that the success of the new system is dependent on all parties working together.

The broad vision for workforce planning as outlined in *A High Quality Workforce* is as follows.

- 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 will be established as a major objective resource for the health and social care system.

*A High Quality Workforce* announced that the Centre of Excellence will be accountable to the Department of Health's Director General for Workforce and will be hosted by one or more universities. The following core functions were identified.

- To provide an evidence-based analytical function.
- To scan the horizon and gather intelligence for workforce planning through effective networks.
- To develop a capability-building function with tools and resources to support local implementation.

The Centre of Excellence was prescribed a key role in collating, synthesising and analysing SHA plans, and presenting the local and national professional advisory boards with appropriate advice to support their scrutiny of workforce planning.

All this amounts to significant change that will challenge existing ways of working. Realistically the new processes will have different implications for different parts of the service. There may be no immediate impact on frontline staff, but ultimately staff, patients and the public should expect to see significant change in the way services are delivered. The active engagement and support of stakeholders is required to ensure that the new system is owned and delivers for all.

## **Purpose and outline of this report**

- This report has been produced for the DH.
- In August 2008, the Department of Health asked The King's Fund to lead a stakeholder engagement review on the proposal for a Centre of Excellence.

- The Centre of Excellence is a long-term, strategic investment for the workforce planning system, and the DH recognises the need for meaningful engagement with stakeholders across the health and social care system in designing this.
- This report reflects what we heard from stakeholders during the consultation and sets out a series of recommendations that aim to support effective implementation.

## Scope of The King's Fund consultation

The consultation process that has informed this report focused on the three broad functions identified for the Centre of Excellence outlined above.

To consider the functionality in sufficient depth the consultation looked at the following areas:

- the aims, objectives and remit
- the potential benefits and risks
- the detailed content and activities of the prescribed functions
- the necessary leadership characteristics and skill sets
- the principles needed to underpin governance arrangements
- the skills currently available and potential hosts
- the transitional arrangements that might need to be put in place.

## Methodology

A wide range of stakeholders across health and social care were consulted, including health care providers and commissioners, the education sector, and professional groups and organisations.

Annex A lists the organisations and individuals who contributed to the consultation.

The consultation process consisted of the following activities.

- **Written submissions invited from key stakeholders**

A questionnaire and supporting consultation material was circulated to a wide range of stakeholders across health, social care, the education sector and the professions. The consultation questionnaire can be found in Annex B. There were 103 responses received, with a good mix of responses from a variety of organisations and individuals.

- **Stakeholder engagement events**

Workshops were held in Leeds and London to bring together stakeholders and hear their views on the Centre of Excellence.

- **A working dinner with leading experts from a range of industries**

Discussion at the dinner focused on:

- the strategic challenges facing other sectors, labour markets and countries
- how they have responded to these challenges
- the lessons to learn to inform the development of the Centre of Excellence.

■ **One-to-one interviews**

To build on the feedback received through the written submissions and stakeholder events, interviews were held with a small number of individuals.

## **The current workforce planning landscape**

A range of organisations currently have a stake in workforce strategy and planning issues and these are referred to regularly throughout this report. Annex D describes the core roles of some of these organisations and provides useful background information.

## **Recommendations and discussion**

In this section we discuss what we heard throughout the consultation and make recommendations to support effective implementation.

In general the majority of respondents were positive about the proposals for a Centre of Excellence and could see its potential benefits.

There were a number of issues that arose during the consultation that the DH will need to address in communications about the Centre and in drawing up the specification for the tender process. While we focus on the risks and concerns raised and how we propose these are addressed, this should not detract from the overwhelmingly positive response and potential benefits that such a Centre would bring.

**We suggest that in communication about the Centre the following key benefits are highlighted.**

- **The Centre will be a one-stop shop for expert advice and support on workforce strategy and planning.**
- **It will take a longer-term perspective on workforce trends informed by an analysis of the broader environment.**
- **It will facilitate improved knowledge management and communication of intelligence on workforce issues.**
- **It will facilitate better co-ordination of activities on workforce planning and reduce duplication.**

A further summary of what we heard during the consultation is set out in Annex C.

*Purpose and remit*

**The DH must be clear about the primary purpose of the Centre of Excellence.**

The scope set out in the consultation document was felt to be too wide ranging and ambitious. There is a danger that if the Centre is given too many different tasks it will be overloaded and not be able to deliver on its functions effectively. It is important that the Centre is given clear priorities and that expectations are actively managed from the beginning.

**We suggest that the following is at the core of the Centre's mission.**

- To be an objective, trusted, credible source of workforce intelligence, analysis, and evidence for the health and social care system.
- To facilitate access to high-quality leadership, technical and management development support relating to workforce strategy and planning.

Being clear about the overall purpose of the Centre is important for at least three reasons: to ensure the Centre is established with the appropriate skills and leadership requirements; to ensure that the expectations of key stakeholders are managed; and finally to ensure that the Centre delivers expected benefits.

There was some concern expressed about the choice of name. Centre of Excellence suggests that the Centre itself will be a place where the best workforce planning is done. We believe this might be misleading. Furthermore, in its short form the name does not convey anything about workforce and the long form, Centre of Excellence for Workforce Planning and Strategy, is too long and does not convey that it is for health and social care. The DH may wish to consider an alternative name that makes it clearer what the Centre will actually do.

**The DH needs to communicate clearly the rationale for having a national organisation and the benefits it is expected to deliver.**

It is important that the creation of the Centre of Excellence does not undermine the clear message that workforce strategy and planning are first and foremost a local responsibility. The vast majority of workforce planning is done at local level. The Centre needs to be positioned as providing intelligence and evidence to enable decision-makers at all levels in the system to make better decisions and judgements and to put in place changes that will mitigate the risks identified by the Centre. The Centre will not have executive or decision-making powers. Its role will be to identify, assess and communicate the risks. It will be for other bodies with which it connects to ensure that action is taken to address the problems, gaps or risks that the Centre may identify.

It must be clear that the Centre itself will not do planning but will provide the intelligence to be used within a more devolved system of planning, the support to make that planning process more effective, and the networking to enable a sector-wide perspective to be maintained. By providing a sector-wide perspective, it can support risk assessment by ensuring that significant and critical skill gaps in the labour market are identified that would not

necessarily be visible to individual organisations within the sector. It can provide a pan-professional, pan-regional, cross-sectoral and international perspective on workforce issues that will support more effective workforce planning at local level.

**We recommend that funding is made available to evaluate the impact of the Centre either within the Centre's own budget or by the DH, and that data on a set of key performance indicators is regularly reported and made publicly available.**

Measuring the benefits of the Centre will be challenging. Many of the success criteria suggested in the consultation were not easily measurable and would not be directly attributable to the activities of the Centre. For example, achievement of a broad balance between supply and demand, whether forecasts of supply and demand had been accurate, whether identified skills deficits or undersupply of staff had been successfully addressed, increased capabilities at local level, and clarity of roles and responsibilities. Measurement will have to focus on activity and process measures as well as user satisfaction. This might involve collecting usage statistics and response times and gathering customer feedback about the services provided, for example, the reports it publishes, data it makes available, the tools and resources it produces, a survey of stakeholder views. Services should be assessed for their accuracy, quality, accessibility, usability and utility.

### *Who is the Centre of Excellence for?*

The original consultation document mentioned a number of different 'customers' for the Centre including the DH, SHAs, and professional advisory boards, as well as local commissioners and providers. Concerns were raised that it would not be possible to satisfy equally and fully all of these customers and that some of their demands might well conflict. In particular, questions were raised about whether the Centre was intended primarily to meet the requirements of the DH, for example, to support the comprehensive spending review (CSR) process, development of government policy, and performance assessment of SHAs, or to provide support to regional and local organisations.

**It is essential the Centre is given a clear remit as to who its primary customers are, and that as far as possible its services and products are useful to a wide range of different customers.**

We expect that there will be a wide range of customers for the Centre's intelligence, analysis and evidence but that many of these will have interest in similar issues. The Centre will be in a position to reduce any unnecessary overlap of work and can work to minimise the potential for conflict. The capability support will primarily be of interest to local commissioners and providers.

There was clear agreement that the Centre should cover both health and social care, and the public, private and voluntary sectors in its analysis.

There were concerns raised about its ability to address the needs of both health *and* social care. We had limited direct engagement with local authorities and directors of adult social services during the consultation and their views may be under-represented in the recommendations presented in this report.

**We suggest the DH engage further with social care stakeholders to ensure where possible the Centre is designed to support integrated**

**workforce strategy and planning at local level between PCTs and local authorities (LAs).** A particular issue was raised with regard to children's services. There is a statutory duty for children's trusts to produce workforce plans but these span other sectors, in particular education.

The Centre must be able to establish credibility quickly and to maintain direct and effective relationships with a range of provider organisations to ensure it is able to deliver on this whole system approach. This will be more challenging particularly in social care where the market is not consolidated and many providers are small private employers. There is already a growing diversity of providers in the health sector and this is set to increase with the changes occurring in primary care and community services. In health care it is vital that the Centre is established so as to be both a source of intelligence for and a trusted recipient of data from non-NHS providers.

*What is the Centre there to do?*

### **Analytical function**

The Centre will need to produce objective and rigorous analysis but stay in touch with technology/service/policy changes. There has been an assumption that if only we had the perfect model we could get the numbers right. A model is only as good as the data in it, the assumptions made and the capability of those to interpret the findings and take action appropriately. Therefore, it is more important for the Centre to secure high-quality and timely data, to test assumptions and to do scenario modelling rather than to build ever more complex models. If workforce planning is to be patient centred and based on clinical pathways, the Centre will need to develop the ability to model by competencies rather than professional roles.

**We recommend that the following key activities underpin the analytical function of the Centre.**

- **Collate and synthesise data on dynamics in the labour market and workforce supply, and where necessary collect data to supplement that which is routinely available.**
- **Regularly update projections of workforce supply.**
- **Commission research to establish and validate key assumptions underpinning the projections.**
- **Present risk and sensitivity analysis for all projections, estimates and forecasts.**
- **Ensure that high-quality intelligence on the labour market is made regularly available, where possible broken down by region.**
- **Build demand models that estimate the workforce requirements for clinical pathways (beginning with the eight set out by Darzi), making assumptions transparent to allow them to be changed by local organisations.**
- **Examine the potential for productivity gains by changing the skill mix and use of technology (competency assessment, role design and modelling).**

- **Produce occasional papers that focus on a new policy or technology and model the workforce implications.**
- **Produce evidence-based research about the impact on quality and value for money of using a different skill mix and new roles (evaluation).**
- **Undertake scenario modelling.**

It is proposed that the Centre will collate SHA plans in order to develop a national overview. While it is important that the Centre has data on training places that have been commissioned, if an accurate national picture is to be developed the data should not only be on places commissioned by SHAs but as far as is possible cover all qualification levels. It is likely that the Centre will rely on further education and higher education institutions (HEIs) for this data. The Centre will need the capacity to develop its own broader estimates of labour market dynamics in order to be able to contextualise SHA plans, identify likely risks, and test planning assumptions.

It is important that the Centre is able to provide a whole system perspective. This means having data not only on NHS providers but also on independent and voluntary sector providers of health care. In social care where the majority of providers are small- to medium-sized enterprises, gathering data may rely on data from commissioners (ie, local authorities) or will require data from a representative sample of providers.

In order that data on the labour market is useful to local organisations, the Centre would have to not only produce national data but also break it down by region and locality. This would highlight risks in supply of labour due to distributional problems rather than overall shortages.

The Centre will need to scan the horizon for future issues on the workforce and labour market, but also identify issues in the wider context such as political, economic, societal and technological changes that are likely to have an impact on the health and social care workforce. The Centre will need to interpret these trends and describe their prospective impact on health and social care workforce supply and demand. Given its capacity it is unlikely that the Centre will be able to undertake this horizon and environmental scanning itself but will instead have to connect with organisations who do (see below).

A number of concerns were raised in relation to the Centre's role in quality assuring SHA plans. Any suggestion that the Centre might support the DH in a performance management role was strongly opposed. The majority of respondents felt that this should not be the responsibility of the Centre and would seriously compromise its credibility with local organisations. While the Centre will clearly have a role in collating and analysing information at a high level it must be seen to do so in an impartial and objective way.

