The King's Fund>

Ideas that change health care

Workforce planning in the NHS

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1 Introduction

The NHS workforce – an estimated 1.4 million people[1] – is the primary driver of future health costs. The economic and demographic challenges facing the health system in England are intensely felt by the health care workforce delivering services on the front line. Given that around 70 per cent of recurring NHS provider costs relate to staffing, and that the NHS is one of the world's largest employers, it is vital that the service invests in making the best use of staff to ensure they can deliver the care required by patients into the future. Focusing attention on this workforce is essential to addressing cost pressures and the delivery of future care models such as those outlined in the *NHS five year forward view* (Forward View) (**NHS England *et al* 2014**).

This report explores experiences with workforce planning, and how they align with strategic policy in a number of areas: mental health, general practice and community nursing. All three are key to the delivery of more integrated care, delivered in the community and central to delivering the care models outlined in the Forward View. We examine available data sets alongside interviews with expert stakeholders to consider recent workforce trends and how they align with these broader policy ambitions. We consider how these processes and strategies align with a changing approach to workforce planning at a local and national level, eliciting lessons for how to align workforce with policy ambitions to fundamentally change the organisation and delivery of health care (**NHS England *et al* 2014**).

Health and social care needs have changed substantially over the past two decades, mainly due to rising levels of chronic and complex conditions and an increase in the number of older people who need long-term care. Changing demographics and continued inequalities in outcomes and access to health care have also played a role. During this time, numerous policies have aimed to directly or indirectly affect workforce numbers and patterns of care provision. They include Transforming Community Services (launched in 2009), which led to an increase in the proportion of community health care delivered by voluntary and independent sector providers. More recently, the Francis Inquiry has led to a greater focus on increasing the nursing workforce in secondary care.

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1 In addition to administrative and unqualified staff, in 2014 the NHS employed 150,273 doctors, 377,181 qualified nursing staff, 155,960 qualified scientific, therapeutic and technical staff and 37,078 managers (2014 figures). NHS Confederation website, 'Key statistics on the NHS', www.nhsconfed.org/resources/key-statistics-on-the-nhs

This report draws together national statistics, key publications and interviews with expert stakeholders. Section 2 describes what is happening in the workforce now by exploring some of the main trends, focusing on three areas – mental health, primary care and community nursing – alongside an assessment of the current increasing reliance on temporary staff and regional variations. Section 3 discusses how workforce issues have been addressed across the system up until now. Section 4 discusses the main challenges to current workforce planning, and Section 5 concludes with recommendations for change.

There is an immediate pressure to ensure that existing workforce numbers are sufficient to meet current demand, but there also has to be a longer-term consideration of whether the current composition of the workforce can achieve the ambitions of future care models. Given the clinical and financial importance of developing a workforce that is fit for purpose, and the cost and complexity of workforce planning itself, it is vital that we really understand the nature of workforce pressures and what can be done to address them in both the short and the long term.

There are large data gaps on key areas of the workforce, particularly primary and community care, use of agency and bank staff, vacancy rates, and independent and voluntary sector providers. The information needed to guide workforce planning at local and national levels has failed to keep pace with the growing plurality of providers delivering NHS-commissioned services.

Our analysis demonstrates the need for a more joined-up approach to overseeing and managing the current NHS workforce. This requires a number of changes at a national level to support providers as they develop strategies locally and across health systems. At local level, there is no single solution to address immediate workforce challenges. Rather, providers will need to consider a range of sustainable strategies – individually and in partnership with others in their local health economy.

Key workforce drivers

Short-term pressures

The NHS clinical workforce is a unique asset for which the consequences of imbalance or insufficient supply can be significant and persistent. Workforce shortages are difficult to rectify quickly because of the time it takes to train staff

(three years to train a nurse and up to 15 years to train a medical consultant). The complex and highly technical nature of many clinical roles also means that staff trained in one discipline cannot be redeployed to fill shortages in another.

The consequence of undersupply is unmet need, which negatively affects outcomes, quality of care and the patient experience, while oversupply can lead to unemployment and wasted resources. Training the medical and nursing workforce requires considerable investment by taxpayers and the individuals concerned, so it is inevitable that workforce planning will come under close scrutiny, particularly at times of financial constraint. Finally, rising pay due to shortages or gaps in service provision may not only be unsustainable but have wider implications for public sector pay policy.

Delivering new models of care

The care models outlined in the Forward View emphasise integrated out-of-hospital care based on general practice (multispecialty community providers), aligning general practice and hospital services (primary and acute care systems), and closer alignment of social and mental health services across hospital and community health settings. These ambitions require a workforce that reflects the centrality of primary and community care and the need for more 'generalism'; is able to deliver increased co-ordination across organisational boundaries; and can address inequalities in treatment and outcomes across physical and mental health services.

The uncertainty around predicting long-term workforce needs, alongside policy ambitions to radically change the organisation and delivery of care, indicate a need to build a flexible and adaptable workforce. The workforce of the future needs to be able to take on a greater breadth of tasks to meet increasingly complex patient needs while working across different care settings and in teams of multidisciplinary providers. The challenge for the health service is to ensure that there is sufficient staff for current models of care while also moving towards this very different future.

The next section explores some of the current workforce trends across mental health, primary and community care, highlighting disconnects between those trends and the ambitions for a different service.

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❷ What is happening in the workforce now?

In this section we review recent experience in three areas of the workforce that are critical to the strategic direction set out most recently in the Forward View: mental health, primary care and community nursing. The ambitions to provide better mental health and out-of-hospital services are not new; providing better care for people with mental health problems has been a policy focus for many years, encapsulated in the 2011 White Paper, *No health without mental health* (**Department of Health 2011b**); and the aspiration to deliver more and better services in primary and community settings was the cornerstone of the 2006 White Paper, *Our health, our care, our say* (**Department of Health 2006**). However, evidence suggests that the NHS has struggled to realise these service and outcome objectives when it comes to the workforce. Combining the lessons from this struggle with an assessment of the current reliance on temporary staff, we go on to draw out recommendations for the future relevant to the Forward View but also to strategic planning more generally. (*See* box below for more information on the sources of data used in this section.)

Data sources

The main source of data in this section is the Health and Social Care Information Centre's (HSCIC) 'NHS Workforce Statistics', produced monthly. This dataset is based on extracts from the NHS electronic staff record, which launched in September 2009. We examine five years of data, from September 2009 to September 2014. The data includes any member of staff who had a return submitted to the electronic staff record during this period, and so includes almost all NHS staff, though not all voluntary and independent sector workers.

We have also been given access to data by NHS Professionals, one of the main providers of bank and agency staff in England. These staff are not included in electronic staff record returns, so this data allows us to bridge at least some of the gap within the HSCIC data set. NHS Professionals is not the only provider of temporary clinical staff in England, but the sample they have provided allows us to approximate the level of demand for temporary staff over time and in several different areas of care.

We also interviewed a range of expert stakeholders from Royal Colleges and national agencies and held discussions with a number of NHS trusts. We have combined their insights with published reports, secondary analyses and literature.

Mental health services

The Forward View highlights mental health as the largest cause of disability in England. It is also one of the greatest areas of inequality in health outcomes – people with prolonged or severe mental illness die 15–20 years earlier, on average, than other people. For these reasons, parity of esteem between physical and mental health services was enshrined in the Health and Social Care Act 2012. Yet continuing concerns have recently led the Royal College of Psychiatrists to set up an independent commission to review the provision of adult inpatient psychiatric care to assess whether the system has sufficient capacity.

One area of mental health has been the focus of targeted action. The Improving Access to Psychological Therapies (IAPT) programme – piloted in 2006 with people of working age but broadened to include all adults in 2010 and extended to children and young people in 2012 – has changed the organisation and delivery of mental health services related to talking therapies. The programme has national targets, and has seen a major co-ordinated push to increase the number of trained staff and improve outcomes for all vulnerable people.

Outside IAPT, the picture on mental health services is less clear. This is partly because independent and voluntary sector providers deliver a considerable amount of mental health care in England. They account for about 20 per cent of the mental health budget: £1.72 billion compared with £7.08 billion for NHS providers (Lafond 2014).

While the data provided by HSCIC covers NHS providers, there is relatively little data on the independent and voluntary sector workforce in mental health. This subsection presents what we know about the total mental health workforce, highlighting inconsistencies or knowledge gaps. We begin with the medical workforce.

