# United Kingdom – country profile

These profiles are reproduced here in the same language as they were submitted to WP6. We have not edited or translated any of these submissions and the approaches are described in their own words.

Each of the four countries of the United Kingdom has, since 1999, had devolved responsibility for their health systems (and this includes health workforce planning and forecasting). As a result the responses in this section are under the headings of each of the four countries of the United Kingdom: England, Northern Ireland, Scotland and Wales.
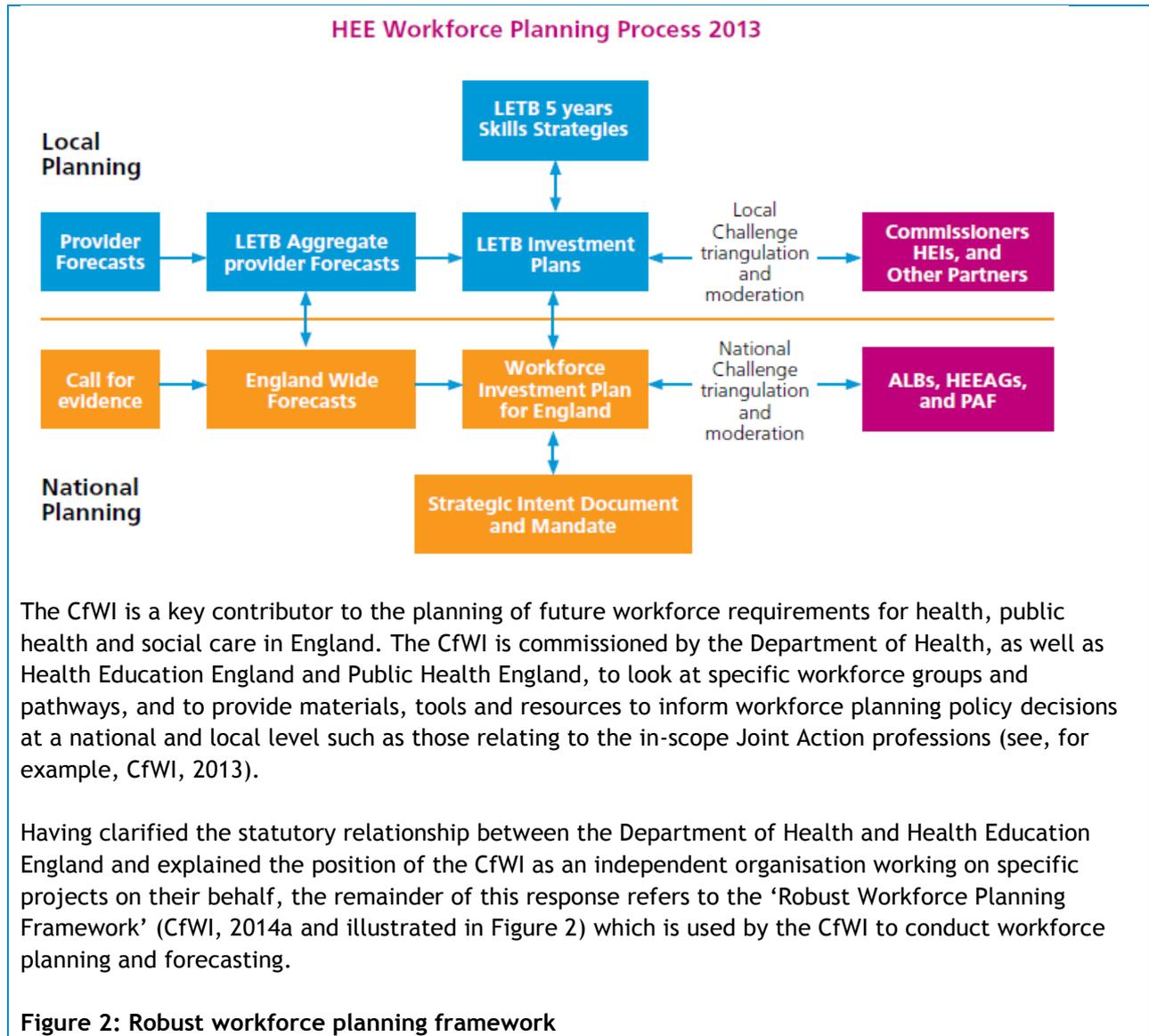
## Overview of the health workforce planning process (series of actions taken)