**We recommend that the role of the Centre, in relation to SHA plans, is limited to peer reviewing the quality of the data used, the accuracy of the models and the evidence underpinning the assumptions made in these plans, not the plans or actions proposed.**

Any such review should be shared with the SHAs and the DH in order that the SHAs can address the issues raised before finalising their workforce strategies. In effect they are providing a quality assurance function for SHAs.

Such a quality assurance function could also be of value to PCTs, LAs (in

relation to the social care workforce) and to providers. The Centre would need to assess the demand for such support and ensure that it had the capacity to deliver this. It would be anticipated that this would be linked to capability building and that as skills developed locally demand would reduce.

*A High Quality Workforce* sets out clearly that Medical Education England (MEE) and potentially other professional boards will have a role in scrutiny of workforce plans. The role of the Centre in supporting this process needs to be worked through.

### *Who will the Centre need to work with?*

#### **We suggest that networking is not a distinct function.**

However, it will be essential that in order to deliver its primary purpose(s) the Centre will have to establish and maintain effective networks.

In order to carry out its core analytical function the Centre will need to be well connected to organisations who collect and report data (see page 38 for a list of the sorts of organisations identified) in order to ensure it has access to high-quality data in a timely way, and can also provide relevant and reinforcing feedback. It will also need to connect with organisations that have particular expertise, for example, horizon scanning new technologies, analysing policy developments, etc.

In order to deliver benefits, the Centre will need to establish relationships with organisations it expects to make use of its data and products such as the professional boards, SHAs, etc. Where SHAs are establishing their own regional workforce intelligence units (as is proposed by NHS London), the Centre will need to establish close links to ensure that the work is complementary. The Centre should also engage actively and systematically with those directly responsible for workforce planning. Its responsibilities will lie in ensuring that its advice and support is timely, accurate and targeted.

During the course of its work it is expected that the Centre might identify issues that need to be addressed in order for it to fulfil its functions. For example, it might identify a need for the Information Centre to change the items recorded in the electronic staff record (ESR) to provide more data on the NHS workforce. The Centre might also identify areas that are inhibiting local organisations in effectively addressing workforce issues. For example, where regulators need to enable role diversification and more flexible career pathways, or where educational providers need to change curricular content or selection criteria. The Centre will have an important role in identifying such issues and feeding these to the DH as the appropriate body to decide to take action.

It is likely that the Centre would also need to be connected with international organisations that collect data on global health care workforce trends, for example, the Organisation for Economic Co-operation and Development (OECD) and the World Health Organization (WHO). The Centre may be required to contribute data for England to such cross-national projects but will also benefit from access to international data and analysis.

**We recommend that the Centre put in place clear rules of engagement with external organisations on whom its work will rely heavily and invests in developing strong and effective channels of communication, for example, by establishing a corporate**

**communications and stakeholder management function.**

**Where these bodies are DH sponsored we recommend the DH ensure that when agreements are renewed explicit reference is made for the need to co-operate with the Centre.**

**We recommend that the Centre is resourced and assessed on its ability to effectively communicate and disseminate its products and services to the key audiences/customers identified for it, as well as how well the Centre engages with stakeholders on whom it relies to carry out its remit effectively.**

### *Capability function*

It is essential that those working in the health and social care system have the capacity to use the data and information provided by the Centre and have the skills to react to and act on the data provided.

It was not clear from the consultation whether this support for capacity building needed to be provided directly by the Centre or whether it was appropriate for this activity to be centrally funded. An alternative would be for the Centre to accredit other support and development for providers and commissioners. We do not feel strongly on this point but suggest that in general the responsibility for developing capacity and capability lies with local organisations as they are best placed to identify their own skill requirements. We therefore suggest that the role of the Centre is somewhat limited in the direct provision of developmental support.

Where the Centre would be well placed to directly provide support is through the following activities.

- Produce, publish and recommend tools and processes to support local organisations in workforce planning.
- Examples of model workforce plans, exemplars of best practice, disseminate and share learning.
- Accredited quality of data and provide guidance on most relevant/accurate sources for use in local planning.
- Identify and promote best practice in workforce planning.
- Establish forums or networks for testing best practice and sharing ideas in a safe environment.

South West SHA has supported a parallel work stream in the South West led by Poole NHS Foundation Trust and Plymouth PCT. This work looked at the capability-building needs of the NHS and how the Centre of Excellence might support this agenda. A paper summarising the outcomes of this work is provided at Annex D.

**We recommend that before developing the model for, and scope of, the capacity and capability-building work, the Centre should undertake a systematic mapping of skills deficits and development needs of organisations across the health and social care system.**

It has not been possible to do this in the context of this review and the information provided by the South West SHA does not enable us to make firm recommendations about this. The Centre could, for example, work

with Monitor to identify the needs of foundation trusts and ensure that the capability to secure the appropriate workforce is a key component of authorisation and ongoing monitoring of effective governance. It might also be appropriate for the Centre to work closely with the Skills Academy for Adult Social Care and the Children's Workforce Development Council.

In terms of the capability-building function of the Centre, the proposals consulted on suggested the main customers for 'leadership, technical and management development support to broaden understanding and use of workforce planning techniques' would be service providers and commissioners, SHAs, educational commissioners and providers. In addition it was expected that providers, commissioners and SHAs would be the main recipients of exemplars of good practice and clients for consultancy support.

It is vital that the scope of any development support goes beyond the traditional focus on workforce planners within the HR functions of providers. For example, there needs to be board leadership development to ensure workforce capabilities are represented at this level, training and development of all senior managers to include a component of workforce strategy and planning including chairs, chief executives, finance directors, directors of commissioning, medical directors etc.

### *Governance*

#### **We propose that the following principles should underpin the governance of the Centre. It should:**

- be representative of health and social care, public and private sector, commissioners and providers, national, regional and local bodies.
- have clear lines of accountability.
- be open and transparent.
- have a clear statement of purpose.
- have defined and explicit objectives.
- have clear deliverables and performance criteria.
- have robust business and communication processes.
- be Responsive and flexible.
- be sustainable.

There were strong views expressed about the need for the Centre to be independent. This was not simply about the need for the Centre to be objective and impartial in its analysis (on which there was a clear consensus) but was about the relationship between the Centre and the DH.

As part of the review we looked at a number of other research centres sponsored by the DH. Academic research centres appear to have different arrangements for setting their work programmes. Some have a broad framework set at the outset and then the centres are largely free to decide on priorities and to publish whatever they wish (as long as they give the DH 30 days' notice). Others require that each proposed project is signed off by the sponsoring government department. Others operate a call-off facility where priority issues are set by the government department. For the credibility of the Centre it will be important that it is seen to be independent, in particular that it

is free to publish its analysis and findings even where these may be contentious. The important point is that the data and assumptions underpinning analyses are transparent. There is a risk that if the Centre's activities are too tightly controlled by the DH it will stifle innovation, undermine its credibility and may reduce its relevance to local organisations in the health and social care system.

**We suggest a number of mechanisms are put in place to ensure the work programme reflects the needs not only of the DH but a wider range of stakeholders.**

In several of the research centres we looked at, ongoing determination of the work programme is informed by an Advisory Board with representatives from policy makers on it. We propose that the Centre establish an Advisory Board made up of people from a range of relevant organisations who are able to provide guidance on the important issues affecting workforce strategy and planning, which could guide decisions about the Centre's priorities. The Centre should have a transparent system of topic selection whereby any organisation can suggest workforce topics on which evidence-based guidance would be useful. In addition, it should periodically consult stakeholders more formally on the types of issues it should be analysing (perhaps bi-annually).

The DH may wish to identify a number of key issues, in consultation with key stakeholders, that the Centre will work on in its first year of operation while it establishes a process for setting future priorities. These might, for example, include identifying the implications for workforce strategies of the clinical pathways established through the NHS Next Stage Review. It has also been suggested that the opportunity is taken to pick an area where workforce issues span health and social care, for example, mental health, long-term conditions or children's services. This would allow the Centre to test the model of engagement with the NHS, the voluntary sector and social care. It will take time for the Centre to become fully operational and therefore thought needs to be given to the phasing of its work programme.

**In addition we recommend that the Centre establishes an expert panel of peer reviewers whom the Centre can call on to review and validate its work.** This will ensure the Centre is rigorous, authoritative and objective in its work.

The relationship between the Centre and DH will need to be open and realistic. The most important issues when negotiating a contract or service level agreement (SLA) and work programme are that achievable goals and objectives are set with realistic timelines; the programme is not so rigid that it does not allow the Centre to respond to emerging issues; and additional activities such as dissemination, stakeholder management, data collection, evaluation, etc, are covered in the contract.

### *Organisational model*

In preparing this report we looked at a number of international examples of workforce planning centres in North America, Australia and Europe. Further details of these are in Annex F.

In common with the Centre they do not actually do any workforce planning but rather support, inform, analyse and synthesise data to inform workforce planning. It would be useful for the Centre to tap into this international

network of organisations. While these examples suggest some of the analytical functions of the Centre as identified above are appropriate even in systems with more devolved planning and diverse providers, they did not provide a blueprint for the organisational form that we would wish to recommend for the Centre. The majority of these organisations are academically based, are linked to educational providers rather than service providers, and the majority are regional in focus (in part reflecting the devolved responsibilities for health care). It is not clear the extent to which the information they produce is used within the health system.

Different opinions were expressed about whether it was desirable to have the key analytical and capability functions delivered by one organisation or separate organisations. In addition, there were some views expressed that it was not possible for all these activities to be undertaken by one organisation but rather a series of linked organisations (eg, a consortium).

**We suggest that one organisation with simple and clear lines of accountability to the DH needs to act as the hub.** This would house the core corporate functions such as communications, stakeholder relations, governance, finance, etc, together with a group of highly skilled research commissioners. Similar to NICE, the hub would commission modelling and evidence reviews from linked academic centres and through subcontractors would deliver the key functions around capability building.

### *Contractual model and funding*

The Centre will need to have some stability of funding to allow it to get established. **We suggest that initial funding should be committed for a minimum of five years.** One possibility would be the use of a rolling contract ensuring that longer-term planning can continue.

**We further recommend that the Centre should not rely solely on funding from the DH, but that it should demonstrate how it will secure other sources of revenue to support its work, in particular the funding model for the capacity-building functions. The DH should consider whether a system of matched funding should apply for some elements of the Centre's activities to ensure it remains responsive to the needs of local organisations.**

It is expected that at least initially the Centre will rely on the contract with the DH for the bulk of its revenues. However, it may be appropriate over time, as the Centre develops, for it to diversify its revenue streams. One possibility suggested during the consultation was that the Centre be funded by SHAs or by subscription. There is a risk that there will be free riders to such a scheme, and that if forced to 'chase' funds the Centre might become too tactical and unable to invest in longer-term studies. However, where more detailed or tailored analysis is requested by a region or locality it may be appropriate to charge additionally for this service. There is a need to differentiate between its core functions that need sustainable and secure funding and those areas of its activities that could be part or fully funded from other sources.

Proposed changes to the funding of the NHS Institute for Improvement and Innovation (NHS III) reflect a shift to devolved funding for and commissioning of leadership, management and development support to SHAs. The capability building element of the Centre's activities should be developed with a business model that ensures that the majority of these

activities could be self-financing in the long term. It will therefore need to be extremely responsive to customer need. There may be some pump priming needed to map the capability and skill requirements, to develop new programmes, and to develop tools and resources.

### *Transitional arrangements*

Strong views were expressed by all parties consulted that the Centre must build on the expertise of existing organisations. There was recognition that the Workforce Review Team (WRT) and Skills for Health already undertook some of the functions. We also heard that there is a limited pool of people with the requisite skills to carry out the work expected from the Centre. Therefore, it will be important to ensure that these staff do not leave the sector during the transition. **We recommend that during the tendering process applicants are asked to state explicitly how they will secure staff with appropriate skills and how they propose to build on the work of existing organisations.**

While the Centre will need to build on the work of WRT it will also need to go beyond it. For example, the analysis currently undertaken by the WRT has tended to be focused on the NHS and over a short-term time horizon, and to focus on NHS professional/occupational groups. The Centre's work will be broader in scope and needs to focus on the medium to long term.