Mental health medical workforce

Figure 1 Yearly total full-time equivalent (FTE) psychiatry doctors (average total FTE psychiatrists by grade), September 2009 to September 2014

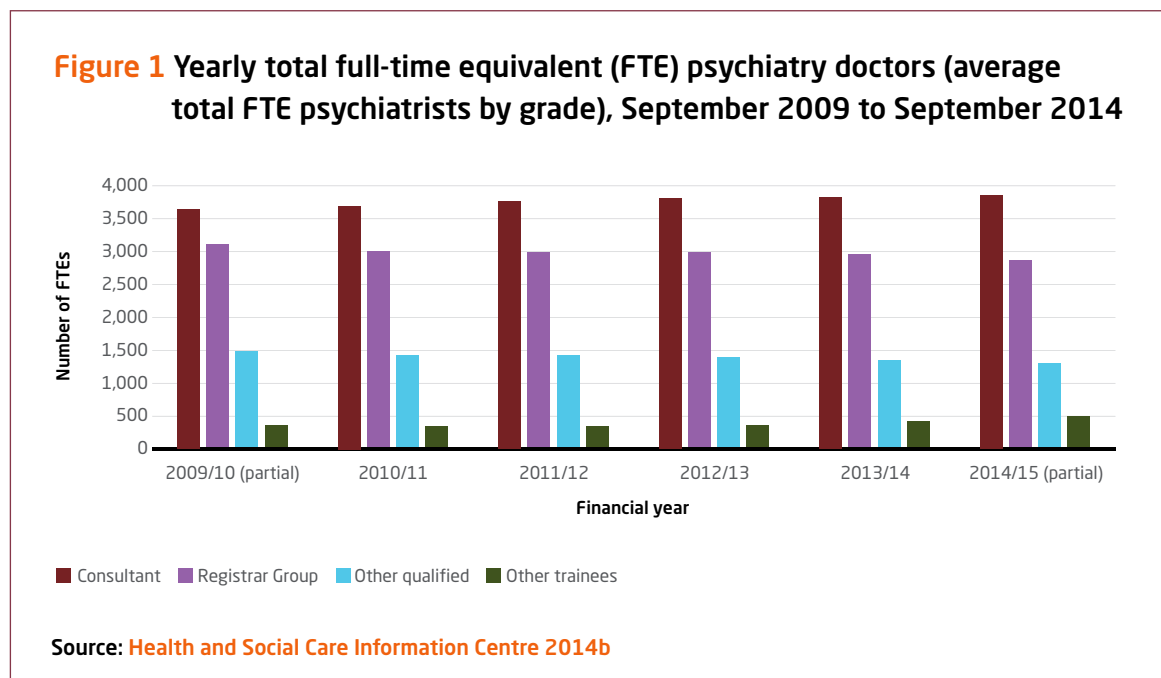Source: Health and Social Care Information Centre 2014b

Figure 1 shows changes for all grades of psychiatry doctors over the five-year period, broken down into trainee roles (covering registrars and all other grades of trainee psychiatry doctor) and fully qualified roles (covering consultants and all other qualified grades). The number of consultant full-time equivalents (FTEs) has increased by 6 per cent (to 215 FTE). While the number of FTEs in the registrar and other qualified staff categories has fallen, the total number of FTE psychiatry doctors has generally remained steady. The Centre for Workforce Intelligence (2014b) identified two key indicators of pressures in the psychiatry workforce, as follows.

- There is a high vacancy rate in psychiatry consultant posts (6.3 per cent) (Health Education England 2015).

- Nearly one in five doctors undertaking core psychiatry training in 2014 did not progress into higher specialty training.

Looking back over the past decade or so, 10 years of growth in the number of FTEs (amounting to 40 per cent) meant that, by 2013, there were 4,084 FTE consultant psychiatrists in total (Centre for Workforce Intelligence 2014b). However, this was the lowest rate of growth across all specialties, and nearly 10 percentage points lower

than growth in the total consultant workforce – a disparity that continues. The Centre for Workforce Intelligence (2014b) attributes this to the high consultant attrition rate for psychiatry, which at 3.3 per cent (for those aged under 53) is higher than the rate for all NHS consultants.

Historically, there have generally been low recruitment rates into psychiatric training (Royal College of Psychiatrists 2012), although the situation had improved by 2014 according to unpublished data from the Royal College (Centre for Workforce Intelligence 2014b). Psychiatry tends to be regarded as a less attractive career path, associated with lower status and pay, perceived as 'unscientific' and requiring interaction with 'difficult' patients (Royal College of Psychiatrists 2012). However, the British Medical Association's (BMA) cohort study found that, after qualifying, doctors working in psychiatry were most likely to indicate they were happy with their choice of specialty (British Medical Association 2014).

Mental health nursing workforce

Figure 2 Indexed trend in FTE psychiatric nursing staff, September 2009 to September 2014

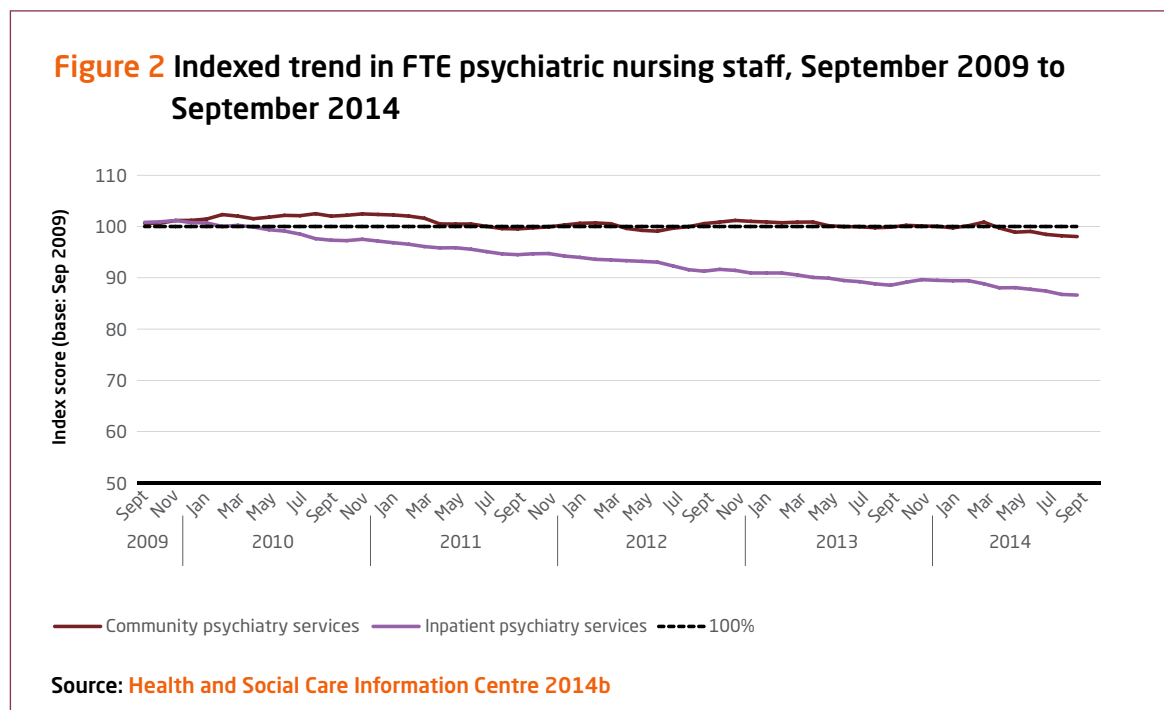Source: Health and Social Care Information Centre 2014b

Figure 2 shows the indexed trends in community and inpatient psychiatric nursing FTEs over the five-year period. Inpatient nursing numbers have fallen consistently, by 15 per cent, with a more gradual decline in the number of community mental

health nurses. This is in a context of small increases in the overall size of the nursing workforce.

A recent report from the Royal College of Nursing (RCN) (**2014**) showed that, since 2010, the nursing workforce in mental health (which comprises just over 12 per cent of the total NHS nursing workforce) has also experienced 'de-banding' – that is, a larger fall in the number of staff in senior roles (band 8 FTEs fell by around 18 per cent over the same five-year period).

The RCN explains that the HSCIC data (on which its analysis and our own analysis are based) may be overstating the reduction in mental health nurse employment, as some nurses have transferred over to voluntary and independent providers – some of which are not counted in the data but are still employed in NHS-commissioned services (**Royal College of Nursing 2014**). It is likely that this primarily affects inpatient services and their associated workforce. As noted, HSCIC data excludes many of those working in the independent sector; it is therefore possible that reductions in NHS nurse staffing have been partially offset by increases in non-NHS providers, given evidence of recent growth in this sector. However, even taking this growth into account, the NHS still accounts for 81 per cent of overall mental health provision (**Lafond 2014**). Very rapid growth would be required in the independent sector to offset such consistent declines in the NHS.

While the big rise in the use of agency staff in acute nursing over the past three years is well known (*see* Figure 7 on page 19), recent data suggests that this phenomenon has also spread to mental health providers. Figure 3 shows a big rise in demand for temporary staff by mental health trusts (particularly notable since 2013), based on data for the period between April 2009 and January 2015 (this was provided by NHS Professionals, one of the leading providers of temporary staff to the NHS).