### England

The Department of Health acts as the steward for the health, social care and public health system by setting strategic outcomes, securing resources, setting the regulatory, policy and legal frameworks and providing oversight and leadership (Department of Health, 2012). The Department of Health sets strategic objectives around workforce planning, health education and training and development in *The Mandate to Health Education England* (Department of Health, 2014).

Health Education England ensures 'that the future workforce has the right numbers, skills, values and behaviours' and annually sets out its commissioning intentions in the *Workforce Plan for England* which is subsequently used as the basis of the contracts that each Local Education and Training Board (LETB) places with local education providers for that academic year (Health Education England, 2014). To inform these training commissions Health Education England take the five year plans from LETBs, who in turn have taken five year projections from NHS projections from NHS providers. For approximately 110 workforce roles HEE then decides on whether to increase or decrease training commissions based on triangulation of the local planning forecasts with the national planning forecasts (as shown in the diagram below).

*Figure 1: Health Education England workforce planning process 2013*

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**HEE Workforce Planning Process 2013**

The CfWI is a key contributor to the planning of future workforce requirements for health, public health and social care in England. The CfWI is commissioned by the Department of Health, as well as Health Education England and Public Health England, to look at specific workforce groups and pathways, and to provide materials, tools and resources to inform workforce planning policy decisions at a national and local level such as those relating to the in-scope Joint Action professions (see, for example, CfWI, 2013).

Having clarified the statutory relationship between the Department of Health and Health Education England and explained the position of the CfWI as an independent organisation working on specific projects on their behalf, the remainder of this response refers to the 'Robust Workforce Planning Framework' (CfWI, 2014a and illustrated in Figure 2) which is used by the CfWI to conduct workforce planning and forecasting.

**Figure 2: Robust workforce planning framework**

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Source: CfWI, 2014a

**Northern Ireland**

In Northern Ireland, the responsibility for regional workforce planning for health workforce planning across Health and Social Care (HSC) is undertaken by the Department for Health, Social Services and Public Safety, in conjunction with the six Health and Social Care Trusts and the Health and Social Care Board (HSCB) – the commissioner. The Department recognises the importance of workforce planning in identifying appropriate staffing levels and structures. Local staffing arrangements are the responsibility of individual HSC employers, taking into account factors such as service needs and available resources. The Department has a role in ensuring that sufficient suitably qualified staff are available to meet the needs of the service overall. The Human Resources Directorate has in place a programme of comprehensive workforce planning reviews carried out at regional level across the main professions and a number of supporting groups in the HSC.

The main aims of the reviews are to establish information on the supply/demand dynamics relevant to the workforce group, thereby informing the Department's decision-making on the number of training places to be commissioned and to develop understanding of the issues impacting on the recruitment, retention and career progression of those employed.

The workforce planning cycle comprises a major review of each group periodically, supported by annual update reviews. The purpose of the annual update reviews is to maintain current workforce information and identify any new issues impacting on the workforce group thereby enabling any necessary action to be taken at an early stage.

**Scotland**

NHS Scotland has an overall structure of:

- 14 regional NHS Boards which are responsible for the protection and the improvement of their population's health and for the delivery of frontline healthcare services

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- Seven Special NHS Boards and one public health body who support the regional NHS Boards by providing a range of important specialist and national services

For workforce planning, The National Workforce Planning Guidance – CEL 32(2011) available at http://www.sehd.scot.nhs.uk/mels/CEL2011_32.pdf – was issued as a national guide to support an evidence-based framework for workforce planning. It is designed to support and assist those responsible for leading on workforce planning, in particular the development of workforce plans at service, NHS Board and regional level.