We have summarised briefly the activities of existing organisations in Annex E. Prior to the tendering process the DH needs to be clear whether it plans to change the SLAs of any of the existing organisations and therefore whether they are expected to have to re-tender (with others) to continue to provide these services. To support this process **we recommend that the DH undertakes a more detailed and systematic mapping of the roles and responsibilities of each body identified in this report and ensures full alignment between these bodies and the roles and responsibilities that are finally agreed for the Centre.**

The overlap with Skills for Health and Skills for Care may be more difficult to resolve, though there would be flexibility to change some of the terms of the SLA with the DH, some of the requirements of these bodies are set out by DIUS and are common to all Sector Skills Councils. It is therefore likely that the Councils will continue to play a significant role in collecting intelligence about the labour market. For example, Skills for Care have developed a national minimum dataset for social care. In building on the Councils' activities, the Centre will need to be assured of the quality of data collected.

It will be important that the findings from the reviews currently under way of Skills for Health and Social Care Delivery Chain Review of Skills for Care, SCIE and the GSCC, are taken into account in designing the Centre in order that any revised SLAs for the Sector Skills Councils are complementary and do not duplicate functions. **We recommend that the DH together with DIUS review the remit of these bodies and ensure they are compatible with the roles and responsibilities of the Centre.** Where appropriate, they should require the Councils to share data and collaborate with the Centre.

The role of the Centre will need to be clarified in relation to a number of existing organisations. For example, the NHS Information Centre for Health

and Social Care (IC) collates information from the ESR and is beginning to analyse this by trust and SHA. In addition the IC is planning to undertake data collection for the social care sector in future. The IC will be a key contact for the Centre as the main repository for workforce data. They also have staff skilled in interrogating the data and could do similar analysis to that which the Centre is expected to produce.

It is likely that the Centre will still rely on data from other organisations, in particular the detailed data on specialty medical staff collected through censuses by royal colleges.

NHS Employers provides some advice and information on how to manage particular staffing issues. It will be important to ensure that such advice does not conflict with the evidence-based guidance produced by the Centre.

There is a small analytical team within the DH. It is not envisaged that the Centre would replace the Workforce Directorate Analysis Team (WDAT), but there may well be ways in which the work of the Centre could enhance the in-house capabilities and provide some externally validated and more transparent workforce strategy assumptions to inform national policy making. We suggest that included in the spec for the Centre is an 'on call' facility for the DH through which specific pieces of policy-related workforce scenarios and modelling could be undertaken in response to specific requests. The operation of such an on-call facility could learn from the experience of the on-call facility for International Healthcare Comparisons (IHC) currently hosted by the London School of Hygiene and Tropical Medicine (LSHTM) (see Box).

**The 'on-call' facility for International Healthcare Comparisons, based on the London School of Hygiene and Tropical Medicine, funded by the DH**

Set up in October 2005 through DH funding, the on-call facility brings together experts from 13 countries, co-ordinated by a research team based at the LSHTM in London. The purpose of the Facility is to act as a data collecting and sharing body reflecting the common goals and experiences shared by health systems internationally (eg, rising health care costs, advancing technologies, increased public expectations, etc).

The facility is intended to provide timely, targeted, relevant and concise information on a range of health policy themes from Europe, Canada, Australia and New Zealand to facilitate learning from the experience of other health systems to inform health policy developments by the DH in England. The information provided ranges from in-depth analyses to 'rapid response' briefings from surveys of the facility's experts.

The facility also responds to specific requests for information on international experience in a range of areas selected in close consultation with the DH and reflects both the Department's interests and a specific theme's relevance in other countries. The facility are keen to point out that although DH are consulted to select areas of research, outputs do not necessarily reflect the Department's views and no DH presence has been advertised on the facility's Steering Committee.

In terms of capacity building the main overlap is with the work of the Skills for Health (Workforce Projects Team) and some of the activities of the NHS III. The decision that the responsibility for commissioning support from NHS III will lie with SHAs in future means that the potential for overlap is reduced. As recommended (above) rather than duplicate the sort of support offered by NHS III the Centre may seek to work with other third parties to develop appropriate training and development programmes and to then accredit those which meet the standards set by the Centre. It is possible that the type of support provided by Skills for Health (Workforce Projects) could be accredited under the model proposed for capacity building.

Other changes to the workforce planning system signalled in the *Next Stage Review* are still in the process of being developed and implemented (eg, Medical Education England). There were concerns expressed that setting up professional advisory bodies might be at odds with the ambition of the Centre to look at the health care workforce across professional and non-professional groups. It is important that the timeline for setting up the Centre is consistent with these changes and that as roles and responsibilities of other organisations are clarified that the Centre is able to adapt.

**We recommend that the DH maps the relationships between the Centre of Excellence and other organisations involved in collecting and analysing workforce data, and providing capability support and training in this area. Using this information the DH should discuss with each of these organisations how they will interact with the new Centre when it is established. The DH should assess whether these partnerships are working effectively and whether further changes are needed 12–18 months after the Centre has begun operations.**

### *The workforce planning system*

The recommendations concerning the Centre need to be set in the context of the wider proposals for the future of workforce planning. During the consultation it was clear that there remained some confusion about roles and responsibilities in the new system. Respondents found it difficult to be clear about the role of a Centre of Excellence without greater clarity about the system in which it would operate. The following issues were raised.

- **The role of PCTs as commissioning-only bodies in workforce planning.**
- **The relationship between local workforce plans and regional educational commissioning in the NHS.**
- **The role of new professional advisory bodies, especially MEE.**
- **The review of social care workforce strategy**
- **The relationship between local authorities and PCTs in developing the workforce across health and social care**
- **The ability of SHAs to include the health care workforce needs of the non-NHS sector in their educational commissioning plans**

**The DH will need to communicate clearly the respective roles and responsibilities for workforce planning in both the NHS, social care and children's services, and how the Centre fits within the new system.**

It was outside the scope of this report to propose further reforms to the system of workforce planning. The King's Fund is producing a separate report on the future of workforce planning in which we make some recommendations about how the system could evolve in future.

## Annex A – List of participating organisations and individuals

Table A: Written submissions to the consultation

Anne Moore	Hartlepool PCT, Middlesbrough PCT, Stockton on Tees Teaching PCT and Redcar & Cleveland PCT	Acting Director of Workforce and OD
Hazel Carpenter	NHS Eastern and Coastal Kent, On behalf of South East Coast PCT HR Directors	Director of Human Resources and Organisation Development
John Snell	Shropshire County Pct	Workforce Planning Manager
Jo Woolgar	West Sussex PCT	Deputy Director Workforce
Dr Linda Harris	Wakefield Integrated Misuse Services (WISMS) Wakefield District Primary Care Trust	Clinical Director, GP and Director RCGP Substance Misuse
Neil Simpson	NHS Leeds	Workforce Planning and development Manager
Sue Hepworth	NHS Nottinghamshire County	Head of the Nottinghamshire Health and Social Care Community Workforce Team
Colin Holden	Sandwell and West Birmingham Hospitals NHS trust	Director of HR
Fiona Grove	Coventry and Warwickshire Partnership Trust	Assistant Director of Workforce
Helen Cooke	Great Ormond Street Hospital	Head of Workforce Planning and Development
Jennie Cogger	Medway NHS Foundation Trust	Head of Human Resources
John Ledbury	Derbyshire Workforce Development Team	Workforce Planning manager
Marjorie Kingston	North Bristol NHS Trust	Head of Strategic Workforce Planning
Dr Minesh Khashu	Poole Hospital NHS Foundation Trust	Lead Neonatologist and Associate Medical Director (Workforce Strategy and Planning)
Dr Patrick Geoghegan OBE	South Essex Partnership NHS Foundation Trust	Chief Executive

Sara Wood	Heart of England NHS Foundation Trust	OD Business Consultant
Sinead Partridge	Devon Partnership NHS Trust	Assistant Director - Workforce Planning and Development
Susan Tyler	The Mid Yorkshire Hospitals NHS Trust	Deputy Director of HR
Terri Evans	Tameside Hospital Services NHS Foundation Trust	Workforce Development Manager
John Wolfe	South West Strategic Health Authority	Interim Director of Workforce
-	NHS North East Strategic Health Authority	-
Chris Mullen	NHS North West	Associate Director of Workforce and Modernisation
Ruth Monger	Strategy South Central SHA	Head of Workforce
Tim Gilpin	NHS Yorkshire and Humber	Director of Workforce and Education
Trish Knight	NHS East Midlands	Deputy Director of Workforce
Sarah Copley	NHS West Midlands	Associate Head of Workforce Transformation
Rob Smith	NHS London	Head of Education Contracting and Commissioning
Paul Holmes	NHS East of England	Deputy Director of Workforce
Julie Toulson	NHS South East Coast	Workforce Planning Manager
Jan Marr	Birmingham City Council, Adults and Communities Directorate	Head of Workforce Learning and Development
P J Cook	Adult Social Care Department, East Sussex County Council	Project Manager (Workforce)
Matthew Baker	Surrey County Council	Resourcing and Reward Manager
Professor Sue Hill	Department of Health	Chief Scientific Officer
Professor Steve Field	Royal College of General Practitioners	Chairman of Council
Charlie McLaughlan	Royal College of Anaesthetists	Director of Professional Standards
Sabaratham Arulkumaran	Royal College of Obstetricians and Gynaecologists	President
Miss Brenda Billington	Royal College of Ophthalmologists	President

Bee Brooke	Royal College of Paediatrics and Child Health	Acting Head of Health Services
Dr T J Stephenson	Royal College of Pathologists	Director of Workforce Planning
Professor Andy Adam	Royal College of Radiologists	President
Mr Bob Greatorex	Royal College of Surgeons of England	Council Lead for Workforce
Dr Sally Pidd	Royal College of Psychiatrists	Workforce Lead
-	Royal College of Physicians	Faculty of Public Health
Ms Ellie Pond	The Academy of Medical Sciences	Biomedical Careers and Policy
Dr Rodney Burnham	Royal College of Physicians	Registrar
Dr C M Crawshaw	British Psychological Society	Professional Practice Board
Kamini Gadhok	Royal College of Speech and Language Therapists	Chief Executive Officer
Richard Evans	The Society and College of Radiographers	Chief Executive Officer
Sue Kellie	The British Dietetic Association	Head of Education and Professional Development
Alan Wainwright	Institute of Biomedical Science	Executive Head of Education
-	College of Occupational Therapists	-
Hazel Colyer	Canterbury Christ Church University	Dean of Health and Social Care
Professor Ian Baguely	Centre for Clinical and Academic Workforce Innovation University of Lincoln	Director
Professor Kathleen McCourt	Northumbria University	Acting Dean
Professor M Griffin	Aston University	Executive Dean Life and Health Sciences
De Montfort University	De Montfort University	-
Bonnie Sibbald	Institute of Health Sciences, The university of Manchester	Director
Professor Rhiannon Billingsley	Sheffield Hallam University	Pro Vice-Chancellor for Regional and Public Health Development
Margaret Fahey	Southampton University Hospitals NHS Trust	HR Manager Workforce Planning

Professor Peter Kopelman	St George's University of London	Principal
Professor Michael Preston-Shoot Dean	University of Bedfordshire	Faculty of Health and Social Care
Dr Mitch Waterman	University of Leeds	Pro-dean for Learning and Teaching, Faculty of Medicine and Health
Sue Bernhauser	University of Huddersfield	Dean of Human and Health Sciences
Professor Barry Hunt	University of Hertfordshire	Dean, Health and Human Sciences
Helen Langton	University of Derby	Dean of Faculty, Education and Health and Sciences
Professor Jeff Lucas	University of Bradford	Deputy Vice-Chancellor
Rosalynd Jowett	University of Southampton	Associate Dean, Faculty of Medicine, Health and Life Sciences
Alan Maynard, Karen Bloor	University of York	Professor, Senior Research Fellow
Jodie Anstee	University of the West of England	Policy Support Officer
Jon F Baldwin	University of Warwick	Registrar
Professor Charles Easmon	Thames Valley University	Professor and Director of the Centre for Policy and Practice
Ron Kerr	Association of UK University Hospitals	Chairman
Eve Jagusiewicz	Universities UK	Policy Advisor
Professor Terence Stephenson	Medical Schools Council	Chair, Clinical Staffing and Employment Subcommittee (Medical Schools Council) Dean, Faculty of Medicine and Health Sciences, University of Nottingham
Professor William P Saunders	Dental Schools Council	Chair, Dental Schools Council, Dean School of Dentistry University of Dundee
Paul Turner	Councils of Deans of Health	Executive Officer
Professor Chris Franklin	COPDEND	Postgraduate Dental Dean and Chair of UK Committee of Postgraduate Dental Deans and Directors
Dr Vicky Osgood	Wessex Deanery	Postgraduate Dean Wessex
Professor David Black	Kent Surrey and Sussex Postgraduate Deanery	Dean Director