Requests for temporary mental health nursing staff have increased by two-thirds since the beginning of 2013/14. The future supply of mental health nursing staff may also be constrained, as Health Education England expects the ageing profile of the mental health workforce to start slowing its growth from around 2017 as more people leave due to retirement (**Health Education England 2014**). Yet, as part of its commissioning process for mental health nurses, Health Education England reported a very small increase in demand from providers for nurses in 2014/15 (possibly consistent with the rise in agency costs) followed by a sustained predicted

Figure 3 Agency and bank staff requests from mental health trusts, April 2009 to December 2014
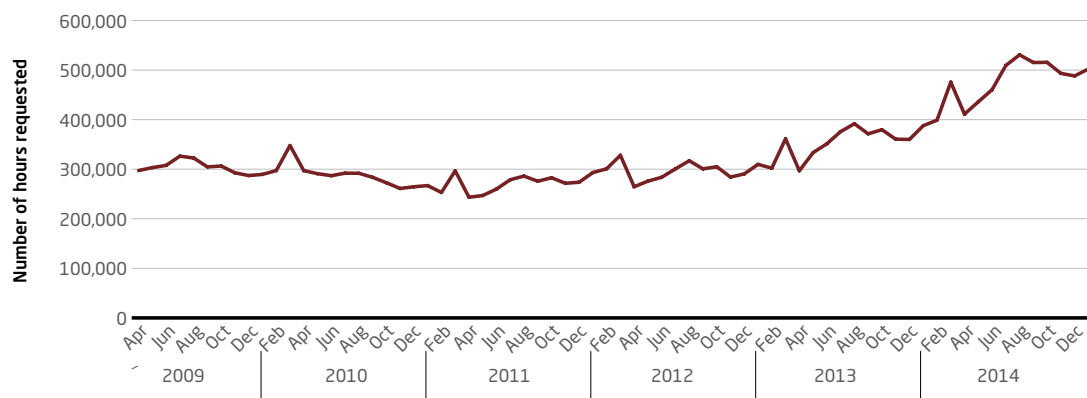
Source: Data extract of main records provided by NHS Professionals.

fall every year after to 2019. This is consistent with responses to a survey by The King's Fund (Appleby *et al* 2014) on plans for further nurse recruitment in which one mental health provider noted its plans to reduce its clinical staff, and a second was also reducing overall posts and only recruiting in order to reduce its reliance on agency staff. This was in sharp contrast to the ongoing recruitment plans of most acute providers. While some of this difference may reflect a continuing switch to independent providers, it does not seem consistent with the policy on parity of esteem. As a result, instead of commissioning fewer mental health nurses, Health Education England has chosen to commission more (Health Education England 2015).

The experience with mental health staffing, in recent years as well as over a longer timescale, suggests a number of challenges to workforce planning in its broadest sense.
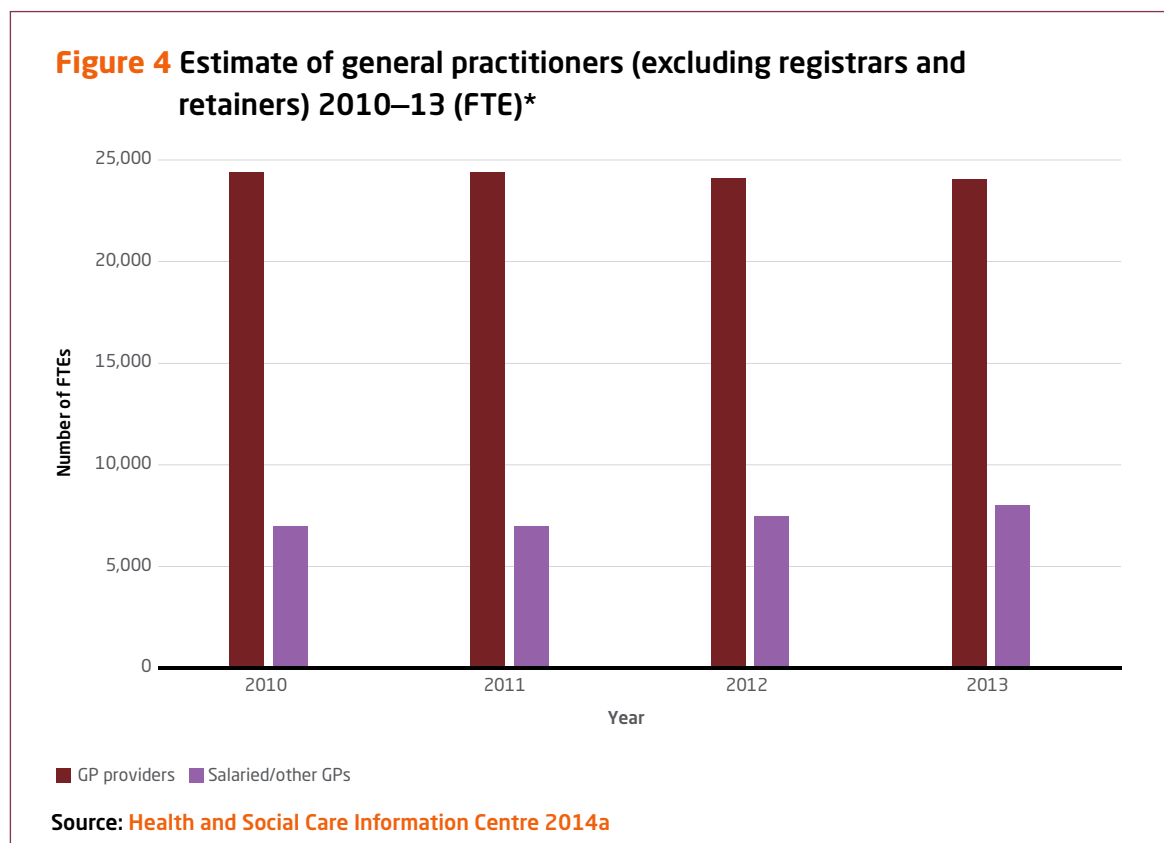
- Where the independent sector plays a major role in delivering care, it is difficult to assess current or future workforce needs because it is largely excluded from workforce data. This presents particular challenges for Health Education England, which is responsible for the future workforce of NHS-*commissioned* care, not NHS-*provided* care.

- In the mental health workforce (medical and nursing), it is difficult to see any dramatic impact of the strategic goal to prioritise mental health other than IAPT. That this does not simply reflect the time it takes to train new staff is

underlined by the low (and falling) numbers of staff that service providers have said they want up until 2019 (despite emerging problems with increased reliance on agency staff). The driving factor behind this may be affordability: providers can only employ staff for services paid for by commissioners; the pattern up until 2014 and provider forecasts to 2019 suggest that the greater strategic priority given to mental health may not be translating into extra funding for staff numbers on the ground. This represents another major disconnect between policy and workforce planning.

Future delivery of primary care

Future care models such as those outlined in the Forward View and described in recent reports by The King's Fund (Addicott and Ham 2014; Robertson *et al* 2014) all emphasise the centrality of primary and community care, and a more adaptable

Figure 4 Estimate of general practitioners (excluding registrars and retainers) 2010–13 (FTE)*

Source: Health and Social Care Information Centre 2014a

* Figure 4 is taken from HSCIC's report on GP practice staffing, and has data on GP practitioner FTEs since 2003. However, a change in the estimation of headcount figures means that there may be a break in the data in 2010, making it more accurate, but incomparable with that which was estimated before. Direct comparisons should not be made between any time period after 2010 and any period before then. The most recent data only covers the period 2010–13, so no information is available for 2014 at the time of publication.

and multidisciplinary workforce. The data (*see* Figures 4 and 5) tells an interesting story about the workforce central to delivering this care: namely, GPs and community health nurses.
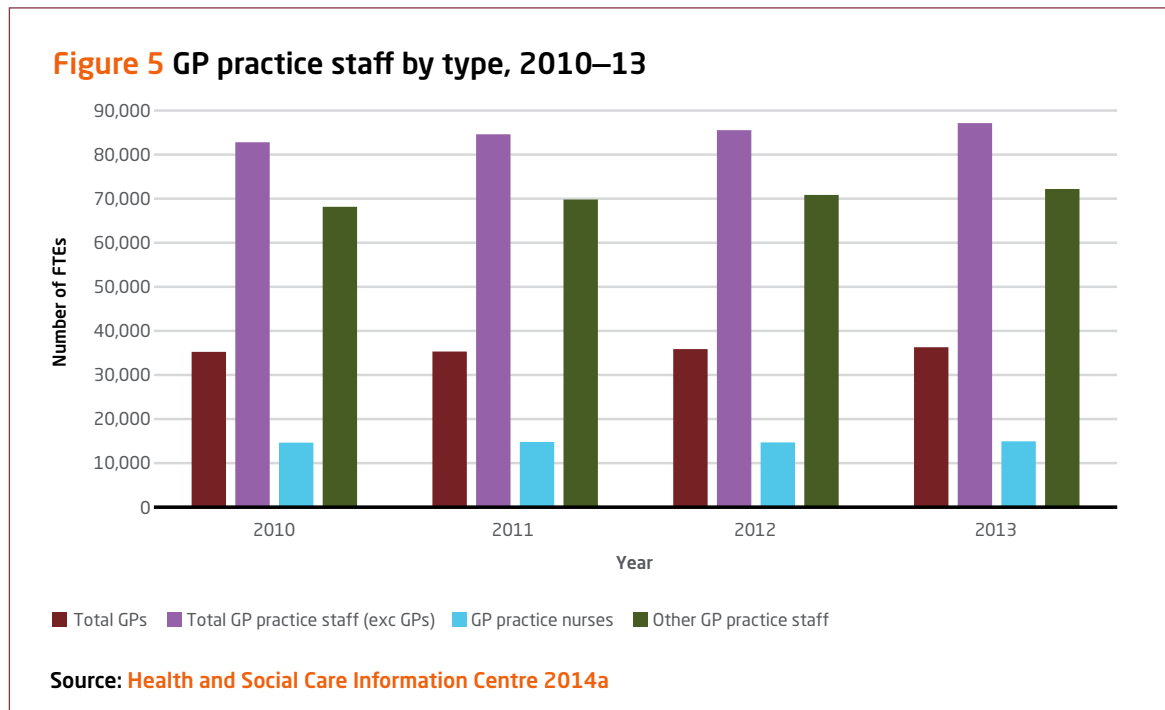
HSCIC provides estimates of the total number of staff employed as general practitioners or employed by a GP practice. These are derived from an electronic system that covers 90 per cent of GP practices, and HSCIC's own estimate of the other 10 per cent based on information provided by clinical commissioning groups.