Scotland has a single healthcare system where NHS Boards manage all services in their Board area. The workforce planning process begins with the Local Delivery Plans due in March each year which describe the staffing capacity and capability requirements for the delivery of national targets.

Detailed NHS Board Workforce Projections for one and three years are submitted to the Scottish Government at the end of June each year. The template is issued to Boards in March each year. A primary function of this is to plan the Nursing and Midwifery Intake numbers with education. In the case of Nursing and Midwifery workforce projections, the Board Nurse Director should have professional oversight of the numbers and endorse these as part of the NHS Board Workforce Plan. NHS Boards should also provide details of the workload/workforce planning tools used (where available) in the planning of their nursing and midwifery workforce.

NHS Boards' Workforce Plan Narratives are published each August, these are required to be signed off by local Area Partnership Forums and Staff Governance Committees.
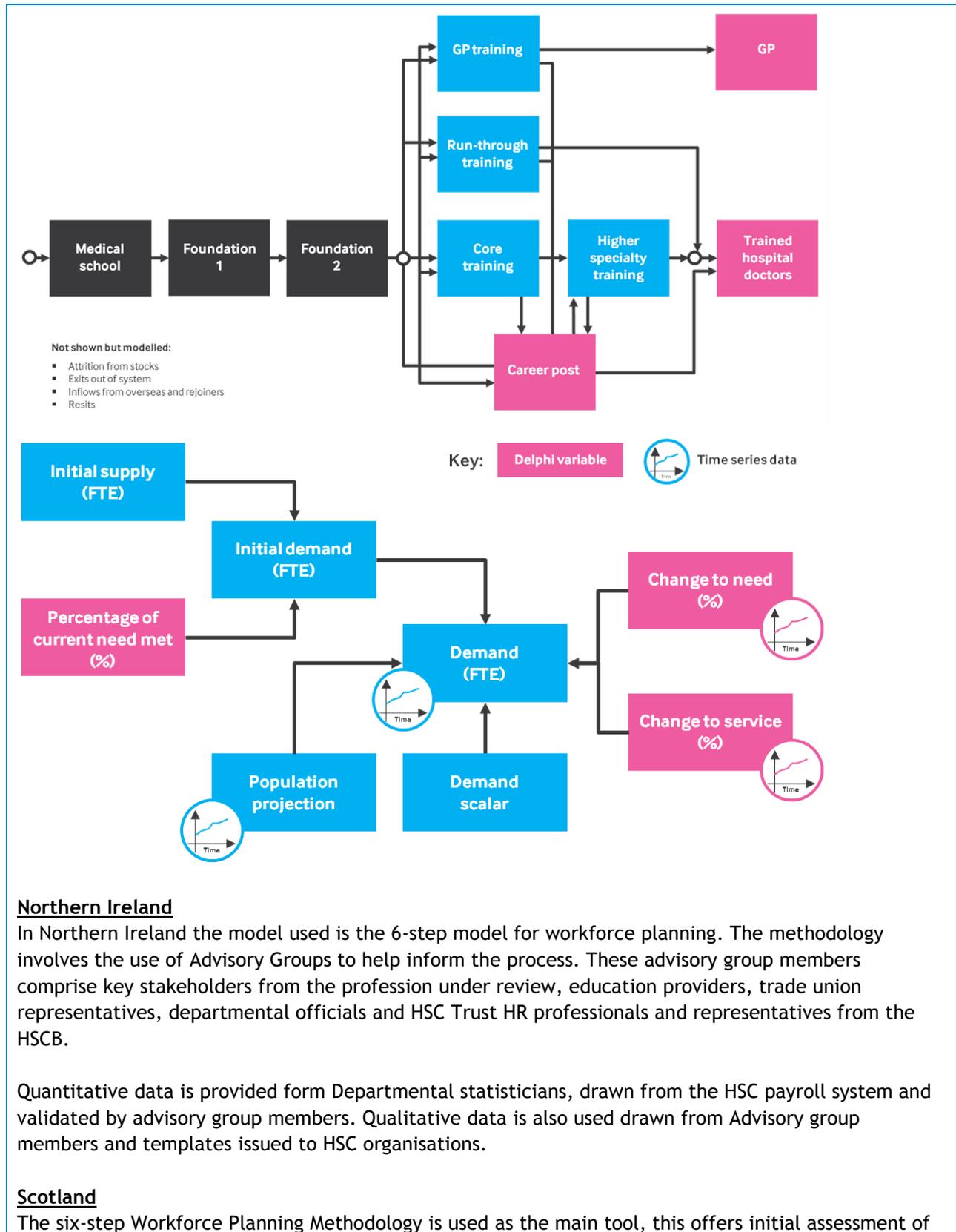
**Wales**
NHS Wales (seven Health Boards and three Trusts) currently undertakes an integrated medium term planning cycle (3 years) of which workforce planning is a core element.  This planning cycle uses an adaptation of Skill for Health's six-stage workforce planning process and provides predominantly qualitative information of the current and future workforce. This is for the whole workforce and covers acute, community and primary care services.  The six-steps model is supported by the Workforce Configuration Tool, which collects quantitative workforce data.