Professor Martin Beaman	South West Peninsula Deanery	Postgraduate Dean
Elisabeth Paice	London Deanery	Dean Director
Arthur Hibble	COGPED	Director of Postgraduate General Practice Education
Rachel Padolak	British Medical Association	Senior policy Executive
Dr Peter Carter	Royal College of Nursing	Chief Executive and General Secretary
George Georgiou	Royal College of Midwives	Employment Relation Advisor
-	NHS Employers	-
-	Foundation Trust Network	-
Roslyn Hope	NIMHE National Workforce Programme	Director
-	NHS Professionals	-
Dr Judy Curson	NHS Workforce Review Team	Director, WRT
John Rogers	Skills for Health	Chief Executive
Iain Bradley	The NHS Information centre	Head of Workforce Analysis
Karen Scott	Toward 2010 Programmer	T2010 Workforce Lead
-	Organisational Development Services Ltd	-
Justin McCracken	Health Protection Agency	Chief Executive
Deidre Quill	Children's Workforce Development Council	Director Workforce Reform and the Regions
Frances Evesham	On behalf of the Children's Workforce Network (CWN) YES	Head of Cross Sector Workforce Reform, Children's Workforce Development Council providing project management services to the Children's Workforce Network
Dilys Robinson	Institute for Employment Studies	Principal Research Fellow
Helen Cooke	Great Ormond Street Hospital	Head of Workforce Planning and Development
Dr Laurie Baxter	Derriford Hospital	ENT Associate Specialist
Mr Bob Greatorex	Queen Elizabeth Hospital	Consultant general Surgeon

Dr Deidre Kelley-Patterson	Thames Valley University	Head of the Centre for the Study of Policy and Practice in Health and Social Care
Tim Roebuck	The Information Centre	Acting Director of Workforce
Paul Stanton	Ealing Hospital NHS Trust	Director of HR
Janis Stout	Care services Improvements Partnership	National Programme Lead for Workforce

*Table B: Attendees for 15 October stakeholder meeting (Leeds)*

<b>Name</b>	<b>Organisation</b>	<b>Job title</b>
Madeline Andersen-Warren	British Association of Drama Therapists	Chairperson
Jonathan Brown	NHS Yorkshire and the Humber	Workforce Planning Manager
Professor Tony Butterworth	University of Lincoln	Professor Emeritus for Healthcare Workforce Innovation
Nancy Cooke	NHS East Midlands	Strategic Workforce Development Manager
Seth Crofts	Faculty of Health, Edge Hill University	Dean
Mathew Crowther	NHS North East	Workforce Project Officer
Martyn Dell	Workforce Review Team	Deputy Director
Dr Anna Dixon	The King's Fund	Director of Policy
Jonathan Firth	Department of Health	Workforce Planning Directorate
Jean Flanagan	Sheffield Hallam University	Head of Nursing and Midwifery
Sue Ford	Professional Education and Training University of York	Deputy Head of Department
Tim Gilpin	NHS Yorkshire and the Humber	Director of Workforce and Education
June Goodson-Moore	Leeds PCT	Executive Director of Workforce Planning
Julie Hull	Calderdale and Huddersfield NHS Foundation Trust	Director of Personnel and Development
Mandy Jacklin	DH NSR Leadership Workstream	Programme Lead
John Ledbury	Derbyshire Hospitals NHS Foundation Trust	Workforce Planning Manager

Julie Moore	University Hospital Birmingham NHS Foundation Trust	Chief Executive
Dr Mark Purvis	NHS Yorkshire and the Humber	Director of Postgraduate General Practice Education
Helen Smith	NHS Yorkshire and The Humber	Associate Director, Workforce Strategy
Aaron Tucker	NHS South of Tyne and Wear	Workforce Modernisation and Commissioning Manager
Diane Whittingham	Calderdale and Huddersfield NHS Foundation Trust	Chief Executive
Paul Turner	Council of Deans and Heads	Executive Officer
Joseph McCardle	North West SHA	Assistant Director of Education and Commissioning
Dan Hughes	Skills for Health	Senior Project Manager

*Table C: Attendees for 8 October stakeholder meeting (London)*

<b>Name</b>	<b>Organisation</b>	<b>Job title</b>
James Anderson	McKinsey and Co	Consultant
George Blair	Share Solutions Consulting	Managing Consultant
Michael Blomfield	Council for Healthcare Regulatory Excellence	Policy Analyst
Bee Brooke	Royal College of Paediatrics and Child Health	Head of Health Services
Sir Cyril Chantler	The King's Fund	Chairman
Jonathan Chappell	NHS Workforce Review Team	Programme Development Manager
Sarah Copley	NHS West Midlands SHA	Associate Head of Workforce Transformation
Celia Cornwell	Southwest London Academic Network	Partnership Programme Manager
Dr Judy Curson	NHS Workforce Review Team	Director
Chris Day	NHS Professionals	Director of Marketing and Communications
Sue Dean	Skills for Health	Director, Workforce Projects Team
Dr Anna Dixon	The King's Fund	Director of Policy

Professor Charles Easmon	Health Protection Agency	Deputy Chairman
Helen Falcon	NHS Education South Central (NESC)	Dental Dean/ Postgraduate Dental Director
Sean Hilton	Royal College of General Practitioners	-
Chris Fowler	Barts and The London	Dean for Education
Kamini Gadhok	Royal College of Speech and Language Therapists	Chief Executive
George Georgiou	Royal College of Midwives	Employment Relations Adviser
Dr Nick Goodwin	The King's Fund	Senior Fellow
Mike Grant	University of Cardiff	Director of NHS Liaison Unit
Val Huet	British Association of Art Therapists	Chief Executive
Candace Imison	The King's Fund	Visiting Fellow
Wyn Jones	Organisation Development Services Limited	Senior Organisational Development Consultant
Mandip Kaur	NHS Confederation	Senior Policy Officer
Emma Kingston	NHS Workforce Review Team	Critical Issues Manager
Jennie Lau	NHS London	Strategic Manager
Martin McColgan	Royal College of Paediatrics and Child Health	Workforce Information Officer
Lorna McDougall	Haringey TPCT	Senior Specialised Commissioning Manager
Rachel Noble	Postgraduate Medical Education and Training Board	Policy Executive
Rachel Podolak	British Medical Association	Senior Policy Executive
Ellie Pond	The Academy of Medical Sciences	Grants Officer
Nicola Power	Royal College of Nursing	Research and Information Officer
Rob Smith	NHS London	Head of Education and Commissioning
Peter Stansbie	Skills for Health	Executive Director
Lene Gurney	Independent Healthcare Advisory Services	Director
Dr Richard Stephenson	University of East Anglia	Dean of School of Allied Health Professions
Steven Weeks	NHS Employers	Policy Manager

Ian Wheeler	Skills for Health	Divisional Manager, Research and LMI
Mary Wickstead	Guy's & St Thomas' NHS Foundation Trust	Head of Workforce

*Table D: Attendees for 15 October Dinner at The King's Fund*

<b>Name</b>	<b>Organisation</b>
David Albury	Independent Organisational and Policy Consultant
Nina Bhatia	Partner, McKinsey & Co
Cynthia Bower	Chief Executive, Care Quality Commission
Sir Cyril Chantler	Chairman, The King's Fund
Clare Chapman	Director General of Workforce, Department of Health
Niall Dickson	Chief Executive, The King's Fund
Anna Dixon	Director of Policy, The King's Fund
Jonathan Firth	Workforce Directorate, Department of Health
Patricia Hamilton	President, Royal College of Paediatrics and Child Health
Alastair Henderson	Director NHS Employers
Nicolaus Henke	Director, McKinsey & Co
Peter Howes	Chief Executive Officer, Infohorm Group Ltd
Will Hutton	Executive Vice Chair, The Work Foundation
Karen Jennings	National Secretary, Health, Unison
Debbie Mellor	Workforce Directorate, Department of Health
Barry McCormick	Chief Economist, The Department of Health
Sir Robert Naylor	Chief Executive, UCLH NHS Foundation Trust
David Stout	Director, PCT Network
Paul Streets	Chief Executive, PMETB
Ralph Tabberer	Director General, Schools, DCSF
David Williams	Dean of the Faculty of Medicine, Health and Life Sciences, Southampton University

## Annex B – Consultation material

The NHS Next Stage Review report *A High Quality Workforce* announced that a Centre of Excellence would be established to support workforce strategy and planning in the NHS. The aim of the Centre is to ensure that workforce strategy and planning is supported by evidence and analysis at every level in the health and social care system.

The King's Fund have been asked to carry out a process of engagement on the proposed Centre for workforce planning with stakeholders across the health and social care system with a view to producing a report for the DH.

The report will put forward a series of recommendations covering:

- functions and remit,
- leadership,
- principles for governance,
- transitional arrangements
- potential hosts.

The DH has established an Advisory Board to support and inform the programme of work to establish the Centre.

This document provides further background to the proposals for the Centre and sets out the consultation questions.

The deadline for responses is **Friday 24th October 2008**.

There are a number of ways of submitting your response:

- by post to Anna Dixon, The King's Fund, 11-13 Cavendish Square, London W1G 0AN
- by email to [workforce@kingsfund.org.uk](mailto:workforce@kingsfund.org.uk)

Please use the template for your consultation response, available for download at [www.kingsfund.org.uk](http://www.kingsfund.org.uk), or attach the enclosed coversheet to your response. Please limit your response to **3,000** words and provide any particularly lengthy supporting documentation as appendices or by web link, where appropriate. We may wish to quote from your response in our report – please let us know if you are not happy for us to do so.

## *Functions*

Consultation in the development phase of *A High Quality Workforce* reached a consensus that the fully established Centre should have three broad functions.

### **1. Analytical function**

- To build a deep understanding of workforce supply and demand in the health and social care system.
- To build models for forecasting and scenario-modelling, undertake risk and sensitivity analysis and provide expert support to planners, policy-makers and professional advisory mechanisms.
- To translate patient pathways into affordable workforce models.
- To provide an objective, authoritative, evidence-based source of workforce, analysis and planning expertise, held in common by the health and social care system.
- To provide workforce data, labour market intelligence and modelling to support new policy development, and implementation of the SHA clinical visions.
- To collate, synthesise and analyse SHA plans, and present the professional advisory boards, DH, SHAs and other educational commissioners with appropriate advice for consideration.
- To provide support and advice to MEE and any other similar professional advisory bodies that are established.
- To provide advice and support to the bilateral processes between the DH and the SHAs.
- To provide support to DH in preparation of Comprehensive Spending Review proposals.

### **2. Networking function**

To facilitate the development of new ideas, to gather and exploit new information and best practice – locally, nationally and internationally.

- To provide or commission high-quality research and evidence.
- To foster engagement between the DH and leading practitioners and academic thinkers.
- To scan the horizon and gather intelligence for workforce planning by linking with key stakeholders in health, social care and in other sectors of the economy.
- To strengthen links across the network of workforce development agencies and professional bodies.

### **3. Capability-building function**

- To develop a capability-building function with tools and resources to support local planning and implementation.

- To provide leadership, technical and management development support to broaden understanding and use of workforce planning techniques for service providers and commissioners, SHAs, educational commissioners and providers.
- To disseminate exemplars of good practices and provide consultancy support to providers, commissioners and SHAs.

### *Vision*

The Centre of Excellence will aim to achieve the following.

- Put the patient at the centre of planning.
- Address patient pathways across the health and social care system.
- Focus on the whole workforce.
- Be open minded and innovative.
- Seek to provide the earliest possible advance warning of risks and opportunities, and be dynamic and responsive when the unexpected happens.
- Be pragmatic and aware of the realities of the health and social care system, and government.
- Be respected by stakeholders as objective, rigorous and authoritative.
- Be able to work with a wide range of stakeholders, both nationally and in local health economies.
- Build on good practice and expertise already in the system.
- Have a strong academic record and credibility, and potential to develop an international and world class reputation.