The total number of GPs in England has increased by 2.3 per cent, from 31,356 in 2010 to 32,075 FTEs in 2013. But modelling by NHS England and the Royal College of General Practitioners (RCGP) has demonstrated that this rate of increase will not even come close to meeting future demand (Health Education England 2015). The Centre for Workforce Intelligence (2014a) has said that there is likely to be a significant undersupply of GPs by 2020 unless immediate actions are taken to redress the imbalance between supply and demand, as well as increasing training numbers for longer-term sustainability. Over the longer term, the rate of increase in the number of GPs has also been dramatically outstripped by increases in the medical workforce in secondary care. At face value, these workforce trends are at odds with the ambition of future care models to deliver more care in the community.

To meet the policy ambitions of Transforming Primary Care (Department of Health and NHS England 2014), the wider primary care team within the general practice setting will also need to expand. Here, we examine current workforce trends across these primary care teams.

Overall, the number of support staff increased by 5.2 per cent between 2010 and 2013, from 82,802 to 87,144 FTEs (*see* Figure 5). This was predominantly driven by an increase in the number of administrative staff and, to a lesser extent, those in the 'direct patient care' staff category (defined as 'anyone who is directly involved in delivering patient care but who is not a nurse or GP', which includes physiotherapists or pharmacists within the practice). The number of nursing staff has stayed relatively stable (just over 14,500 FTEs), an increase of just 2 per cent, following 10 years of more rapid growth (Dayan *et al* 2014).

Set against this context, the situation has been described as an 'emerging workforce crisis' (Dayan *et al* 2014). The RCGP estimates that the number of unfilled GP posts

Figure 5 GP practice staff by type, 2010–13

Source: Health and Social Care Information Centre 2014a

has increased fourfold since 2010, up to 7.9 per cent in 2013 (Kaffash 2013). In 2014, 12 per cent of GP training posts went unfilled (Health Education England 2015). And the number of GPs aged below 50 who plan to stop direct patient care within five years has increased (Dayan *et al* 2014).

In 2012, GPs reported lower job satisfaction than at any point in the previous 10 years (Hann *et al* 2013). Survey data and measures of workload and stress indicate significant pressures on GPs, who had the lowest morale among all medical graduate groups in the BMA's most recent cohort study (British Medical Association 2014). All this points to a profession increasingly perceived as unattractive by medical trainees as well as existing GPs. Undersupply and worsening morale pose a serious risk to current policy ambitions to shift to models of care that rely more heavily on delivery within a general practice setting.

These figures call into question the current and future capacity of general practice to deliver new models of care outlined in Transforming Primary Care (Department of Health and NHS England 2014) or the Forward View (NHS England *et al* 2014). Yet in some respects this is unsurprising; despite longstanding commitments to enhance primary care, there has been no clear attempt to rebalance the workforce into primary care settings; instead, general practice has drifted into crisis. The comparison

with the acute sector – where the commitment to reduce waiting times after 2000 led to a sharp and sustained increase in the number of consultants – is striking.

Why has it proved so difficult to balance supply and demand within the primary care workforce? Two factors have contributed.

- There are no clear ways to measure demand for primary care services. This is compounded by the absence of any recent measures of activity (the most recent national survey dates back to 2008). Recent analysis from the Nuffield Trust using a sample of GP records suggested only low growth in the number of appointments with GPs, although this study could not control for the rising complexity of illness in patients or for other aspects of a GP's role (**Curry 2015**). This difficulty in assessing the adequacy of the primary care workforce leaves policy-makers at risk of adding more and more responsibilities to primary care without a clear view of the pressures under which staff are working. A clearer view of the workload and workforce in primary and community services would also help to quantify the benefits of changing skill-mix in out-of-hospital settings. This could help to reduce pressures on existing staff as well as make better use of the skills of a wider group of clinicians. Recent moves by the RCGP and the Royal Pharmaceutical Society to enhance the role of pharmacists in general practice settings is one such example.

- As with mental health provision, broad national commitments to better out-of-hospital care (including primary care) have not translated into a combined commissioning and workforce strategy designed to increase the proportion of NHS resources (and staff) going into primary care. The share of NHS resources going into general practice has, in fact, been declining.

Future delivery of community nursing

Community health services have around 100 million patient contacts each year, account for approximately £10 billion of the NHS budget, and cover a huge range of essential services (**Lafond** *et al* **2014**). The sector includes a wide range of providers, from community nursing (district nurses, health visitors, paediatric community nurses and school nurses) to physiotherapists, occupational therapists, speech and language therapists, and podiatrists. With the strategic goal to increase the scale and scope of out-of-hospital services, we might expect to see rapid growth in the

community workforce. The available data does not allow a clear separation of the range of staff working in most community settings. Therefore, we restrict our analysis to health visitors, district nurses and community matrons but recognise the essential contribution made by the wider group of clinicians working in the community.

Community health services have been subject to recent reorganisation as part of the Transforming Community Services programme. In 2011, two years before their abolition, primary care trusts (PCTs) were required to separate their provider and commissioning arms. In response, community health service provision transferred to a range of different organisational forms and structures. Some providers established themselves as standalone NHS trusts; others merged with existing acute or mental health trusts; some established charities or social enterprises; and others were taken over by private sector providers (**Addicott 2011**). The independent sector has thus become a significant provider of community health services, and spending on non-NHS providers is increasing rapidly. For example, in 2012/13, 69 per cent of NHS spend on community health services went to NHS providers, 18 per cent to the independent sector, and 13 per cent to voluntary organisations and social enterprises (**Lafond *et al* 2014**). Here, we focus on nursing workforce trends within community health services.

Figure 6 shows the trend in the number of selected professionally 'qualified' community nursing groups between 2009 and 2014.[2] The total number of qualified staff has fallen slightly during this time, but the data reveals some complex patterns and changes.

The largest increase (22.7 per cent) was in the number of FTE health visitors, up to 10,167 in September 2014. This reflects the government's 2011 Health Visiting Programme (**Department of Health 2011a**), which aimed to support families with young children. Over the same period, the number of FTE community matrons fell to 84 per cent of the September 2009 level. The number of 'first level' (ie, most senior) district nurses also fell by 30 per cent over the same period.

The impact of the Transforming Community Services programme complicates the picture, because to some extent the decreases in community and district nursing staff will be explained by some staff transferring to non-NHS providers (which are generally not covered by HSCIC data, although this is not clear cut – some newly formed third sector providers continue to submit data to HSCIC). With the
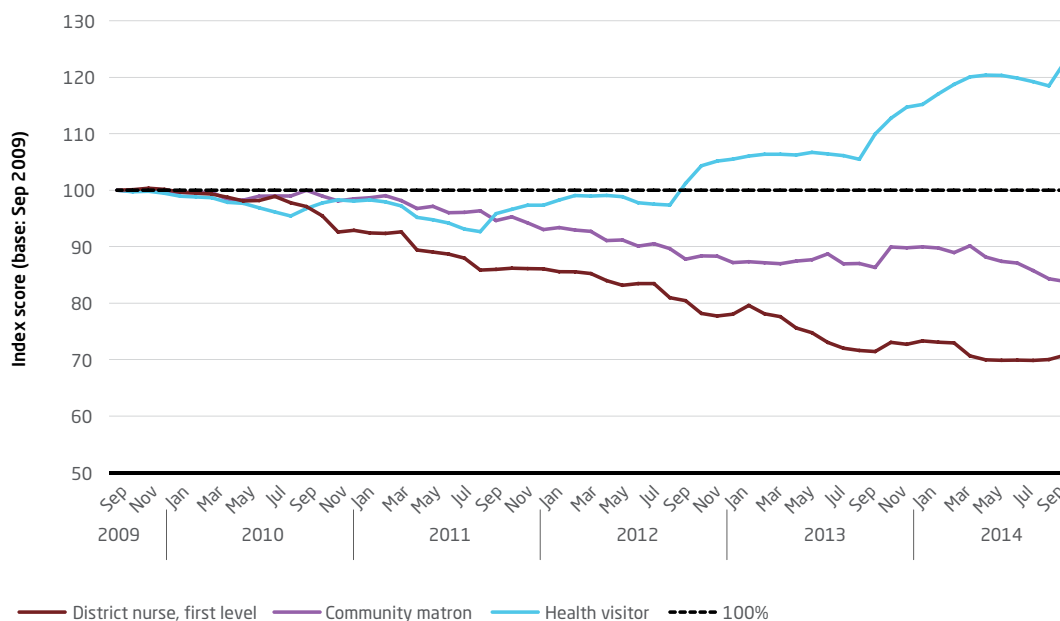
2 We have not included unqualified or non-clinical 'support' staff, health care assistants, managers or administrators.

Figure 6 Indexed change in FTE community staff by role, September 2009 to September 2014

Source: Health and Social Care Information Centre 2014b

programme officially coming into force only in March 2011, the Department of Health reported an associated reduction in PCT staff costs over this transition period, from £7.4 billion in 2010/11 to £2.4 billion in 2011/12 (Department of Health 2012).