## Overview of the health workforce planning model

**England**
A description of the system dynamics model comes from the one used by the CfWI to quantify the future supply and demand of doctors as part of a project for the Department of Health to inform a Health and Education National Strategic Exchange review of the intake to medical and dental school is provided in the CfWI's *Technical paper No. 3* (CfWI, 2014b). The diagrams below show a high-level stock and flow diagram containing the key training and workforce stocks that make up the medical workforce model and the generic demand structure implemented in the medical model.

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### Northern Ireland

In Northern Ireland the model used is the 6-step model for workforce planning. The methodology involves the use of Advisory Groups to help inform the process. These advisory group members comprise key stakeholders from the profession under review, education providers, trade union representatives, departmental officials and HSC Trust HR professionals and representatives from the HSCB.

Quantitative data is provided form Departmental statisticians, drawn from the HSC payroll system and validated by advisory group members. Qualitative data is also used drawn from Advisory group members and templates issued to HSC organisations.

### Scotland

The six-step Workforce Planning Methodology is used as the main tool, this offers initial assessment of

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supply and demand. Further augmentation of this model is offered by a Tiered Model of assessing information; Demographics, & epidemiology – informs service model and service demand – informs workforce requirements – informs education needs.

The 5x5 Risk Matrix – which assesses risk by scoring the likelihood of a risk occurring and the impact this could have on service provision, the two scores are then multiplied to give a scoring for each risk, the higher the score the greater the risk to service provision – is also increasingly used by Board Workforce Planners, this enables the application of a consistent approach to workforce risk assessment, once this is fully utilised across NHSS it will allow for improved national aggregation of risk. The assessment of risk crosses capacity and capability and therefore quantitative and qualitative information.

The Nursing and Midwifery Workload and Workload Planning Tools are applied across a range of environments, and will be mandated in April 2014. Central to workforce planning is uniting capacity and capability intelligence as these core elements are inextricably linked to provide more robust intelligence
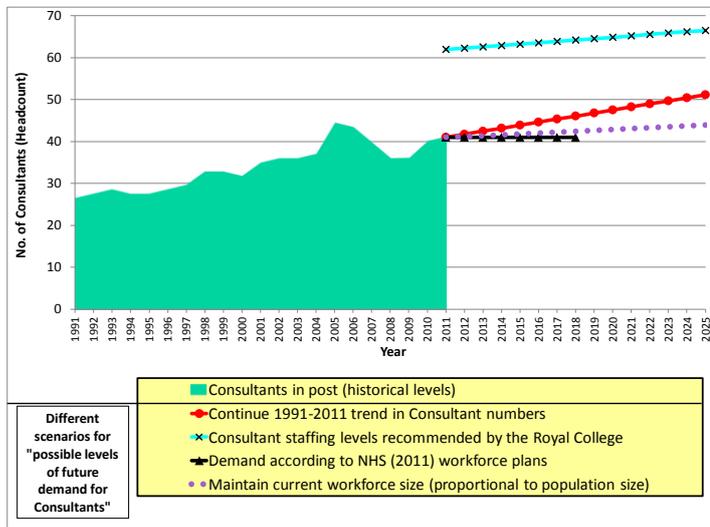
**Wales**