### *Questions*

#### **General**

- What do you think the main benefits will be of establishing a Centre of Excellence for workforce strategy and planning? What should be the key success criteria by which to measure the performance of the Centre?
- Are there any factors that threaten the ability of the Centre to realise these benefits? How could these risks/threats be mitigated?
- How can the Centre ensure that it operates in line with the values set out above? In particular, how can the Centre help promote workforce planning along clinical and patient pathways as opposed to professional lines?
- How can the Centre strike a balance between strategic and immediate requirements?

### *Functions and remit*

Three main functions have been identified for the Centre (analytical, networking and capability building), are these the right ones? Are there any gaps? Which of the functions should be given greatest priority?

#### **Analytical function**

- A key role for the Centre is to develop forecasting, workforce projections and scenario models. How can the Centre ensure that this process is accurate, evidence based, relevant and timely? In particular, the following questions.
  - How should the Centre develop and test its assumptions?
  - What data sources will the Centre need access to? What can be done to ensure that the Centre has access to high-quality data and information?
  - At what level should the models be developed – national, regional, local or multi-level?
- The NSR identifies a role for the Centre in scrutinising workforce plans. How can this be achieved effectively? How will the Centre ensure it is able to provide simple, clear advice and options to the DH, SHAs and the professional advisory boards?

#### **Networking function**

- What are the key relationships and networks that the Centre will need to establish and how could these best be facilitated? How can the Centre build the necessary networks and delivery mechanisms to ensure it communicates with and reflects the priorities of core stakeholders?

#### **Capability function**

- How best can the Centre support capability building at local level and disseminate best practice?
- What types of consultancy support might the Centre commission in order to support capacity and capability building? How does this fit with their other functions?

#### **Leadership**

- What characteristics will the leadership of the Centre need to demonstrate?
- What skills will be required among those working in the Centre?

#### **Governance**

- What are the principles that need to underpin the governance of the Centre?

**Hosts and transitional arrangements**

- What form should the Centre take and in what type of organisation would it most appropriately be located? For example should it be a single organisation or a managed network of organisations based on a hub and spoke model?
- Which existing organisations have the skills to provide all or some of the functions of the Centre? Where new functions are proposed, do the necessary skills exist to deliver? If not, how could these skills be developed?

## **Annex C – What we heard: a summary of the key issues**

### **Q1. What do you think the main benefits will be of establishing a Centre of Excellence for workforce strategy and planning? What should be the key success criteria by which to measure the performance of the Centre?**

We observed broad support at all levels in the health and social care system for the concept of a Centre of Excellence.

#### *Benefits*

The following potential benefits were highlighted.

- The creation of a national focal point for workforce strategy and planning, with the potential to help raise the profile of workforce planning issues among clinicians and senior managers.
- Cohesive strategy with stakeholder buy-in.
- Access to trusted, credible source of intelligence, evidence and data for the health and social care system, with strengthened methodologies and metrics.
- Improved confidence in the workforce planning system with better match between supply and demand and early alert of risks.
- Greater alignment with service and financial planning, and better integration across the health and social care and with the education sector.
- Support with embedding an approach to workforce strategy and planning based on a patient pathway.
- Support in creating a robust infrastructure and strengthened capability at local level.

#### *Success criteria*

Stakeholders identified the following areas as important in measuring the impact of the Centre.

- Contribution to better outcomes – impact on patient care, quality, productivity – probably impossible to establish the extent to which better workforce planning played a part in better (or worse) patient outcomes.
- Progress in bringing together stakeholders and facilitating a shared vision for workforce strategy and planning.
- End-user feedback on the added value the Centre is achieving, for example, in terms of the reports it produces, the intelligence it gathers, and the take up of tools and resources it provides.
- Impact on education and training – are we developing a workforce that is fit for purpose?

- The ability of the workforce planning system to stand up to scrutiny from stakeholders, including parliament, ie, Health Select Committee.
- Peer review – quantitative and qualitative evidence reports might need to be commissioned to measure the overall difference the Centre is making.

Respondents noted that some indicators of success would be difficult to measure.

**Q2. Are there any factors that threaten the ability of the Centre to realise these benefits? How could these risks/threats be mitigated?**

Potential risks associated with setting up the Centre included the following.

- Lack of clarity in terms of who the core customers will be and who the Centre will be accountable to.
- Setting a remit that is too ambitious and too focused on short-term issues, with unrealistic stakeholder expectations.
- Insufficient stakeholder engagement.
- Potential loss of experience, skills and expertise already in the system, for example, NHS Workforce Review Team, Skills for Health (Workforce Projects).
- Getting the right balance on governance and accountability.
- Co-ordination with reviews of other bodies.

In addition, potential risks for the established Centre could include the following.

- Confusion over its role.
- The quality of informatics available.
- A reluctance of some providers to engage and share commercially sensitive information.
- Not being valued by local organisations – ignored by commissioners and decision makers.
- Too remote from providers and commissioners – products not relevant at local level or do not promote innovation and flexibility.
- The perception that the Centre and MEE will be scrutinising or performance managing workforce plans could have a negative impact on stakeholder buy-in and the credibility of the Centre.
- Professional silos fostered by MEE and other professional boards or groups.
- Inability to engage with social care and independent sector.
- Sustainability of funding – the Centre needs stability and a long-term strategy to become a success, not a quick fix.
- Political interference could lead to the Centre not being viewed as objective and credible.

These risks could be mitigated by the following actions.

- Identifying and promoting clear terms of reference.
- Setting achievable goals and objectives within realistic timelines.
- Managing stakeholder expectations – being clear what the Centre does and does not do.
- Putting in place clear rules of engagement with stakeholders and developing strong and effective channels of communication.
- Scoping out existing good practice and building on what has already been achieved across the system.
- Ensuring the Centre is a supportive, enabling body not a performance manager.
- Quality assuring data and ensuring there is a clear framework for collection and feedback.
- Establishing clear and transparent governance mechanisms that allow freedom to think creatively and objectively.

**Q3. How can the Centre ensure that it operates in line with the vision set out in *A High Quality Workforce*? In particular, how can the Centre help promote workforce planning along clinical and patient pathways as opposed to professional lines?**

There was widespread support for promotion of workforce planning along patient pathways. The Centre could play an important role in supporting this approach by taking the following steps.

- Building on the existing clinical networks/clusters (eg, NSR networks) to secure clinical and frontline engagement and identify existing good practice to underpin workforce methodology, tools and process.
- Working with MEE, the other professions and the wider non-qualified workforce to develop common principles for pathway-based approaches to workforce planning.
- Ensuring the framework for planning builds up from commissioning plans, reaches across organisational boundaries and is developed in partnership with the HE sector and employers.
- Promoting a competency-based approach to planning as a common currency for the whole health system.
- Influencing policy development to ensure workforce is at the heart of all policy.
- Influencing the focus and technical aspects of data collection.

There was some concern expressed about the need for flexibility. Patient pathways are dependent on local needs and service configurations, and therefore there are local differences. Models will need to be flexible and adaptable.

**Q4. How can the Centre strike a balance between strategic and immediate requirements?**

The overwhelming view was that the emphasis should be on longer-term strategic issues. The focus should be on strategy, not just numbers and money. The Centre is not being set up to do workforce planning so where possible it should avoid being sucked in to short-term issues. If the Centre is forced into short-term thinking, poorly evidenced decisions could undermine its credibility.

To support a strategic approach it will need to do the following.

- Have a clear vision with short-, medium- and long-term objectives.
- Take a risk assessment approach to prioritisation.
- Tackle fundamental system issues first and strengthen local/regional capability in dealing with shorter-term planning issues.
- Establish effective communications with local networks to map local priorities and inform thinking.

**Q5. Three main functions have been identified for the Centre (analytical, networking and capability building), are these the right ones? Are there any gaps? Which of the functions should be given greatest priority?**

The consultation revealed broad support for the three functions. Concern was expressed about the potential role for the Centre in scrutinising workforce plans – this is addressed in greater depth at Q7.

Additional suggestions included the following.

- To influence policy development and assess the impact on the workforce.
- To develop effective communications and delivery mechanisms.
- To evaluate education curricula and ensure they are patient centred and linked to competencies.
- To quality assure existing informatics.

Although the analytical and capability building functions were the focus of most attention, there was recognition that all three functions are interdependent. The quality of the models and analysis is dependent on the gathering and exploitation of new information and ideas, and the outputs from the Centre will be limited in value unless there is the local capability to interpret and utilise them.

**Q6. A key role for the Centre is to develop forecasting, workforce projections and scenario models. How can the Centre ensure this process is accurate, evidence based and timely? In particular, the following questions.**

- **How should the Centre develop and test its assumptions?**
- **What data sources will the Centre need access to? What can be done to ensure that the Centre has access to high-quality information and data?**
- **At what level should the models be developed – national, regional, local or multi-level?**

### *Development and testing of assumptions*

- Must be done in consultation with end users – providers, pathway groups, networks, clinicians, and with the professions (MEE, royal colleges and professional bodies).
- Must be a transparent process – the end product has to be understood and owned by end users.
- Scope for, and use of, scenario modelling.
- A good process of challenge/contestability at an early stage is essential to avoid flawed models – peer review.
- Best practice nationally and internationally will need to be the barometer – commission research where evidence is unavailable.
- Local piloting may be helpful.
- Use NHS Workforce Review Team expertise and build on their networks and experiences.

### *Data sources, access and quality*

- A wide range of potential data sources were identified by respondents. A selection of these is set out below.
  - health and social care providers and commissioners
  - SHAs and deaneries
  - Information Centre
  - Office for National Statistics
  - Electronic Staff Record
  - National Minimum Data Set (for social care workforce)
  - Sector Skills Councils
  - eKSF
  - regulators
  - professional bodies
  - higher education and further education sector
  - academic research centres (UK and international)
- The Centre will need access to activity and financial data as well as clinical and workforce data.
- The Centre will need to quality assure any data that it uses – the emphasis must be on continuous improvement, reliability and validity.
- There may be difficulty in some instances accessing data held by foundation trusts, social care providers and the private/voluntary sector.

### *Models*

- The overwhelming consensus was that models will need to be multi-tiered to allow application in different settings.
- A mix of different models will be required to allow local flexibility.

**Q7. The NSR identifies a role for the Centre in scrutinising workforce plans. How can this be achieved effectively? How will the Centre ensure it is able to provide simple, clear advice and options to the DH, SHAs and the professional advisory boards?**

The strongly held view of the majority of stakeholders was that the process of scrutiny of workforce plans, as outlined in *A High Quality Workforce*, is neither practical nor appropriate. For many, it is viewed as a bureaucratic, performance management procedure and goes against the principles of devolution. There is also the concern that local plans can become meaningless once aggregated.

Many stakeholders commented that a scrutiny role for the Centre could detract from its more important role in supporting and developing the workforce planning system, and consequently impact on co-operation with stakeholders and the overall credibility of the Centre. If the Centre is to have a scrutiny role, the emphasis should be on scrutiny of the appropriateness and technical effectiveness of planning systems and processes, not the outputs. It will need to understand workforce plans and be able to capture intelligence from them to inform strategic thinking.

There is value in understanding workforce planning risks at regional/national level, particularly in terms of education commissions, and value for money of education subsidy. It was suggested by some that the DH should lead this process and not necessarily the Centre. Others felt the Centre could play a role in supporting PCT or SHA assurance. The Workforce Review Team annual risk assessment was highlighted as an area to strengthen and build upon.

What is clear is that clarity is needed around what is meant by a workforce plan – the consultation revealed that this can mean different things to different people and can include anything from education investment plans to leadership plans or pay/reward strategies.

**Q8. What are the key relationships and networks that the Centre will need to establish and how could these best be facilitated? How can the Centre build the necessary networks and delivery mechanisms to ensure it communicates with and reflects the priorities of core stakeholders?**

Stakeholders agree that better co-ordination and a coherent voice is needed for workforce strategy and planning. It is essential that the Centre has access to the best quality information and evidence to inform its analytical work and the tools and resources it produces for workforce planning.