Using additional data from HSCIC, we can see that during the implementation of Transforming Community Services, a higher proportion of community nurses left their post to transfer to a non-NHS provider. Between April 2011 and September 2012, for example, 25 per cent of level one and level two district nurses who were leaving their posts but not transferring to another NHS trust, were moving on to employment with a non-NHS provider. In contrast, from September 2012 to September 2014, only 7.6 per cent of staff not moving to an NHS trust were leaving for another (non-NHS) organisation. This suggests that the main impact of Transforming Community Services was relatively time-limited.

While Transforming Community Services may account for some of the decrease in staff numbers, it does not fully explain the apparent decline in the number of community matrons and district nurses, which pre-dated the programme. Through our interviews for this analysis, the RCN indicated that there has been an actual decline in the overall number of district nurses since the introduction of Transforming Community Services. However, other national leaders suggest that these patterns reflect deliberate attempts to redesign the community nursing workforce – to introduce a broader skill-mix and range of qualifications to ensure that the patient receives care from a nurse with the appropriate level of skill to meet their needs.

Health Education England recently reported a nursing vacancy rate of 6.5 per cent (which includes adult nursing for the acute and community sectors) (**Health Education England 2015**). In the wake of the Francis Inquiry, demand for nurses within the acute sector has risen considerably, and Health Education England reports that this has caused a slowdown in the previous trend that saw nurses moving in the other direction (from acute to community nursing): 'Although we are training enough nurses to work in both acute and community settings, employers tell us that the post-Francis expansion in acute based nursing means that nurses are not moving from secondary to community care at the rate previously observed' (**Health Education England 2015**, p 6).

Some of our expert interviewees also believed that community staff were being absorbed by the acute sector as it attempted to expand. They suggested additional explanations for these patterns across community nursing, including the reclassification or relabelling of existing roles, and leavers being replaced by lower grade nurses or health care assistants.

As with primary care, there is incomplete information on demand for community services or current vacancy rates. A recent study by Foot *et al* (**2014**) raised serious concerns about workforce pressures within community services, with staff shortages a recurring theme. According to one interviewee in that study, there is a 15–20 per cent vacancy rate in all nursing teams in the community sector. When combined with evidence from the acute sector and mental health, this underlines a general cross-sectoral difficulty in nurse recruitment. Planning and managing the community services workforce is particularly challenging, largely due to the volume of demand and increases in patient acuity; it is exacerbated by patients being discharged earlier into the community to relieve pressure on acute services.

Foot *et al* (**2014**) also found that a number of community providers expressed concerns over ensuring adequate nursing staffing numbers, skill-mix and caseload. Some interviewees suggested that temporarily closing the district nurse training course in recent years has had a disastrous effect on the supply pipeline, while others had encountered specific problems in recruiting nurses and had increased their use of agency staff in the meantime, at significant cost. Respondents became even more negative when talking about the future, suggesting that recruitment issues were likely to worsen as many nurses approach retirement age and fewer nurses seem to enter training or develop specialist skills. This is particularly worrying given the recent emphasis on supporting people to live in their own homes and offering a wider range of housing options in the community, as well as making more effective use of community health services and related social care, and ensuring that these services are available 24/7.

Yet the recent difficulties in recruiting nurses to community services are not a new phenomenon. In 2012, the RCN found that the policy rhetoric to shift care into the community had not been supported by a corresponding shift in the workforce to support that care (**Royal College of Nursing 2012**). More than 10 years earlier, in 2001, 14.5 per cent of the nursing workforce was designated as community, rising just 0.6 percentage points to 15.1 per cent in 2011 (in the context of nearly 20 per cent growth in nursing numbers overall).

The recent experience with recruiting community nursing staff reinforces the lessons for workforce planning from mental health and primary care.

- Data on the community workforce has not kept pace with the development of a more pluralist market. This is particularly problematic given the policy impetus of Transforming Community Services and subsequent tenders of community services by commissioners.

- Notwithstanding these data gaps, it appears that, despite longstanding aspirations to raise the level and range of services provided in the community, it is difficult to see any increases in the key staff groups covered here. As with mental health, increases in the workforce have been limited to areas with specific national targets: health visitors in community services and IAPT in mental health.

Reliance on a temporary workforce

The RCN recently submitted Freedom of Information requests to NHS providers of acute, community and mental health services about their spending on agency nurses since 2012/13 (**Royal College of Nursing 2015**), to indicate the extent to which employers are having to resort to agency staff to fill workforce gaps. Of the 73 per cent (168 of 231) of trusts that responded, expenditure on agency staffing in 2014/15 was already 50 per cent more than the previous year. The RCN estimated that those trusts would have spent £714 million by the end of the financial year – up from £485 million and £327 million in 2013/14 and 2012/13 respectively. Extrapolating to the non-responding trusts, the RCN estimated that a total of £980 million would be spent on agency staffing by the NHS in England in 2014/15. Monitor and the NHS Trust Development Authority have also repeatedly identified rising agency spend as a key driver behind the deteriorating finances of acute trusts. The consequences of this recent trend – in terms of higher wage bills, poor continuity of care and low staff morale – underline the urgency with which this particular workforce challenge needs to be addressed. Here, we present our own analysis of agency nursing requests from acute trusts, based on data provided by NHS Professionals.
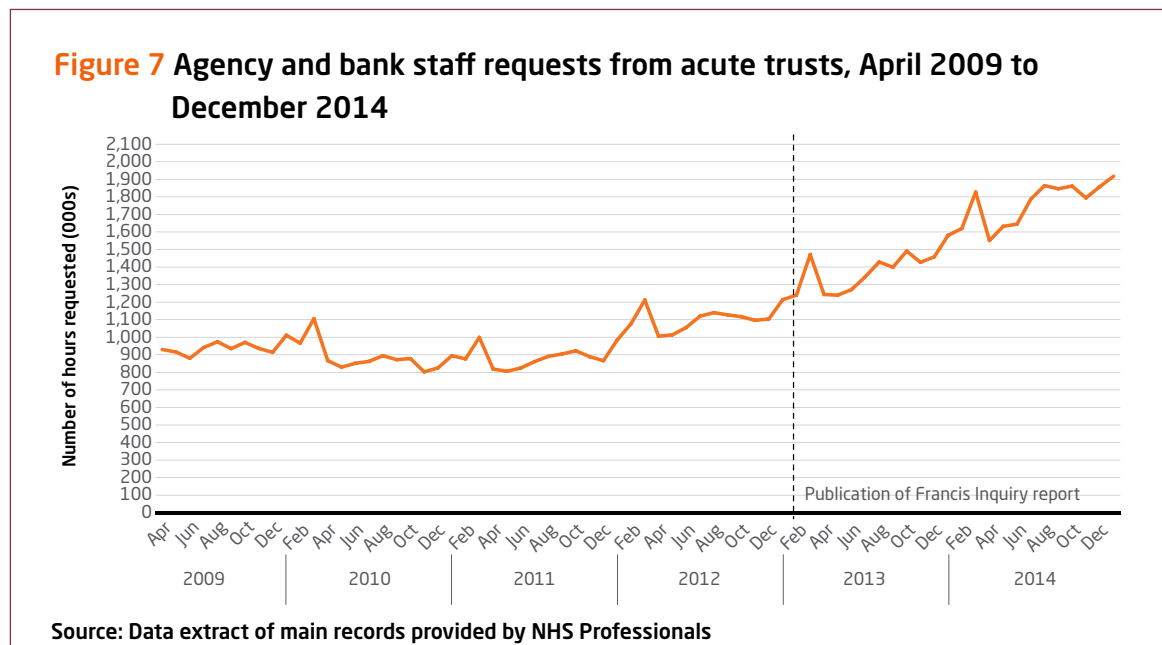

Figure 7 Agency and bank staff requests from acute trusts, April 2009 to December 2014

Source: Data extract of main records provided by NHS Professionals

Figure 7 shows the total hours requested[3] by acute trusts for agency and bank staff between April 2009 and January 2015. It is clear that demand for agency and bank

3 A 'request' does not necessarily mean that NHS Professionals was able to fill the shift.

staff increased considerably following the Francis Inquiry report (**Mid Staffordshire NHS Foundation Trust Public Inquiry 2013**). However, it can also be seen that the trend started before Francis; overall, the number of agency hours requested from NHS Professionals has more than doubled from 930,000 in April 2012 to 1,917,000 in January 2015. This trend does not seem to be slowing; this suggests that there are serious continuing problems with staffing levels, which trusts are solving by using temporary nursing staff in the absence of sufficient permanent workers. This supports anecdotal evidence that acute trusts are heavily reliant on temporary clinical staff. The number of trusts requesting temporary shift cover is also increasing, which may indicate that these nursing shortages are becoming more widespread. As HSCIC workforce data excludes agency staff, it also means that the increase in nurses in the acute sector is underestimated if we look at the permanent workforce alone.

In addition to the higher financial cost of agency staff, which has already been discussed, there are indications that overuse of agency staff can reduce quality and continuity of care. The relatively high use of temporary nursing staff was highlighted as a potential factor in poor quality care by the Keogh Review of 14 hospitals with high Hospital Standardised Mortality Ratios (**Keogh 2013**). One review found that using temporary nurses places extra demands on the time of permanent nurses, that they are less likely to be given inductions, their performance is less likely to be assessed and they can have a negative impact on continuity of care (**Mercer** *et al* **2010**). The same review found that the limited research available suggests a negative relationship between use of temporary staff and quality of care, but that contextual factors must be taken into account. While there is a clear argument for using some agency nurse capacity to cover unplanned absences and vacancies, and to meet unexpected spikes in demand, an increasing reliance on temporary staff to fill permanent posts raises concerns for financial as well as quality reasons.