NHS Wales currently uses a version of the Skills for Health Six Step methodology, which has been adapted for use in Wales.  The steps look at the Strategic Environment, the current workforce, the future workforce, the education development and commissioning required to achieve the future workforce, the plan to achieve the future workforce and the engagement with other partners such as Social Services.

This methodology is a means, predominantly of gathering the qualitative information required for workforce planning.  A workforce tool is used to gather the quantitative workforce data to support the qualitative information within the plans.  Bothe the qualitative and quantitative information taken from the organisational plans are utilised to extract information on future education commissioning and educational development needs for NHS Wales.
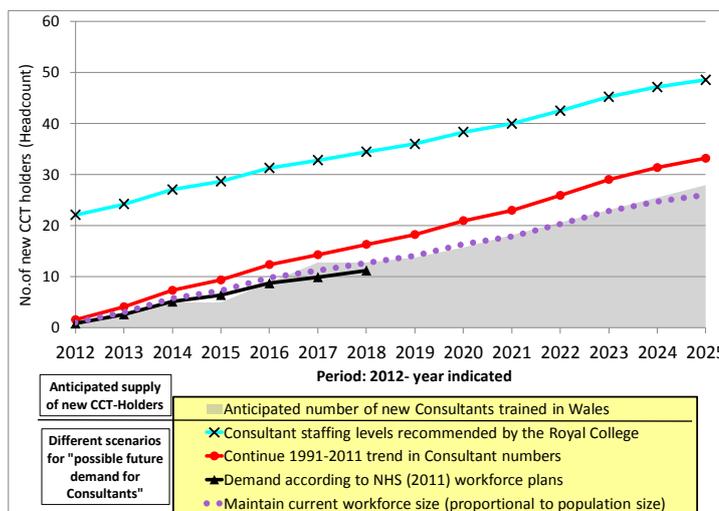
An extended model is used for forecasting supply and demand for medical and dental staff:
- This uses stock-flow models developed within NHS Wales to forecast the future supply of CCT-holders, dentists, Core Trainees and Foundation Doctors, and compare it against a range of demand scenarios (e.g. staffing forecasts created by Local Health Boards/Trusts, continuing historical growth trends, meeting staffing guidelines set by various Royal Colleges).
- Most of the modelling work undertaken relates to forecasting the supply/demand for CCT-holders.  The model built to do this allows different variables to be adjusted (e.g. duration of specialty training, consultant retirement age, consultant vacancies, attrition from training, migration of new CCT-holders into/out of Wales etc) and graphically shows the effect of this change on Wales' anticipated supply/demand for CCT-holders.
- The data and assumptions used in the models are validated by a range of stakeholder groups and networks (e.g. Royal Colleges, Deanery, specialty-specific networks). Specialty-specific forecasts are then produced comparing Wales' future supply for CCT-holders against the various demand scenarios.
- The model produces two main graphs, examples of which are given below:

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1) Illustration of different scenarios for Wales' future demand for consultants in specialty X



**Different scenarios for "possible levels of future demand for Consultants"**

- Consultants in post (historical levels)
- Continue 1991-2011 trend in Consultant numbers
- Consultant staffing levels recommended by the Royal College
- Demand according to NHS (2011) workforce plans
- Maintain current workforce size (proportional to population size)