Respondents highlighted an extensive range of organisations with which the Centre will need to develop relationships and networks with. These included:

- policy-makers in the DH and other government departments
- service leaders and managers
- clinical networks
- SHAs and deaneries
- local authorities
- national workforce organisations including NHS Employers, sector skills councils, Workforce Review Team, NHS jobs
- organisations collecting data (see response to 6b)
- improvement and development organisations such as NHS Institute, IDeA, Social Care Skills Academy

- professional bodies and royal colleges
- MEE and other professional advisory boards
- health care regulators
- Care Quality Commission
- patient forums
- higher and further education sector
- trades unions
- academic research centres.

It was suggested that the Centre needed to map existing networks and build upon these.

Investment in effective multi-way communications and technology will be essential.

**Q9/10. How best can the Centre support capability building at local level and disseminate best practice? What types of consultancy support might the Centre commission in order to support capacity and capability building? How does this fit with the other functions?**

Stakeholders acknowledged that support is needed to build capabilities at local level, however, it is not simply about skilling up workforce planners. The Centre has the potential to play an important role in engaging commissioners, clinicians and senior leaders and making them aware of the importance of workforce strategy for service delivery.

It was suggested that it would be helpful to map and evaluate what support is already on offer. In particular, many respondents were keen that the Centre build upon initiatives already in place across SHAs or led by the Skills for Health (Workforce Projects) team, for example, Postgraduate Certificate for workforce planning.

Capability could be strengthened through the following actions.

- The development of a best practice framework for workforce planning.
- The development and dissemination of tools and resources.
- Training programmes, masterclasses and e-learning.
- Sponsorship of local pilots.
- The development of a library of evidence, expert guidance and best practice.
- Investment in high-quality research and dissemination of findings.
- The creation of an advice and support resource centre with discussion boards and a web portal.

[Not just capability building for workforce planners. Need support for commissioners, CEs and Boards]

There was mixed support for the commissioning of consultancy support by the Centre. Some stakeholders felt this might be helpful in the first instance to help build relationships, but many felt that lots of expertise is already out there, and better co-ordination and dissemination is what is needed.

A large number of respondents, particularly those from the NHS, felt that capability building must have a strong local/regional emphasis and ownership to be truly effective.

**Q11. What characteristics will the leadership of the Centre need to demonstrate?**

Stakeholder responses emphasised that leadership should enable the Centre to be independent, authoritative and well connected. In particular, the leadership of the Centre should demonstrate the following attributes.

- A clear strategic vision.
- The ability to establish credibility at an early stage.
- Objectivity, impartiality, trust and respect.
- Innovation, creativity and a willingness to explore new ideas.
- Courage - the freedom to think the unthinkable.
- An 'in touch' approach with the needs of users.
- Inclusivity.
- Excellent communication skills and an ability to listen.
- Political awareness.
- Authority - the ability to challenge the DH, medical profession and others.
- Pragmatism – to live in the real world and recognise that workforce is not a perfect science.

**Q12. What skills will be required among those working in the Centre?**

In addition to the competences identified above, respondents identified the following skills as being required by the team at the Centre.

- Breadth of knowledge of health and social care.
- Access to clinical expertise.
- Strong analytical capability.
- Forecasting and horizon-scanning capability.
- Ability to access and link information.
- Programme and project management abilities.
- Influencing skills.
- Research and evaluation skills.
- IT skills.
- Communication skills – sensitivity in working with diverse stakeholders and understanding complex relationships.
- Consultative – ability to listen.
- Report writing and presentation skills.

- Academic credibility, but with an understanding of the NHS and public sector values.
- Access to experts in a range of fields.
- Familiarity with existing tools and resources.

**Q13. What are the principles needed to underpin the governance of the Centre?**

- Integrated approach across health and social care.
- Stakeholder representation – service, professional, patient – grounded in reality.
- Clarity of role, purpose, objectives – clear deliverables.
- Clarity of accountability, particularly the relationship with the DH – a significant number of respondents called for independence from DH and political interference.
- Robust business and communication processes.
- Open to scrutiny.
- Value for money.
- Transparency of funding.
- Security of funding.
- Responsive and flexible.
- Avoid duplication.

**Q14. What form should the Centre take and in what type of organisation would it most appropriately be located? For example, should it be a single organisation or a managed network of organisations based on a hub and spoke model?**

The majority (80 per cent) of responses received favoured the network model, with many taking the view that no single organisation has the complete range of skills required.

The hub and spoke model found much support. Many saw the spokes as regional bases for the Centre facilitating better stakeholder engagement and capability building. Others interpreted the spokes as being national organisations such as universities, the WRT or the Skills for Health (Workforce Projects) team.

A minority favoured a single organisation, with some level of partnership with a university.

Any academic link-up must engage with employers and ensure balance between need for objectivity and rigour and the need to provide practical, timely, meaningful information and evidence.

**Q15. Which existing organisations have the skills to provide all or some of the functions? Where new functions are proposed, do the necessary skills exist to deliver? If not, how could these skills be developed?**

Stakeholder responses highlighted a broadly held view that a lot of relevant expertise already exists, and that it needs to be mapped and brought together in a coherent and co-ordinated framework.

There was a strong message from stakeholders not to dispose of existing skills, corporate memory and progress made to date.

Skills relevant to workforce planning and to the core business of the Centre exist in a wide range of organisations, including:

- national workforce bodies – in particular the Workforce Review Team and Skills for Health
- SHAs and deaneries
- providers and commissioners
- DH
- Information Centre
- NHS Employers
- universities
- sector skills councils
- Improvement and Development Agency (IDeA)
- NHS Institute
- royal colleges and professional bodies.

## **Annex D – The report of the employer consultation in the South West**

### *Background*

The NHS Next Stage Review report, *A High Quality Workforce*, announced the establishment of a Centre of Excellence to support workforce strategy and planning in the NHS. The purpose of the Centre is to ensure that workforce strategy and planning is supported by evidence and analysis at every level in the health and social care system. In particular, the vision is that the Centre will achieve the following.

- Put the patient at the centre of planning
- Address patient pathways across the health and social care system
- Focus on the whole workforce
- Be open minded and innovative
- Seek to provide the earliest possible advance warning of risks and opportunities, and be dynamic and responsive when the unexpected happens
- Be pragmatic and aware of the realities of the health and social care system and government
- Be able to work with a wide range of stakeholders, both nationally and in local health economies
- Build on good practice and expertise already in the system
- Have a strong academic record and credibility, and potential to develop an international and world class reputation.

With this in mind, The King's Fund has been asked to carry out a process of engagement on the proposed Centre of Excellence for workforce planning with stakeholders across the health and social care system, with a view to producing a report for the DH. This exercise will focus on the three broad functions originally identified for the Centre.

- Analytical function
- Networking function
- Capability-building function

NHS South West has been working with its partner organisations to develop increased capacity and capability during the year with an ambitious programme linked to the competencies in workforce planning developed by Skills for Health.

The NHS in the South West was asked to explore in further detail the role of the Centre in capacity and capability building. The following issues are identified for consideration around capacity and capability building.

- The development of a capability building function with tools and resources to support local planning and implementation.
- To provide leadership, technical and management development support to broaden understanding and use of workforce planning

techniques for service providers and commissioners, SHAs, educational commissioners and providers.

- To disseminate exemplars of good practices and provide consultancy support to providers, commissioners and SHAs.

The work has been led by Sue Donaldson, Director of HR/OD for Poole Hospital NHS Foundation Trust, and Helen Allen, Director of Workforce Development, NHS Plymouth.

Additional support has been provided by Christine Whitehead Associate Director NHS South West. John Wolfe, Interim Director Workforce NHS South West provided national and regional expertise and experience.

This report summarises:

- the process used to obtain employers' views
- a brief summary of key findings
- recommendations from employers which can be submitted for further testing across the country.

### *Consultation*

#### **Process**

The brief timescale shaped the process of consultation which consisted of the following.

- The consultation was discussed at the NHS South West Chief Executives and Chairs regular meeting.
- Distribution of a questionnaire focusing on capacity and capability to:
  - chief executives
  - directors of human resources
  - directors of nursing
  - directors of medicine
  - directors of public health.

The questionnaire was tested at a meeting already planned for the NHS South West Strategic Workforce Planners Network and their response incorporated in the findings.

Sue Donaldson and Helen Allen held local consultations, to which a wider range of stakeholders were invited.

#### **Response rate**

Attendance at the local consultations was limited but provided some interesting information particularly about working with local authorities.

A response was obtained from the Employers Council, established as part of the working with Skills for Health in the South West.

Responses to the questionnaire were more diverse with 26 organisations out of 40 in NHS South West submitting a response. Most organisations submitted more than one response as different leads provided views. This allowed for collection of views across a wider group than Human Resources or workforce specialists. However, the majority of responses came from those

with a professional interest or organisational responsibility.

Responses were received from both NHS and foundation trusts including providers of mental health care, care trust and PCTs, as well as a local authority from the following groups:

- chief executives
- 1 medical director
- directors of nursing
- public health leads
- 1 clinical specialist
- directors of human resources
- 1 world class commissioning lead
- workforce planning leads.

The King's Fund consultation was being carried out at the same time and two directors of human resources from foundation trusts forwarded their response to The King's Fund questionnaire in lieu of responding to the NHS South West one.

### **Summary of findings**

The findings provided a rich source of information about the views of employers in NHS South West. The process has provided an audit of the current programme being implemented in partnership with NHS South West and NHS organisations to increase capacity and capability in workforce planning. The responses in part reflect the programme's focus on use of particular models and the transfer of work being carried out by NHS Plymouth.

### **General findings**

There remains a strong need to create a movement of interest in and commitment to workforce planning, with an accepted process that integrates workforce planning, service planning, finance and commissioning. This was seen as essential if workforce planning is to move beyond the current perception of being a responsibility of Human Resources departments. This was seen as the single most significant contribution the Centre should make.

The Centre will need clear governance and demonstrable links with wider government policy, for example, being able to influence decisions on skilled worker immigration.

There was concern about an overly academic approach so the Centre would require key performance indicators, which would be reported on to the wider community.

### **Expectations of workforce planning**

The views of employers were that workforce planning was essential to achieving the following.

- Ensuring sufficient supply of appropriately skilled workforce to deliver good quality care.

- Providing early intelligence about risks to service delivery posed by workforce supply issues, which may include financial restrictions, and allowing organisations to make reasonable adjustment.
- Enabling organisations to adjust current workforce to meet new demands, by improving skills or creating new roles.

Examples included the following.

- Good workforce planning should enable the organisation to be quick to respond, have effective succession plans to develop its future leaders and provision and development of future focused services.
- The correct level of workforce resource, appropriately skilled, based in the right place to deliver excellent health and social care services for the areas we serve.
- To build an affordable workforce with the capacity, capability and flexibility to adopt new ways of working in preparation to meet the needs of the local population and deliver high-quality services. That there is a good understanding of where the workforce will come from and offer training and development programmes that encourage recruitment and retention.

It was seen that this was critical to an effective response to the factors influencing demand.

Commissioners consider that workforce information assisted in assessing the risk to future plans arising from workforce supply shortages.

- Improved commissioning, reduced risk to service delivery due to ageing workforce (loss of skills and experience), informed talent management, service redesign, value for money.

The provision of relevant intelligence assists in the identification of priorities for investment.

- Workforce planning is done through a process of analysing information such as future service needs, staff age profiles, turnover, planned training places, recruitment activity. Workforce planning projections from the NHS South West are also taken into consideration.

Both required assistance with the long-term issues that may affect the workforce supply in the future.

The Centre has a key role in supporting the processes and thinking around long-term workforce planning and the implications of policy and societal changes on the demand for health care.

### **Current practice**

The responses identified the following as current practice.

- Some evidence of a gradual movement where workforce planning is seen as a managerial responsibility, facilitated and led by human resources. The work of the Centre must strengthen this in order to move workforce planning from the margins. One respondent reflected that the work of the Centre was not to replicate models or tools but to energise particularly Boards around this agenda.