In interviews and survey data collected by The King's Fund over recent months, many providers have expressed concerns over their reliance on agency staff and their ability to recruit in general.

- Many expressed doubts over their ability to recruit more permanent staff, though this was clearly the preferred option.

- For some, this did not represent a desire to increase the number of funded ward staff. Instead, recruitment was planned to fill funded vacancies and reduce the use of both agency and bank staff.

- Others noted concerns over the impact of further recruitment on other employers. These included concerns that their 'recruitment was only taking staff from other NHS organisations; that there was evidence of 'poaching' staff; and that some were already aware of worse staffing problems in other key local providers (eg, an acute trust was aware that its local community providers were suffering).

As we have seen, the trend towards higher demand for agency staff also appears to have subsequently spread to mental health service providers. In addition, the underlying demand for more nurses in acute hospitals was also identified by some stakeholders as creating recruitment challenges in community services. Yet these difficulties raise more systemic issues about oversight of the workforce.

- The increase in requests for agency staff appears to have begun in 2012 and continued, taking place alongside increases in the permanent nursing workforce. This has been reinforced (implicitly or explicitly) by the actions of national regulators looking to improve quality of care by raising nurse staffing ratios in acute hospitals. However, on aggregate, the acute sector has looked to recruit more permanent nurses than were available in England, leading to the surge in spending on agency staff. Stronger national oversight of the existing workforce, alongside Health Education England's actions to provide the future workforce, might have been able to avoid or ameliorate this outcome.

- The increase in acute sector nurses has been justified on the grounds of improving quality of care, and represents a positive step in recognising that sufficient, motivated and well-trained staff are needed to deliver better care. However, focusing on the acute sector alone risks disadvantaging mental health and community services, which again supports the argument for a clearer national workforce strategy that covers all NHS-commissioned services.

As the wider UK economy continues to recover, there is a risk that the current difficulties in recruiting permanent staff will grow as the range of alternative career options open to health service staff increases. This is arguably already apparent in some parts of the country, which we discuss in the next section.

Geographical variations

Addressing workforce challenges and pressures requires a robust understanding of regional differences and their underlying causes – not least because the evidence tells us that professionals overwhelmingly tend to stay in the region in which they trained (Department of Health 2014).

Regional workforce variations can be highly significant. For instance, the North East reports the lowest nursing vacancy rates and highest consultant physician vacancy rates. Trusts in London report high vacancy rates for nurses but low rates for consultants (Royal College of Physicians 2014; NHS Employers 2014). These differences might be partly explained by pay scales and the differential cost of living across the country, in conjunction with limited workforce mobility.

A recent NHS Employers survey of provider organisations highlighted variations across the nursing workforce. While the data is incomplete, with relatively low response rates in some regions, the survey is the best estimate of up-to-date vacancy rates. The 104 trusts that responded (43 per cent) reported an overall vacancy rate of 10 per cent. Trusts in London reported the highest vacancy rates – 14 per cent in north, central and east London and 18 per cent in south London. In contrast, trusts in the north east of England and Wessex had the lowest vacancy rates (6 and 7 per cent respectively) (NHS Employers 2014).

There are also regional variations in the challenges facing the medical workforce. London's persisting problems recruiting nurses do not seem to be apparent in medicine – at least for consultant physicians. Most doctors train in London, where there are also greater opportunities for private practice. No consultant physician post adverts were cancelled in London in the first half of 2014, according to the Royal College of Physicians (RCP) (2014), but other regions had relatively high cancellation rates, suggesting that the posts could not be filled. Regions that found it difficult to fill consultant physician posts included the North East, North West, Kent, Surrey, Sussex and the South West.

1 2 **3** 4 5

3 How have workforce issues been addressed so far?

At the national level

Structural and policy changes to education and training

Prior to the Health and Social Care Act 2012, the Secretary of State's education and training functions were largely delegated to 10 strategic health authorities (SHAs). Funding arrangements were based on historical flows rather than actual costs of provision or consideration of future workforce configurations. Furthermore, the workforce budget at SHA level was not ring-fenced, and there is a widespread view that the training budget was often used for other purposes. There were concerns that the system was too heavily focused on medical workforce development and not responsive enough to changing work patterns. It was therefore not considering future or adaptive workforce training needs, and providers and staff were not fully involved in workforce development.

The Act abolished SHAs and established Health Education England, comprising a national board and 13 regional local education and training boards (LETBs). This structure was designed to allow workforce planning and commissioning on a national scale while being responsive to local needs and changing workforce requirements. Health Education England has an annual, ring-fenced training budget of £5 billion. The 13 LETBs took over most of the SHAs' tasks but seek greater provider and clinician input; trusts are required to provide forecasts of workforce needs (numbers and skills). The postgraduate deaneries now sit within the LETB structure. Contracting for education and training has moved to a tariff-based system to enable national consistency in the funding of all clinical placements (both medical and non-medical) and postgraduate medical programmes.

Health Education England's stated approach is that workforce planning should ensure that the right people, with the right skills, are meeting patient needs in the most appropriate settings. For the first time, there is a body tasked with making strategic decisions about workforce planning at local and national levels. It pursues this more coherent approach by interrogating and testing LETB plans, collating inputs from national workforce advisory groups, strategic advisory groups and patient advisory groups, and other stakeholders such as Monitor, the Care Quality Commission and the Council of Deans of Health. In 2014, its annual 'call for evidence' received more than 70 submissions from medical colleges, physician and nursing organisations, the Centre for Workforce Intelligence and other national stakeholders. We have already given one example of how it uses this information: on the basis of a wider range of intelligence Health Education England recently rejected advice from mental health trusts that they did not require additional mental health nurses (Health Education England 2015).

Return to practice

Health Education England's remit covers the workforce of the future, recognising that training new staff in health services takes years, not months. In the more immediate term, return to practice schemes can offer a quicker way to boost workforce numbers.

In 2015/16, Health Education England allocated £200 million to retraining the current qualified workforce to return to practice. This represents a huge increase on previous years – up from £1.5 million in 2014/15, which funded 90 courses, yielding 779 returning nurses. Most of the 2015/16 retraining budget has been set aside for return-to-practice schemes with the RCN, targeting nurses who had left the workforce for retirement or career breaks. These schemes (which generally take three months) are a much quicker and more cost-effective strategy for increasing the nursing supply than creating new training posts – it costs £2,000 (on average) to train a nurse to return to practice compared with around £51,000 to train a new nurse (Health Education England 2015).

Medical colleges have recently focused on strategies to allow doctors to return to practice. While some areas of medicine (such as surgery) do not lend themselves to this, the RCGP is considering more flexible strategies for allowing GPs to return to practice after periods of absence, alongside appraisal and revalidation

routes. As with nurses, training a GP to return to practice is much cheaper than commissioning a new training place. Optional GP induction and refresher schemes run by LETBs take between three and six months to complete. In 2012, one deanery estimated it would spend £7,900 returning one GP to practice through a supervised full-time paid placement as a GP. In contrast, the BMA estimates that each new GP receives £381,000 worth of training before qualification (**Jaques 2013**). While relatively few GPs have re-entered the workforce through this route, Health Education England and NHS England have now announced new targeted investment for 2015/16 to subsidise the costs to LETBs of retraining and employing GPs who want to return to practice.

At the local level

It is, of course, individual employers who decide how to configure their workforce to meet the service requirements set by commissioners and the quality standards set by regulators and others. Foundation trusts also have the flexibility to modify pay scales and other benefits to attract staff, although in practice few have chosen to do so.

Employers have a critical role in ensuring that they have sufficient numbers of high-quality staff. However, there is no magic bullet solution to address more immediate workforce challenges at a local level. Rather, providers will need to consider a range of strategies – individually and in partnership with others within their local health economy. National agencies, such as NHS Providers and NHS Employers, can act as a bridge between national policy and local systems, sharing intelligence and operating networks for trusts and other employers to share successful strategies.

Boards have a responsibility for ensuring that their organisation is a good employer, in terms of reputation and organisational culture. Providers should not only see their staff as a cost, but also as a valuable resource, and the board needs a narrative and strategy that harness that value. The board and wider organisation should have a plan for addressing immediate and long-term workforce pressures, which goes beyond reactive responses to think more broadly about appreciating and supporting the existing workforce – as this will be the workforce delivering care into the future. Providers should consider the health of their own workforce, providing (or providing access to) occupational health and other therapies to support staff to remain healthy and avoid sickness absence.

Here we look at some of the tools employers can use to recruit, retain and retrain their staff.

Recruitment

Recruitment is perhaps the most obvious route for trusts trying to address current workforce pressures, and one common option is to recruit from abroad. A recent investigation by the *Health Service Journal* found that 5,788 nurses were recruited from overseas countries between September 2013 and September 2014. During this period, nearly three-quarters of trusts are estimated to have undertaken overseas recruitment rounds (Lintern 2014). Most nurses came from Spain, Portugal and the Philippines.