2) Comparing Wales' anticipated supply of newly-trained consultants against the number needed to meet each of those demand scenarios



**Anticipated supply of new CCT-Holders**

**Different scenarios for "possible future demand for Consultants"**

- Anticipated number of new Consultants trained in Wales
- Consultant staffing levels recommended by the Royal College
- Continue 1991-2011 trend in Consultant numbers
- Demand according to NHS (2011) workforce plans
- Maintain current workforce size (proportional to population size)

## Qualitative data collection

**England**

With reference to the CfWI's robust workforce planning framework, the following data collection methods are used:

Horizon scanning – semi-structured one-to-one or telephone horizon scanning interviews are conducted with experts and stakeholders, identified because of their expertise on the workforce in question. Representatives are sought from different perspectives and from organisations involved in the commissioning, standard setting and regulation of the profession or specialty, as well as practising professionals and service users.

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Scenario generation – facilitated workshops are used to generate scenarios and Delphi processes are used to quantify scenario variables.

Workforce modelling – for example, the model is validated with stakeholders.

**Northern Ireland**
A range of different types of qualitative data is used based on the professional group under review. Where the workforce is mainly based in the statutory sector, templates are issued to each HSC Trust with 'prompt questions' under a range of themes, such as recruitment and retention issues , future service planning and future workforce development.

Where the workforce is non-statutory in the main it is much more difficult to access robust information however stakeholder interviews are conducted and anecdotal evidence gleaned where possible.

Focus groups can also be used as appropriate.

The advisory group convened under each review provide an excellent source of information in respect of front-line working.

*Stage in the planning process:*

Steps 1-4 of the six-step process. Usually collection of the qualitative data follows compilation of the quantitative data so that comparison can be made between the statistical information and the anecdotal evidence.

*How the qualitative data is collected:*

Methods used in the past include: Templates, telephone and paper surveys, face to face interviews with Key contacts in the profession such Chief Nursing Officer and Nursing workforce leads, as an example, advisory group meetings.

*Collection of qualitative data:*

Stakeholders are identified because of their expertise on the workforce in question. Representatives are sought from different perspectives and from the organisation involved in commissioning, standard setting, and regulation of the profession or specialty, as well as practising professional and on occasion, students.

**Scotland**
Within The National Workforce Planning Guidance CEL32 (2011) there are a number of the stages which require qualitative information to inform workforce requirements. Consultation with staff needs to be demonstrated within Boards as part of the NHSScotland Staff Governance Standard and the final workforce planning narrative.

In assessing workforce requirements it should be noted that it is difficult to separate the qualitative from the quantitative as skill availability impacts on workforce numbers and vice versa.

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The Tiered Model necessitates the qualitative debate takes place to inform the education models.

The qualitative information is collected in a range of formats across NHSScotland. We have some small islands so in this instance information and detail will be locally known, in larger Boards a range of consultative models consistent with the Staff Governance Model will be applied.

These conversations enable the debate to examine both capacity and capability.

*Stage in the planning process:*

Information is collected throughout the year. NHSS has a National Workforce Planning Forum were workforce planners from each Board are represented; this promotes engagement and qualitative discussions in an ongoing basis. The forum has three workstreams:
- Information and intelligence
- Modelling and Profiling
- Workforce Planning Education

The application of CEL32 also promotions conversations within Boards throughout the year.

*How the qualitative data is collected:*

The information is collected in different formats within Boards as described above, and will be reflected in their workforce narrative

*Collection of qualitative data:*

The collection of qualitative data or information is dependent on the work, and the information could come from a range of sources such as specialist projects, NHSScotland Board workforce planning leads, Local redesign projects and Regional developments.