- Most organisations used the data from the Electronic Staff Record as a basis for information. They also accessed a wide range of other sources. However, there was limited evidence of organisations using the national predictors, for example, the Workforce Review Team, as most respondents were looking for data such as labour market availability on a very local scale.
- 45 per cent of organisations had processes that linked workforce data and financial data. Providing researched evidence that this is essential would be helpful. In addition, making such requirements part of the annual health check would encourage organisations to develop appropriate systems.
- The majority of organisations had a formal process of reporting to the board. There was limited evidence of board-level engagement. The majority of respondents considered this to be a key area for the Centre to promote by incorporating this into board development, leadership development and performance/quality assessments.
- Due to the local programme to increase capacity and capability the majority of organisations used some form of model to develop workforce planning, with the 6 Steps Model and the work of NHS Plymouth being most frequently cited.
  - The six steps is the basic methodology of workforce planning within the organisation.
  - Workforce planning is co-ordinated through the Workforce and Organisational Development Directorate. The staff work with managers using a model based on the 6 Steps and including tools developed by the SHA (NHS South West) and Plymouth Primary Care Trust.
- There was some evidence of clinician engagement, particularly in the organisations undergoing change.

### **Evidence of effective practice**

The following were identified by employers as effective.

- Board-level engagement and recognition of the contribution of workforce to effective service delivery.
- When workforce planning was linked to national/regional priorities for service improvement.
- When short-term plans were required.
- The discipline arising from foundation trust status.
- Where sufficient resource is allocated and clear ownership established by an organisation.

### **Evidence of areas for improvement**

The following areas were identified as needing strengthening.

- Integration with service and finance planning.
- Medium- to long-term planning.

- Clarification of the role of the commissioner and the relationship to the workforce planning requirements of the provider.
- Clinical engagement.
- Competency-based workforce planning.
- Productivity metrics that make sense.
- Moving beyond managing within fluctuating financial flows that can lead to reactive workforce planning.

### **Actions identified to strengthen capacity and capability**

There was acknowledgement that there were already resources and sources of data widely available, but that organisations may 'lack the courage to use them'.

The following themes were identified.

- The need to strengthen clinical interest and engagement.
- The need to increase board-level interest and engagement.
- A requirement for reliable and quality assured tools including a model workforce plan.
- A requirement for quality-assured sources of information.
- The identification of evidence-based systems to support managers and clinicians.
- Increased links with education commissioning, particularly in medicine.
- The need for improved support to plan across sectors.
- Commissioner engagement so that workforce planning is driven by and able to respond to service planning rather than in parallel.

### **Additional comments**

- The Centre needs to focus on developing workforce capacity and capability at an operational level.
- Facilitation of cross sector working is essential. The NHS could learn from the approaches used in other sectors.
- Strengthening the links between workforce planning and service planning is essential.

### **Recommendations**

These are presented as a series of actions that the Centre will undertake to support capacity and capability development.

#### **Recommendation 1**

The Centre will provide leadership for workforce planning in the following ways.

- Using the principles of social movement to develop board-level commitment driven by staff and clinical engagement.
- Working with other bodies who provide assessment frameworks for organisational fitness to ensure workforce planning is a key indicator.
- Ensuring incorporation into current curricula for staff education, particularly leadership development.
- Defining the levels of accountability for workforce planning, for example, the role of the SHA in planning raw supply for the non-medical professional groups.
- Establishing programmes to support the understanding of and participation in workforce supply management by non-traditional groups such as finance managers.

### **Recommendation 2**

The Centre will provide support to the creation of a positive climate and high level of interest in workforce planning in the following ways.

- Publishing and recommending tools and processes that can demonstrate that they enhance the activity. Respondents locally valued the 6 Steps methodology developed by the Skills for Health Workforce Projects team and the model developed by NHS Plymouth. This model was valued because it provided organisational coherence, required board-level engagement and by use of the Electronic Staff Record supported manager engagement in a meaningful process.
- Developing organisational champions whose role is to ensure workforce planning is a consideration in all areas of service planning, delivery and review. The champions may not be the traditional sponsors such as planners or Human Resources but finance leaders or service commissioners.
- Providing clarity about the model or framework that could be used by organisations to develop workforce and system planning. Respondents identified a need for a model workforce plan to help in the process. The role of the Centre would not be to tell people how to do this but to provide clearer guidance than people currently feel is available about a framework and core content.
- Providing definite guidance on the relationships and accountabilities of differing stakeholder groups. At present the term workforce planning is used to cover a wide range of activities from the manager developing a small team to a regional process of ensuring sufficient supply. This leads to confusion about accountability. The following is a suggested framework.
  - Employers need to manage supply to ensure activity can be delivered. This requires a series of integrated activities focusing on the workforce profile and its implications.
  - Employers need to feed information about future supply needs to the bodies responsible for commissioning future professional workforce supply, currently the SHA.
  - Commissioners need to work with both workforce

commissioners and employers to ensure that there is sufficient supply to deliver the commissioned service and that this supply is of appropriate quality.

- Support the development needs of a range of groups so that there is understanding and action on their contribution to workforce planning. The following examples illustrate areas for development.
  - PCTs need to understand their role as commissioners in ensuring sufficient workforce supply and managing governance and quality issues.
  - Medical directors need to provide leadership on identifying demand for medical staff as at present the information is about supply patterns.

### **Recommendation 3**

The Centre will focus on the provision of intelligence and intelligence gathering systems to support organisations in service planning and workforce commissioning by taking the following actions.

- The provision of strategic leadership to ensure sector data collection systems can speak to one another.
- Accrediting the quality of data collection provision from sources other than the ESR and providing guidance on the most relevant ones for local planning.
- Working with the relevant policy leads to develop a system that integrates service planning, financial flows and workforce demand.

### **Recommendation 4**

The Centre will support management of risk to service delivery arising from workforce supply issues by taking the following measures.

- The provision of intelligence about long-term developments that will impact on the demand and/or supply of staff groups.
- The modelling of the impact of such development on workforce demand.
- The provision of intelligence not readily available to regional and local workforce planning processes – for example, changes in drug therapies – and modelling their potential impact on workforce need to provide guidance to national, regional and local workforce planning.
- Develop econometric models that will assess risk and provide guidance on resource allocation, particularly if this may require adjustments to demand which may impact on individual staff groups or partners such as higher education.

### **Recommendation 5**

The Centre will seek to enhance quality in workforce planning so that the NHS is seen as a world leader in this area by taking the following steps.

- Critically reviewing national and international research to develop a body of intelligence to support evidence based workforce commissioning.
- Providing a bench mark and accreditation for existing good practice. This may be national work or local developments that wish to be awarded a quality mark.
- Providing a forum for the testing of ideas/views against national and international experience so that organisations can be creative but avoid risk to service from a failure of workforce supply.
- Leading and accrediting development work by SHAs on programmes to develop local capacity and capability.
- Critically reviewing existing tools and models to provide a quality assured guide to local organisations.
- Leading the development of the role of commissioners in workforce governance linked to service commissioning.

**Recommendation 6**

There remains concern about the need for the Centre to demonstrate added value and to support the creation of a community of workforce planning.

- The final recommendation is that the Centre of Excellence commences with a review and rationalisation of current practice. The subsequent gap analysis will identify the areas for immediate improvement to support the expansion of the ownership of workforce planning to the wider N HS community.

## **Annex E – The current workforce planning landscape – key organisations, their roles and responsibilities**

### *NHS Workforce Review Team (WRT)*

WRT is a group of dedicated workforce planners, including information analysts, data modellers and professional advisors (covering medical, dental, pharmacy, AHPs, nursing and midwifery, and health care science) who produce reliable data and analysis covering the whole NHS (England) registered workforce. WRT's primary purpose has been to provide supply and demand modelling to inform and support workforce planning and commissioning in the SHAs, and to inform and influence policy discussions and decision-making in DH and the allocation of the multi-professional education and training budget (MPET).

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. WRT has built up and continues to develop mutually beneficial relationships with 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 – these are published annually, following wide consultation.

WRT supplements its data analysis through its development of technical models and tools, including the ongoing production of 'Christmas trees' and the SHA maps, alongside other recent examples such as the audiology and endoscopy tools ([www.wrt.nhs.uk/index.php/work/tools](http://www.wrt.nhs.uk/index.php/work/tools)) for internal and external use. 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.

### *The Workforce Directorate Analysis Team (WDAT), Department of Health*

WDAT is a small team within the Workforce Directorate at the DH. Its functions include, but are not limited to, providing analytical support on workforce capacity issues, including workforce planning. In this area, WDAT acts as the technical liaison between the DH and WRT and helps to specify and peer review the WRT research and analysis that is commissioned by the DH.

WDAT does not typically undertake the kind of specialty-specific analysis that WRT performs. Its work often has a more aggregate perspective, for example, in supporting the development of the DH's overall workforce strategy, which informs Spending Review discussions with HMT. This includes some demand horizon scanning functions, but these could be developed further. In addition,

WDAT contributes analytical input to the DH 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, although this may sometimes be necessary for specific issues (such as the upcoming CSR process – although the respective roles of WDAT and WRT have yet to be defined), but it does engage in collaborative working on model development with partners such as WRT.

### *Skills for Health (SfH)*

SfH is the Sector Skills Council (SSC) for health care (one of 25 licensed by the Secretary of State for Education and Skills). The key goals of the SSCs are to address skills gaps and shortages, improve learning supply, productivity and performance, and increase opportunities to boost skills (<http://www.skillsforhealth.org.uk/page/about-us>). SfH specific stated aims are to:

- develop and manage national workforce competences
- profile the UK workforce
- improve workforce skills
- influence education and training supply.

SfH aims to meet the challenges facing the health care workforce (eg, an ageing population, increasing emergency hospital admissions) to develop '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 UK and Europe' ([www.skillsforhealth.org.uk/page/about-us/strategic-intent/the-workforce-challenge](http://www.skillsforhealth.org.uk/page/about-us/strategic-intent/the-workforce-challenge)), 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 around the development of 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). WPT offers a range of workforce planning tools, techniques and approaches (including the widely-used '6 Steps Methodology towards Integrated Workforce Planning') to provide support to workforce planners and to facilitate in the development of workforce planning capacity and capability throughout the NHS. WPT runs an 'Introduction to Workforce Planning' course and a more advanced post graduate qualification (PGCert), as well as a number of workshops and 'master classes' on topics such as the 18 weeks wait. In August 2005, WPT was awarded the contract to help the NHS develop solutions to the challenges raised by compliance with the Working Time Directive (WTD). WPT's remit is to help the NHS develop, pilot and make available solutions to the WTD 2009 challenge.

### *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' 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 data bank 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 an annual celebration of the achievements of innovative employers at the SfC national Accolade awards ([www.skillsforcare.org/view.asp?id=36](http://www.skillsforcare.org/view.asp?id=36)).

SfC has nine supporting regional committees who act as brokers for funding dedicated to workforce development training and activities – a sum in excess of £25,000,000 per annum. The regional committees build relationships and develop partnerships with local employers to help them to exploit the resources available to them in the most effective way.

### *NHS Institute for Innovation and Improvement (NHSIII)*

The NHSIII aims to provide 'a national co-ordinated focus to the biggest problems of the service' ([www.institute.nhs.uk/organisation/about\\_nhsi/about\\_the\\_nhs\\_institute.html](http://www.institute.nhs.uk/organisation/about_nhsi/about_the_nhs_institute.html)) and to improve the productivity of its organisations. The Institute prioritises the rapid development and dissemination of new ways of working and technologies, 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 Institute'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'). The Institute also manages the NHS Graduate Management Training Scheme (MTS), which consists of four related management specialisms: general, finance, HR and informatics.

### *NHS Employers (NHSE)*

NHSE 'represents trusts in England on workforce issues and helps employers to ensure the NHS is a place where people want to work' (<http://www.nhsemployers.org/aboutus/index.cfm>). NHSE aims to reflect the views, look after and promote the interests of, and act on the behalf of NHS employers. Specifically, they cover issues concerning pay and negotiations, employment policy and practice, state of the workplace, and recruitment, although they also act 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 policymaking on national workforce issues' through the Social Partnership Forum, NHSE states that it supports

employers with their workforce planning through the provision of advice and information on issues such as how to effectively manage temporary staffing, achieve the 18-week target, and implement role and system redesign ([www.nhsemployers.org/workforce/index.cfm](http://www.nhsemployers.org/workforce/index.cfm)). They also manage the recruitment site NHS Jobs ([www.jobs.nhs.uk](http://www.jobs.nhs.uk)), provide general careers support to current and prospective NHS employees, and work with trade unions and DH 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 (IC)*

IC 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 WRT, the National Institute for Clinical Excellence (NICE) and local decision-makers for use and analysis. The IC is responsible for the verification (with trusts) of the information recorded in the Electronic Staff Record (ESR). The IC 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 IC census are vital data sources for workforce planners throughout the country

A specific goal of the IC is to improve the integration of data from the NHS and independent/private sector providers to align information and enable comparison. The IC is also working with SHAs to develop comparative financial performance indicators (piloting with NHS Yorkshire and Humber) and to build understanding of the analytical tools and data available to SHAs (piloting with NHS North West) to assist them in management of the SHA ([www.ic.nhs.uk/about-us/our-priorities](http://www.ic.nhs.uk/about-us/our-priorities)).