While international recruitment can help fill gaps, it is not a panacea for NHS staff shortages. As organisations run their own recruitment rounds, it is perhaps not surprising that staff shortages have also led to competition between trusts for scarce resources. An investigation by the *Nursing Times* (Merrifield 2015) found that, on average, 17 per cent of international nursing recruits leave the trust within the first two years of employment – with some reporting that none of the international recruits were still employed there. While some of these individuals return to their home country, others are reported to be attracted to transfer to different trusts on arrival – providers with better reputations, or in a more desirable geographical location. This would suggest the need for a more co-ordinated approach to international recruitment. Such co-ordination might be an opportunity to mitigate the risk of attrition of international recruits, where providers can instead work collaboratively to recruit staff for the local system and then support and embed this new workforce (and their families) in the community. Furthermore, some providers are already working together across local health systems to co-ordinate their approach to agency staff – collectively setting prices and procuring a single preferred provider.

Retention

Retention efforts have largely concentrated on the medical workforce. In recent years, professional bodies have been leading efforts to reduce the number of medical staff who leave practice, principally by improving job satisfaction and benefits packages.

To give an example, one particular specialty – emergency medicine – has been marked by high vacancy rates in training, considered unattractive to trainees due to high and increasing levels of demand. Professional bodies have tried to address this by reforming the training process and other interventions to improve the work–life balance, provide more support and promote greater career development. These efforts have helped the Royal College of Emergency Medicine and Health Education England reduce the proportion of unfilled training posts from around 40 per cent before 2014 to 2 per cent last year (Health Education England 2015).

The latest National GP Worklife Survey conducted in 2012 (Hann *et al* 2013) found that an increased proportion of GPs under 50 (8.9 per cent) are planning to stop practising in the near future, as are the highest ever number of those over 50s (54.1 per cent). A recent BMA survey of GPs found that a third (34 per cent) hopes to retire in the next five years (ICM Unlimited 2015) prompting the profession to explore ways to retain experienced GPs in the workforce. One element of the New Deal for General Practice announced by NHS England, Health Education England, the RCGP and the BMA in January 2015 was the creation of a scheme to encourage GPs considering career breaks or retirement to continue working part-time (NHS England *et al* 2015). This scheme will be piloted in areas experiencing the most severe problems recruiting GPs.

Retention of existing staff allows for greater continuity of care and reduces reliance on bank and agency staff, improving the quality of care and addressing escalating staff costs. Providers need to consider the reputation of their organisation as an employer and as a place to work, in order to create a climate that will attract and retain staff. This partly relates to terms and conditions – not just pay, but also pensions and other non-pay benefits. Providers might want to consider how they can optimise existing terms and conditions and take advantage of existing flexibilities in creative ways, such as flexible retirement policies. Or providers might adopt other approaches around working patterns to allow more part-time work and support returners back into the workforce. Additionally, providers can consider improving retention through addressing staff engagement and organisational development. NHS Employers and the NHS Leadership Academy both offer case studies and other resources to support providers in these areas.

Health Education England's 2014 review of nursing retention strategies resulted in a suite of recommendations mostly aimed at providers to help them develop effective

retention strategies. They include developing nurse leadership, providing more flexible shift options, aligning patient mix and staffing, providing mentorship and professional development, implementing performance-related rewards, offering flexible retirement options and developing staff engagement activities. The review highlighted investing in improved nursing environments as the key strategy, but advised implementing several recommendations, depending on the context, for maximum impact.

Retraining

Providers could also think of their workforce model more imaginatively, considering hybrid roles, diversity of expertise and new posts to establish a multidisciplinary skill-mix that matches the needs of the service into the future. For instance, some providers are increasingly developing physician associate (or physician assistant) roles in accident and emergency, primary care organisations and other settings to supplement the skills of nurses and junior doctors. These more imaginative approaches allow providers to use the skills they have within their organisation differently, to add value and deliver care in more adaptive ways. Providers might need support in developing these new roles, clarifying future career paths and establishing appropriate resources for development.

Retraining has traditionally been the remit of individual providers, with limited input or leadership from national bodies. At present, there is very little opportunity for retraining within medicine, yet the changing care needs of the population demand a more flexible and adaptable clinical workforce. The Shape of Training review recommended that retraining programmes should recognise existing qualifications, thus shortening the time it takes to retrain staff (Greenaway 2013). Retraining the current medical and nursing workforce could be simplified even further through a more comprehensive assessment of skill-mix. This can include current initiatives to relieve pressure on the GP workforce by using pharmacists for medicines management or review, or greater involvement of allied health professionals in the management of patients with long-term or chronic conditions such as musculoskeletal disorders.

Some providers have also taken closer control over training clinical staff in their region. Lancashire Teaching Hospitals NHS Trust has signed an agreement with the University of Bolton to train its own nurses, who are then guaranteed a job at

the trust on successful completion of their degree. There is no Health Education England funding attached to these training commissions. Students are self-funding and support themselves, as they would on other non-clinical degree programmes. When they finish their degree, students are free to take a job at other trusts, but Lancashire Teaching Hospitals NHS Trust can mitigate this risk by strengthening its organisational culture to make it a desirable place to work.

Providers working together

For the future, as well as potentially co-operating on international recruitment, providers could also come together across local health systems (possibly with the support of their LETB) to develop a more co-operative approach to both clinical education and workforce planning. A collaborative approach would allow providers across the system to develop shared roles and deploy staff in different ways, where staff have a more flexible range of transferable skills to work across different care settings. This can be supported by enhanced information technology (especially for rotas), while creating flexibility in the local workforce to adapt to changing demands.

④ Challenges

Balancing national and local planning

The complexity of the health care workforce, the long lead times in training new staff and the need to provide care now to those that need it – all within the cash-limited, tax-funded NHS – mean that workforce planning is an essential function. The 2012 reforms created a new structure for planning the future workforce, built around Health Education England. However, given the lead times in training new staff, it will be years before the NHS feels the impact of this new approach to planning, at least in terms of a transformed workforce. But the new approach does offer real opportunities. In April 2015, Health Education England will have been operational for two years; alongside the Forward View, it can provide greater clarity about system objectives, with a new opportunity to align strategy with future workforce planning and address the historical disconnects between workforce planning and service strategy. However, its remit is to commission training numbers for the future; its statutory responsibilities do not include responding to immediate workforce pressures or directly supporting providers to address workforce gaps. Although it is undertaking some initiatives to ease immediate pressures – particularly in nursing – this is not its enduring function. Indeed, at a national level, there is no institution that has clear responsibility for overseeing the current workforce, and this has led to a piecemeal approach to addressing the pressures that have arisen.

Oversight of the current workforce is devolved to individual organisations, working with NHS Employers and others. As essential as good employment practices are to ensure that the NHS does all it can to retain and retrain its workforce, there are limits to this localist approach. As some interviewees noted, successful recruitment campaigns by individual organisations can come at the expense of other organisations delivering NHS services, and retention schemes may also reduce the pool of potential recruits for other organisations. From an NHS-wide perspective, a local and regional approach combined could help to:

- ensure that as many staff as possible can, and want to, work within the NHS out of the total pool of available qualified staff; among other things, this means ensuring that there is strong staff engagement and that job redesign occurs where necessary

- draw on international recruitment where necessary, ideally working together to maximise the benefit of additional staff

- review skill-mix and the need for retraining to maximise the full range of existing and potential skills of staff.

Health Education England's remit on the workforce of the future, combined with the primarily local approach to the current workforce, has left substantial gaps. The lessons from mental health, primary and community services as well as the recent surge in agency costs all point to wider difficulties in workforce planning. In particular, the lack of a clear national assessment of current workforce demand and supply, backed up by appropriate national measures to increase supply where necessary, has contributed to current difficulties. For example, the response to the Francis Inquiry has been a welcome focus on quality of care; yet this has also led to a recruitment round for acute sector nurses that exceeded the number of qualified nurses willing to work in the NHS. In turn, this has led to an unaffordable surge in agency staffing and possibly drawn staff away from other sectors. A more planned approach would have looked to balance retention, return-to-practice and international recruitment, helping to ensure that sufficient nurses were available. Instead of such proactive planning, actions by national bodies have tended to be reactive, responding to problems after they have arisen. Recent efforts to raise GP numbers and reduce the pressure on primary care are welcome, but have come late in the day.

In addition, the long-term strategic goals to increase services available in primary and community settings and to raise the standard of mental health services do not appear to have translated into the workforce, at least in comparison with the level of ambition. This is in sharp contrast to the continued sustained growth in the number of hospital consultants and the recent growth in acute nursing.

Data gaps

Our analysis has demonstrated that there are substantial gaps in the available data on workforce numbers, measures of demand and workload, and estimates of the workforce numbers required to address this demand. These gaps are particularly pronounced in four key areas.

- **Primary and community care** There are systematic problems in the collection of reliable workforce data in community and primary care. These gaps have also been highlighted in other analyses (Dayan *et al* 2014). In addition, there is little robust information regarding the quality of services being provided outside the acute sector, so we cannot make any quantitative judgements about whether the changes seen in the general practice, community and mental health workforce have had an effect on quality of care.

- **Agency and bank staff** The HSCIC data set does not include information on staff employed by agencies. Here we have presented a snapshot from a single agency provider. We do not have a comprehensive picture of the full extent of the temporary clinical workforce delivering NHS-commissioned care.