**Wales**
There is an all Wales formal structure to discuss the workforce – Strategic Education Development Group (SEDG) which looks at strategic workforce issues including workforce planning and education commissioning requirements and to ensure that there is wide and comprehensive engagement with the service with regards to the future educational requirements of the workforce.  This group is supported by a number of strategic sub groups to ensure that the requirements of the whole workforce are considered. Changes to the arrangements for SEDG have recently been announced by the Minister for H&SS.

The Welsh Government and NHS Wales also has a formal structure of meetings with different professional groups, trade unions and others where workforce issues, linked to service and scientific/technical developments are discussed and flagged up between professional groups and the service.   Again, these arrangements are currently under review.

These are the main current mechanisms for the discussion of qualitative workforce information.

The WEDS team also has its own network of individuals and groups (particularly in relation to medical &

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dental staff) which it uses to validate information and planning assumptions (e.g. Royal Colleges, clinical directors within NHS Health Boards/Trusts, Deanery leads).

Qualitative information and data is collected as part of the workforce planning cycle. Organisations capture this information typically during the Autumn and submit at the end of the financial year. The Welsh Government is currently reviewing the planning cycle and is about to introduce a fully integrated planning cycle across service, finance and workforce. This will tie the workforce planning cycle within the overall planning cycle for NHS Wales by 2014/15.

The WEDS team also collects qualitative data throughout the year via discussions with its more informal network of stakeholders.

Qualitative workforce information is collected via the workforce planning cycle and from discussions with the professional bodies via the above mentioned formal meetings structure. It is also collected via other meetings structures and the WEDS central team undertaking specific analyses on an ad hoc basis.

Apart from via the workforce planning templates, qualitative information is also collected by the Professional bodies and Wales-level networks (identified by asking stakeholder views on who best represents a particular specialty/staff group/service etc).

There are a number of recognised groups who provide advice to Welsh Government (e.g. Wales Scientific Advisory Group, Wales Therapies Advisory Group, Welsh Medical Committee, National Pathology Programme Board)

## Analysis of qualitative information
- How is qualitative information processed?
- Stages which use expert groups

**England**
Horizon scanning interview data is collated and used to feedback to participants at the scenario generation stage. Following scenario generation experts are invited to participate in a Delphi process which is used to quantify key workforce variables. These quantitative judgements are shared over two rounds to refine the variables.

Stakeholders and experts are used throughout the robust workforce planning framework, for example in the qualitative understanding of quantitative data, to validate assumptions, as well as at the defined stages of stakeholder and expert involvement in horizon scanning and scenario generation, as described above.

**Northern Ireland**
Qualitative data is themed and shared with Advisory Group members to allow sharing of best practice between HSC organisations and to stimulate and encourage debate between organisational representatives who may have opposing perspectives at times. This helps to provide a 360 degree view of the workforce. The Advisory Group members are also helpful in challenging the assumptions underpinning scenario generation.

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The expert groups would be the Advisory groups as described previously. They are identified at the outset of the project and each project has a different set of stakeholders.

**Scotland**

The use of the data very much depends on the reason for collection or the purpose of examining it. Workforce intelligence is constantly examined and assessed at local, regional and national level but it is not formally described as analysis. There are no formal tools other than the 5x5 Risk Matrix and Nursing & Midwifery Tools described above.

Professional judgement and experience describe the main application and different pieces of work use expert groups to bring context and specialist intelligence to specific pieces of work such as Emergency Medicine and Unscheduled care.

**Wales**

WEDS has analysed qualitative data to verify changes in student numbers for a number of professions (PESTLE analysis using multiple qualitative data sources).

Work has commenced to produce workforce summaries for certain non-medical groups and WEDS intends to explore the use of scenario-generation methodologies

Discussions with clinicians and other stakeholders are used to validate data/assumptions used in WEDS' medical workforce summaries and consultant supply/demand forecasts. Due to Wales' size, this typically involves a small number of stakeholder groups for each specialty. Consensus on issues such as what values to use for modelling assumptions are therefore typically reached organically, rather than using specific methodology.

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