High on the IC'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 they expect 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' ([www.ic.nhs.uk/about-us/our-priorities](http://www.ic.nhs.uk/about-us/our-priorities)).

### *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. 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. Particularly good examples are the Royal College of Pathologists (RCPATH)

and the Royal College of Physicians (RCP), who are particularly active. RCPPath has its own Workforce Database (which members are asked to update individually) and its own Workforce Department; the Department 'collects workforce data for use by WRT and other relevant professional groups...[and] advises the College on trends in recruitment and pathology specialties' ([www.rcpath.org/index.asp?PageID=74](http://www.rcpath.org/index.asp?PageID=74)). The RCP has produced an annual Consultant Census based on individual response forms for the last 17 years (<http://forms.rcplondon.ac.uk/formserver/sprcensus2008>), which is used to help define supply of consultant physicians and helps the College to identify key trends within the physicians' workforce. The RCP also helps to define the demand for the general medicine specialties. However, across the spectrum, workforce functions are less mature, for example, the Royal College of Radiologists (RCR), which is carrying out the inaugural census of its members this year, which will give 'for the first time, accurate data on the composition of the UK workforce in clinical radiology'. The College will share this data with WRT and 'others with a legitimate interest in medical workforce planning' ([www.rcr.ac.uk/content.aspx?PageID=1531](http://www.rcr.ac.uk/content.aspx?PageID=1531)).

## Annex F – Overseas models for workforce strategy and intelligence

### *United States*

A key difference between the health care workforce planning landscapes in the United Kingdom and the United States is that the majority of US planning and research is carried out at state level rather than nationally. Several state universities host or run centres of research and planning – some of these are described below. All of the centres below describe themselves as providing information for the public as much as for professional organisations and policy-makers.

#### **Cecil G. Sheps Center for Health Services Research, University of North Carolina ([www.shepscenter.unc.edu/](http://www.shepscenter.unc.edu/))**

Hosted by the University of North Carolina (UNC), the Sheps Center is self-supporting, using funds from the state and contracts and grants from charities and federal government agencies, including the National Institutes for Health. Oversight responsibility for the Center sits with a Policy Board made up of faculty members of the other schools/departments at UNC.

The Sheps Center seeks to understand the problems, issues and alternatives in the design and delivery of health care services through an interdisciplinary program of research, consultation, technical assistance and training; focusing on the accessibility, adequacy, organisation, cost and effectiveness of health care services in the State of North Carolina. The Center's research programs and projects are often carried out on a long-term basis. They include the establishment of various sub-centres such as the Evidence-Based Practice Center (EPC), which produces systematic reviews and analyses of the scientific evidence on a variety of health care and health policy topics, and the North Carolina Institute of Medicine, which serves as a non-political source of health policy analysis and advice in North Carolina.

The key focus of the Center's research findings and data sets is the addressing of public health problems. As an academic institution, the Center's goal is always to publish and disseminate its findings as widely as possible. They describe one 'framework' for the use of their research and data sets in the alleviation of these problems in some detail on their website: the 'rational program planning process', which serves as 'a bridge between and among measurement sciences, behavioral and organizational theories, health problems, and public health practice' ([www.shepscenter.unc.edu/data/peoples/index.html](http://www.shepscenter.unc.edu/data/peoples/index.html)). The Center offers 'how-to' guides covering the steps in this process, offering 'technical guidance for data and evidence-based planning within a framework that encourages development of creative, responsive and accountable interventions. Each manual presents key principles of a step in the planning process, followed by opportunities to practice applying the principles to public health situations.' These manuals can be used in isolation or as a set to 'demonstrate interconnections among steps in the planning process'.

The Center utilises various data sources including the following.

- The Carolina Cost and Quality Initiative (CCQI) (a collaborative partnership between UNC's School of Public Health and the Sheps

Center) is a patient specific database populated and periodically updated with data from public and private payers.

- The North Carolina Health Professions Data System, which collects state-wide data on licensed health professionals including contact, educational and practice information.
- The Center is under contract with the Division of Health Services to maintain, for use in research and state health planning, the North Carolina hospital discharge and ambulatory surgery data collected by Thompson Healthcare and updated annually.
- The North Carolina Rural Health Research Program Cartographic Archive provides maps of demographics, health status indicators, health care providers and health related services for the state's rural areas.

### **The six Centers of Health Workforce Studies (CHWS)**

Created between 1997 and 1998, six regional workforce centres were funded by a co-operative agreement with the National Center for Health Workforce Information and Analysis within the US Health Resources and Services Administration's Bureau of Health Professions. Although the federal grant for these Centers has ended (cut in 2006 due to federal budget cuts), they continue to exist through various different funding routes and hosted by universities of California, Washington, Illinois, Texas, North Carolina and New York – some of which are described below.

#### **South East Regional CHWS, University of North Carolina**

The South East Regional Center is now part of the Sheps Center at the University of North Carolina (see above). The Center draws on the five health professions schools sited at the Chapel Hill campus: medicine, pharmacy, dentistry, nursing and public health. In addition to its staff of professional analysts, modellers and programmers, the Center supports the work of graduate students from each of the professional schools.

#### **The Center for California Health Workforce Studies (CCHWS), University of California, San Francisco**

CCHWS was created in 1997 and has continued as part of the Center for the Health Professions, supported by private and public sources including the Arkay Foundation, California HealthCare Foundation, The California Endowment, Corporation for National Service, Helene Fuld Health Trust, The Pew Charitable Trusts, Robert Wood Johnson Foundation, Gordon and Betty Moore Foundation, and US Bureau of Health Professions.

The Center examines critical issues in the distribution, diversity, supply and competence of health professionals in California and other western states, as well as a range of issues that impact the health care system and workforce both in California and nationwide. These issues include:

- supply and distribution
- skills and training
- cultural competency and diversity

- leadership, partnership and vision.

### **The University of Washington WWAMI (Washington, Wyoming, Alaska, Montana, Idaho) CHWS**

Established in 1998, the WWAMI CHWS now sits in the University of Washington School of Medicine. The Center works in collaboration with federal and state agencies to conduct health workforce research and policy analysis, providing consultation to policy makers on local, state, regional and national levels. Part of the Center's work is to develop and refine current analytical methods for measuring state health workforce supply and demand.

### **CHWS, School of Public Health, State University of New York, Albany**

The Center at Albany describes itself as a 'not-for-profit research organization', which now sits in the School of Public Health – a joint venture between the University and the New York State Department of Health – and is affiliated with Albany Medical College. The following are key areas of activity.

- The collection, analysis and distribution of health workforce data.
- Assessing the impact of changes in health care on the demand for and use of health workers.
- Medical workforce planning, including projected supply and demand by specialty.
- Providing workforce planning capability and technical assistance to health and education organisations.
- Assessing the relationship between changes in health care and access, quality and cost.

### *Australia*

In Australia, government supported health workforce planning and research occurs at both the national and state/territory levels. Nation-wide activities are undertaken by the National Health Workforce Taskforce (NHWT) overseen and co-ordinated by the Health Workforce Principal Committee (HWPC). The HWPC is Australian Health Ministers' Advisory Council's (AHMAC) principal advisor on national health workforce policy and strategic priorities. AHMAC and the Australian Medical Workforce Advisory Council (AMWAC) are the two main workforce planning groups in Australia and, uniquely, focus on a 'models of care' approach (Bosworth *et al* 2007, p 24) based on the competencies needed for to enable the delivery of best practice health care. 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).

**The National Health Workforce Planning and Research  
Collaboration, based in Melbourne, State of Victoria  
([www.nhwt.gov.au](http://www.nhwt.gov.au))**

The Department of Human Services (DHS) provides administrative support to the National Health Workforce Taskforce (NHWT) – a time-limited (three years – although this is likely to be extended), national body whose purpose is to ‘undertake project-based work and advise on and develop workable solutions for workforce innovation and reform’ and the improvement of workforce data. The NHWT was created in 2006 by the AHMAC, which directs its operations and authorises NHWT expenditure.

This year the NHWT requested that the DHS contract for a number of as yet unspecified research projects. The DHS has put out a tender for bids to form a research organisation known as the ‘Collaboration’ with the NHWT to conduct health workforce research projects. These projects are to include the production of supply and demand projections for priority professions (as defined by the NHWT). The long-term goal of which is to establish a national workforce planning and research capacity and data resource to support the NHWT. Research projects are to be divided into the following three categories based on funding.

- Projects funded wholly by NHWT.
- Projects funded jointly by NHWT and the contractor within the Collaboration.
- Projects not commissioned or funded by NHWT – the contractor would be encouraged to follow up any other funding opportunities that would benefit the Collaboration and enhance its reputation.

Funding appears to be negotiated based on the hourly/daily rates of the individuals carrying out work on individual projects, and will be made on a project by project basis. The NHWT will contribute up to \$1,000,000 per annum for up to three years, and the collaborating contractor is required to match this funding. A Collaboration Steering Committee will be set up with equal representation from the contractor and AHMAC, the Executive Director of NHWT, and a Chair nominated by AHMAC. The Committee will sign off annual work programmes to be drafted by the NHWT and contractor in partnership.

The outcome of the tendering process was due to be released on 7 November 2008 and the project due to begin in December.

*Canada*

**Nursing Health Services Research Unit (NHSRU), University of Toronto  
Faculty of Nursing and the McMaster University School of Nursing**

First established in 1990 as the Quality of Nursing Worklife Research Unit with five-year base funding from the Ontario Ministry of Health and Long-Term Care, the Unit has continued to be refunded as a resource – for five years (from 2004) as the NHSRU.

The NHSRU conducts research and inquiries in order 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, especially around issues such as recruitment, retention and working practices of the nursing workforce. A recent focus of attention was around the shift to a graduate nursing workforce. The McMaster site focuses on the development of the data and analysis used in the various models and databases the Unit uses.

### *Sweden*

#### **Sahlgrenska Universitetssjukhuset (SU), Gothenburg**

Employing around 17,000 staff with a number of facilities spread across the Gothenburg region, the SU is reported to be the largest hospital in Northern Europe and carries out much of its workforce planning 'in house'. The hospital announces its goal is to have 'the right number of employees, with the right competencies and personnel composition that is required to achieve the vision of the hospital and accomplish their mission' (Andersson quoted in Bosworth et al, pg 144). The SU produces annual plans calculating the need for training and recruitment based on estimates of skills supply, demand and mix (worked out three years ahead). These plans are drawn up with reference to the hospital's budget and high-level business plans to provide a connection between the organisational strategy and the workforce planning and HR strategies (Bosworth et al 2007, pp 144-5).

The Warwick Report outlined the infrastructure present in the SU to enable their workforce strategy to be influenced from the bottom up: each operational area has an HR department, which supports the nursing department manager (again one in each operational area) who acts as line manager for the personnel within their area and has responsibility for the planning of the personnel in that area. The personnel management group works with the HR planning and competence development group to feed into the overall plans of the SU (Bosworth et al 2007, p 145).

For further examples and information, please refer to the 2007 report commissioned by WRT and carried out by the Warwick Institute for Economic Research, *Who Does Workforce Planning Well? A Rapid Review for the Workforce Review Team* ([www.wrt.nhs.uk/index.php/publications/56-publications/94-who-does-workforce-planning-well](http://www.wrt.nhs.uk/index.php/publications/56-publications/94-who-does-workforce-planning-well)).

### *Reference*

Bosworth, Wilson and Baldauf (2007). 'Who Does Workforce Planning Well? A Rapid Review for the Workforce Review Team'. *Warwick Institute of Economic Research, The Warwick Report*.