- **Vacancy rates** We also have limited data on vacancy rates and the understanding they can provide of the balance between supply and demand. There is also no comprehensive independent information on the recruitment efforts of providers, which would have allowed us (and workforce planners and commissioners) to create reliable estimates of the effort and cost involved in advertising and recruiting staff.

- **Independent and voluntary sector providers** The HSCIC dataset excludes many (but not all) staff within the independent sector. HSCIC data includes some information from independent sector providers, but it is unclear which providers are included and how many of their staff, and whether the coverage changes over time. Given the impact of Transforming Community Services and the subsequent 'any willing provider' policy on shifting staff into the independent sector, the lack of consistently available workforce data in this area is a significant omission. Anecdotally at least, some independent sector providers appear to be facing exactly the same recruitment challenges as NHS organisations.

Alongside HSCIC data, national bodies and professional bodies rely on survey and census data, commissioned research, Freedom of Information requests, 'advice' and anecdotes. These all help create a fuller picture of the current workforce. However important these may be, the gaps in timely, routine data sources are likely to have contributed to the current difficulties in workforce planning, because some emerging issues – such as the rise in spending on agency staff and shortage of GPs – only become visible once they have become a major problem.

5 Conclusion

The NHS, like every health care system, is a service industry. This means that it is vitally dependent on its staff, indeed, for the public, the NHS is often indistinguishable from the doctors, nurses and other professionals who work within it.

Workforce planning is important because of the complex skill-mix required at local and national levels. We need a workforce that is fit for purpose, able to adapt to changing demographics and the new care models outlined in the Forward View – a workforce aligned to the work and models of care, rather than the other way round. As Imison and Bohmer (**2013**, p 4) state: 'It is not possible to separate workforce redesign from work redesign.' This is not to suggest that planning the future workforce is easy. Given anxieties about potential oversupply of expensive clinical staff, building a more flexible workforce with a breadth of skills and knowledge allows for greater adaptability. Health Education England's long-term approach to workforce planning pays closer attention to the role of generalists in meeting the health and care needs of patients in the future. This requires a new approach to training, with support for adaptation from providers, commissioners and professional bodies and fundamental changes to professional regulation and incentives, where care is delivered in teams based around the patient rather than in professional silos.

Although it is vital to get the workforce of the future right, in the main, the clinical workforce of 2020 is the one we have in 2015. This means that for the Forward View – just as for any strategy that looks to make major changes to services before new staff can be trained in substantial numbers – there needs to be a clear plan of how the current workforce can meet the challenges ahead. Part of this responsibility lies with individual organisations and their boards to ensure that they learn from best practice, whether on retention, retraining or changing skill-mix. It also requires employers to be clear about the extent to which affordability has influenced their estimates of future workforce so the system can understand where it is taking risks.

This report has focused on recent workforce trends in the key areas of mental health, primary care and community services, and has also considered experience with

the rising use of temporary staff and regional variations. These are all important areas, both for current performance but also for the new models of care set out in the Forward View. However, experience in these areas indicates the need for a more joined-up approach to overseeing and managing the current workforce to overcome the difficulties that exist. This requires a number of changes at national level to support providers as they develop strategies locally and across health systems.

First, the information available on the composition of the workforce has not kept pace with the changes in the NHS. The lack of data on the independent sector has become more problematic as it has come to play an increasingly important role in providing mental health and community services, and this also poses a problem for Health Education England when planning for the long-term workforce needs of NHS-commissioned care. The lack of national data on the use of temporary staff and on vacancy rates has also become more critical as shortages have appeared and left policy-makers responding to, rather than proactively avoiding, workforce difficulties.

Second, while Health Education England is responsible for training the workforce of the future, it is less clear who is responsible for managing and recruiting the workforce that is needed today. While most workforce issues are, of course, best left to individual employers, where there is evidence of widespread difficulties at national level it will be difficult for any one employer to take effective action. Whether in relation to return-to-practice campaigns, international recruitment or measures to increase the attractiveness of key professional groups, there is a case for co-ordinated national leadership to ensure that best practice is easily accessible across the NHS. NHS Employers, Health Education England, NHS England and others have all taken on elements of this role, sometimes operating outside their statutory responsibilities. However, this was clearly not enough to prevent the deep recruitment difficulties we are now witnessing in general practice and nursing, among other sectors. Just as the national bodies came together in the Forward View to provide a single perspective on the changes needed, they need to provide the same leadership to address the resulting changes to the workforce.

Third, creating clearer national leadership over the current workforce needs to be based on a robust assessment of the current state of supply and demand. It is striking that in limited areas where a specific national target applies (such as for health visitors), the centre takes a clear and strong role in managing the workforce,

but this does not extend to most other areas. Stronger oversight should avoid placing demands on the workforce that cannot be met, but also needs to ensure that where there are national opportunities to rebalance supply and demand, support is available so that those opportunities can be taken up. This will include new roles for professional groups such as pharmacists in primary care, but should extend across the available workforce. For the time horizon of the Forward View, this means making the most of the staff that are already available.

Fourth, such an approach would also need to ensure greater consistency between national strategy and the workforce. Health Education England can only make trained and qualified staff available to the NHS; it is employers and commissioners that make jobs for those staff available. While the major increase in the surgical consultant workforce in the previous decade was arguably consistent with the target to reduce NHS waiting times, it is striking that repeated aspirations to enhance services in mental health and in the primary and community sectors do not seem to have had the same effect. National and local decisions have not provided the resources to employers to expand their workforce in these areas. This is still noticeable today: Health Education England's work with employers in mental health found that they expected to need fewer mental health nursing staff, although Health Education England ultimately commissioned more training places.

Ensuring greater consistency between national strategy and the available workforce will entail tackling difficult questions of affordability. The NHS has already been through a period of sustained low growth and even the financial forecasts contained in the Forward View suggest only around 1.5 per cent real-terms growth to 2020. With pay overwhelmingly the biggest element of NHS costs, it is not credible for such low growth to sustain any rapid increase in the NHS workforce. Indeed, as the pay freeze weakens, the service may not be able to afford any growth at all. This may explain why Health Education England found employers forecasting such low workforce numbers up until 2019. The risks here are twofold: first, that if demand for health care continues to grow, the workforce will be insufficient to meet it (setting aside affordability), and this may argue for allowing some oversupply; second, that in such a scenario, by default the NHS risks continuing to favour the acute sector over the mental health and community sectors. However, this means it would fail to make the transformative changes needed for its long-term sustainability.

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About the authors

Rachael Addicott has been a senior research fellow at The King's Fund since 2007, where her portfolio includes research on system reform and models of governance and accountability in UK health care, including work on contracting, regulation and integrated care.

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David is a health economics graduate from the University of York, with particular expertise in data analysis, statistical inference and quantitative analysis within health and care.

Before joining The King's Fund, David worked as a graduate intern with the South Eastern Health and Social Care Trust in Northern Ireland. He worked in several areas across an integrated care system and advised on health economics, as well as quantitative evaluation techniques for pilot public health and social care schemes. Previously, he worked with researchers at University College Dublin to establish the value for money generated by a nutritional intervention for pregnant women.

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Previously, Joni worked at the Royal College of Physicians, focusing on the impact of the NHS reforms, developing new models of urgent and emergency care services, and leading the RCP's public health work streams. She has also worked as a senior policy executive at the British Medical Association.

Joni has a particular interest in incentives and behavioural outcomes in health care settings, researching the intrinsic motivation of junior doctors in England. She has also published work on the commissioning structures in the new NHS and on the development of urgent and emergency care services for the future.

She has an MSc in Comparative Social Policy from the University of Oxford.

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Matthew's recent work includes projects on reconfigurations, specialist care in out-of-hospital settings and the future of acute hospitals. He also has an interest in the relationship between health care, public policy and digital technology.

Before joining The King's Fund, Matthew worked at the Innovation Unit, a social enterprise that works with public services to reshape the services they deliver. He was involved in researching and co-ordinating projects across health, education and local government. These projects included running a national, randomised-controlled trial of project-based learning, an innovative teaching method, and co-ordinating a local summit for the Lambeth Health and Wellbeing Board.

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The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

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Ideas that change health care

The NHS workforce – the doctors, nurses and many other professionals that care for patients day in, day out – is at the front line of the challenges facing the health system. But how can the service respond to immediate needs and financial pressures while enabling its staff to adapt and deliver the future care models that people want? *Workforce planning in the NHS* uses national statistics, key publications and insights from expert interviews to consider workforce issues in three key areas: mental health, general practice and community nursing. This analysis is presented alongside data that highlights providers' reliance on agency staff.

The report concludes that:

- lack of national data on key trends (such as use of temporary staff and vacancy rates) and from non-NHS providers (independent and voluntary sector) needs to be addressed

- there needs to be more co-ordinated national leadership to ensure that best practice (whether on return-to-practice schemes, overseas recruitment or making key professions more attractive) is widely shared

- workforce strategies should be based on a robust assessment of the current state of supply and demand, considered alongside the ambitions of future care models

- difficult questions around affordability must be tackled to ensure greater consistency between national strategy and the available workforce.

The report highlights the need for a more joined-up approach to overseeing and managing the current workforce to overcome the difficulties that exist and ensure that there is sufficient capacity and an appropriate skill mix to deliver on the aspirations of the *NHS five year forward view*. But this will require changes at a national level to support providers as they develop strategies locally and across health systems.

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